A Mixed Methods Approach Investigating Cognitive Changes in Vicarious Trauma within Trainees and Qualified Therapists

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Thesis Abstract

Background: Previous research has explored the impacts of empathically engaging with client trauma accounts on therapists. The majority of this has been quantitative, guided by measures of secondary traumatic stress symptoms or belief-disruptions consistent with Constructivist Self-Development Theory (CSDT). Results have been inconsistent and interpretation is affected by methodological shortcomings. There have also been differences in findings between qualitative and quantitative approaches. Whilst most quantitative measures focus on the negative impacts of trauma work, qualitative studies have revealed the presence of positive impacts; referred to as vicarious posttraumatic growth. A review of previous literature, addressing their methodological limitations, is presented.

Aims: This study had four aims. The first was to explore the occurrence of the five belief areas, consistent with CSDT (trust, safety, esteem, control, intimacy), within qualitative evidence. The second was to measure implicit constructions of participants' belief systems to determine whether they constructed themselves as more similar to a client struggling with trauma. The third was to triangulate qualitative findings with quantitative measures widely used in the vicarious trauma literature to determine whether there is consistency in results. The final aim (presented in the extended paper only) was to use an inductive analysis to explore any areas of importance in participant accounts that were not covered by CSDT.

Methodology: Participants were 10 Trainee Clinical Psychologists and 10 Qualified Mental Health Professionals working for the National Health Service (Clinical Psychologists, Social worker, Psychiatrist & Psychiatric Nurse). They were recruited using purposive sampling from three Doctoral courses and two NHS trusts. Repertory grids were followed by semi-structured interviews exploring trauma work experiences. Psychometrics, including a measure of belief disruption, Trauma and Attachment Beliefs Scale (TABS), were completed at the end of the interviews.

Principal Findings: Directive content analysis revealed evidence for all CSDT belief-areas, although some were more frequently identified than others. Positive and negative beliefs co-occurred, suggesting vicarious trauma and vicarious posttraumatic growth can occur in parallel, for both trainee and qualified therapists. Some differences between groups are discussed. Repertory grids suggested both groups construed themselves as least similar to clients struggling with trauma and more similar to clients experiencing posttraumatic growth. Data triangulation revealed some inconsistencies between the TABS and qualitative data. This may be due to the TABS using global statements, whereas qualitative data address specific examples and contexts that the beliefs related to. Finally, the inductive thematic analysis revealed two super-themes: impact and active coping. Participants acknowledged the negative impacts of trauma work but often related this to a process of normalisation, accepting that this was part of their role, which helped them deal with this.

Conclusions & Clinical Implications: The finding that positive and negative beliefs can co-occur, as well as the inconsistencies between qualitative and quantitative data, has implications for measures like the TABS which focus only on negative impacts of trauma work. This study is exploratory, and the first to compare British trainees and qualified therapists, therefore further research is required to determine the relevance of these findings. A critical reflection of the research process is provided.

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Statement of Contribution

Project Design

Emma Millard (supervised by Rachel Sabin-Farrell and Thomas Schröder)

Application for Ethical Approval

Emma Millard (supervised by Rachel Sabin-Farrell and Thomas Schröder)

Literature Review

Emma Millard (supervised by Rachel Sabin-Farrell and Thomas Schröder)

Participant Recruitment

Emma Millard designed the recruitment process. Rachel Sabin-Farrell, Alison Smith (Nottinghamshire Healthcare NHS Trust) and Graham Evans (Lincolnshire Partnership NHS Foundation Trust) assisted with advertising recruitment.

Data Collection

Emma Millard

Transcription

Emma Millard

Data Analysis

Emma Millard (supervised by Rachel Sabin-Farrell and Thomas Schröder)

Write-up

Emma Millard (supervised by Rachel Sabin-Farrell and Thomas Schröder)

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A Mixed Methods Approach Investigating Cognitive Changes in Vicarious Trauma within Trainees and Qualified Therapists

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Abstract

Vicarious trauma is a widely accepted phenomenon within trauma work, grounded in constructivist self-development theory. However, inconsistent findings particularly between qualitative and quantitative designs, and lack of British samples, especially with Trainee Clinical Psychologists, has led some to argue this acceptance is premature. Therefore, the aims of this exploratory study were threefold: to explore the occurrence of the CSDT belief-areas: esteem, intimacy, control, safety and trust in Trainee Clinical Psychologists' and Qualified Therapists' experiences of trauma work; use repertory grids to explore how similarly participants construe themselves to clients who have experienced trauma; and triangulate qualitative and quantitative data to explore any inconsistencies within the same sample. Ten trainees and ten qualified therapists completed a semi-structured interview, repertory grid and psychometric measures including the Trauma and Attachment Beliefs Scale (TABS). Directive content analysis revealed evidence for all CSDT belief-areas, although some were more frequently identified than others. Positive and negative beliefs co-occurred, suggesting vicarious trauma and vicarious posttraumatic growth can occur in parallel, for both trainee and qualified therapists. Some differences between groups were revealed. Repertory grids suggested both groups construed themselves as least similar to clients struggling with trauma and more similar to those experiencing posttraumatic growth. Triangulation revealed some inconsistencies with the TABS. This has implications for the development of quantitative measures of the impact of trauma work on therapists. Further research with larger samples is required.

Keywords: *vicarious trauma, vicarious posttraumatic growth, repertory grids, secondary traumatic stress, trainee clinical psychologists, constructivist self-development theory*

Background

(see Extended Paper for additional information)

In the last 25 years, evidence has emerged on how trauma work impacts therapists. Effects of indirect exposure to trauma through engaging with client narratives of their traumatic experiences has been referred to using several different terms, including Vicarious Trauma (VT), Secondary Traumatic Stress (STS), Compassion Fatigue and Burnout (Sabin-Farrell & Turpin, 2003). There are some conceptual differences between these terms, but often they are used interchangeably, making interpreting evidence difficult (Najjar, Davis, Beck-Coon & Doebbeling, 2009). STS focusses on development of symptoms within therapists that parallel those of clients with traumatic experiences, including hyperarousal and avoidance (Figley, 1995). Compassion fatigue arguably refers to the same collection of symptoms, resulting from engaging empathically with client trauma (Bride, Radey & Figley, 2007). Burnout is more general and can be applied to trauma work and other professions, again focussing on the negative symptoms therapists can experience (Maslach, 1982).

VT goes further than these terms, suggesting cumulative exposure to client trauma causes negative impacts for the therapist (McCann & Pearlman, 1990). It is rooted in Constructivist Self-Development Theory (CSDT); negative changes to inner experience include worldview, ego resources, spirituality, identity, ability to relate to others and central psychological needs (McCann & Pearlman, 1992). The five psychological needs are beliefs corresponding to self and other in control, esteem, intimacy, trust and safety. Symptomatic changes, similar to those described by the other terms, are also thought to occur as a result of these changes in the way therapists view their world, including hyperarousal, agitation and sleeplessness (Pearlman & Saakvitne, 1995).

CSDT offers a cognitive explanation for how client trauma becomes incorporated into therapists' belief-systems. Schemas are cognitive structures which develop based on people's experiences, forming beliefs and expectations about the self, others and the world. Schemas are used to interpret future events, and information from new experiences is assimilated into existing

schemas if it fits with existing expectations. However, information that clashes with expectations and previous experiences may lead to schema-disruptions (Janoff-Bulman, 1992). This occurs through accommodation, whereby conflicting experiences are used to update and alter previous schemas. Client trauma may conflict with therapists' existing schemas. Therefore, schemas may shift to accommodate this information, usually in a negative way, resulting in distress (McCann & Pearlman, 1990).

Personal construct theory offers an explanation of posttraumatic stress disorder (Sewell *et al.,* 1996), which may be useful in understanding VT. Personal construct theory suggests people make sense of events based on past experiences. These are formed as dichotomous constructs which help them predict future events (Kelly, 1955). If predictions are validated, these constructs remain unchanged. If they are invalidated by conflicting events, they may change and psychological distress may occur because of prediction failures (Kelly, 1955). Sewell (1997) suggested people are unable to make sense of trauma because it is beyond the range of convenience of their construct system, therefore construing of traumatic events tends to be under-elaborated. Trauma is isolated from the rest of their conceptual system. However, this model is speculative and limited research has been conducted into it, offering only partial support (Sermpezis & Winter, 2009). More recent research has found the opposite to the theory's predictions. Trauma is over-elaborated rather than under-elaborated, forming a reference point within the conceptual system which starts to have negative effects for the way individual's construe future events (Sermpezis & Winter 2009). This has some similarities to CSDT, both suggest trauma is made sense of in terms of existing beliefs and when trauma is incorporated into the belief-system this can have negative effects.

VT is thought to be cumulative, each client trauma therapists are exposed to reinforces negative schema disruptions. Therefore, more experience leads to greater VT (Trippany, White Kress & Wilcoxon, 2004). However, this view is challenged by disparate research findings. Some have found those with less experience display greater VT effects (Badger, Royse & Craig, 2008; Bober & Regehr, 2006; Kadambi & Truscott, 2003; Knight, 2010; Sprang, Clark & Whitt-

Woosley, 2007; Way *et al.,* 2004; Way, VanDeusen & Cottrell, 2007). Others found VT increased with more experience (Pearlman & Saakvitne, 1995). Trainee Clinical Psychologists are likely to have less experience of working with client trauma than qualified therapists. This lack of experience may increase vulnerability as demonstrated by some studies, or reduce it as hypothesised by CSDT, which suggests VT is based on cumulative exposure to client trauma. Exploring experiences of both groups is important in determining similarities and differences in VT related to clinical experience.

Exploring the effects of VT is important as it has only been previously researched once in British trainees, using quantitative methods (Makadia, Sabin-Farrell & Turpin, *in press*). They found evidence for STS symptoms, but no belief-disruption on the Trauma and Attachment Beliefs Scale (TABS). American Trainees with less experience were found to experience more disruption (Adams & Riggs, 2008) but only on one belief-subscale. VT has been linked to increased likelihood of professionals making poor professional judgements (Munroe, 1999; Pearlman & Saakvitne, 1995); increased anxiety, physical health problems and substance use (Stamm, Varra, Pearlman & Giller, 2002). These potential negative implications are likely to impact trainees' ability to practice so understanding the relevance of VT in this population is important.

Most existing research into VT belief-changes has been quantitative using psychometric measures like the Traumatic Stress Institute Belief Scale (Pearlman, 1996), later revised to the TABS (Pearlman, 2003). However, a review concluded evidence for belief change was inconsistent and inconclusive, with stronger evidence for symptoms consistent with STS (Sabin-Farrell & Turpin, 2003). Differences were noted in qualitative studies, demonstrating more evidence for belief-change (Sabin-Farrell & Turpin, 2003), however only four studies were reviewed. Later qualitative research demonstrated positive changes in therapists, consistent with vicarious posttraumatic growth (VPTG) (Arnold, Calhoun, Tedeschi & Cann, 2005). This included increased appreciation of life, human resilience, satisfaction from observing client growth, spirituality and personal development. Similar findings were found in later research, including amazement at the human spirit (Splevins *et al.,* 2010),

feeling lucky (Pistorius *et al.,* 2008) and increased value in their profession (Shamai & Ron, 2009). This can be explained by CSDT; exposure to client trauma challenges therapists' schemas, triggering cognitive processes. These includes positive accommodation whereby changes consistent with VPTG occur or negative accommodation whereby previous schemas become negative, causing distress (Joseph & Linley, 2008). The self is multi-faceted so therapists may experience no change in some schemas, positive and negative changes in others. Research shows positive and negative changes co-occur (Harrison & Westwood, 2009). A meta-synthesis suggested VT and VPTG are independent processes, leading to different outcomes for different schemas, arguing quantitative investigations treating them as mutually exclusive are limiting understanding of trauma work impacts. Therapists appeared to experience distress alongside VPTG, suggesting the two are not completely separate (Cohen & Collens, 2013).

Limitations of quantitative measures in exploring the full impact of trauma work, potentially missing the experiences of VPTG, as well as other methodological limitations warrant the use of qualitative methods. Combining methods within the same sample can identify any inconsistencies or areas missed by quantitative measures.

Aims

This study had three aims related to exploring the impact of trauma work in British Trainee Clinical Psychologists and Qualified Therapists. The first involved looking for belief-changes in the five CSDT areas within interview data. The second used repertory grids to explore implicit constructions of trauma work experiences in relation to various self and other-states. If VT affected participants, greater similarity would be expected between current-self constructions and a client struggling with trauma.

Finally, data was triangulated with psychometric measures to determine whether different methodologies demonstrate consistency. As the TABS, repertory grids and interviews all aim to measure VT, correlations were expected between results. Mixed methods were appropriate for this aim, as

previous research identified discrepancies between quantitative and qualitative results (Sabin-Farrell & Turpin, 2003).

Method

(see Extended Paper for additional information)

Epistemology

This study was rooted in critical realism, viewing reality as one unitary entity perceived differently by different people, so is unlikely to be measured purely. Therefore, the results are not considered to reflect 'true reality' but that which was co-constructed by participants and the researchers.

Participants

This study received ethical approval from Nottingham University Ethics Committee. Purposive sampling was used to recruit therapists working within the NHS between March and June 2016. Participants self-defined as 'trauma-therapists', fitting with this study's aims of exploring how therapists constructed their trauma work experiences. Qualified therapists were recruited from two National Health Service (NHS) trusts. Trainees were recruited from three Clinical Psychology Doctoral programmes. Heads of NHS services and Course Directors emailed study details to potential participants.

Participants were Trainee Clinical Psychologists or Qualified Psychological Therapists, allowing a range of professions chance to voice their experiences. The final sample included clinical psychologists, a nurse, psychiatrist and social worker. Participants were excluded if they did not speak English, were retired or did not perceive themselves to have recent trauma work experience.

Ten trainees and ten qualified therapists provided informed consent to participate. Mean age of trainees was 28.71 (Range = 26-32) and they were 100% female. Mean time per week doing trauma work was 4.6 hours (Range = 1-16). They were 80% Caucasian, 10% Hispanic and 10% Mixed-Race.

Mean age of qualified therapists was 36.56 (Range = 24-63) and they were 70% female. Mean time per week doing trauma work was 11.1 hours (Range =

4-35). Mean years practising was 8.3 (Range = 0.5-30). They were 80% Caucasian, 10% Asian and 10% Mixed-Race.

Procedure

Participants completed all three elements of the study in the same order, minimising bias. The first element was the repertory grid, followed by a semi-structured interview, exploring participants' trauma work experience. This interview style allowed coverage of areas relevant to research aims, whilst giving participants freedom to elaborate on areas of personal significance. A semi-structured interview schedule based on previous literature aimed to elicit both positive and negative elements of trauma work. Questions were kept broad, rather than asking about specific belief-areas, to avoid leading participant responses (a copy of this interview schedule is included in Appendix G). Finally, questionnaires and demographic details were completed before debriefing participants. The study took 2-2.5 hours to complete. Participants were interviewed in a location of their choice: home, university or NHS premises, minimising the time-burden on them and maintaining anonymity.

Measures

Repertory Grid – Personal Construct Psychology suggests people develop 'constructs' of themselves, others and the world, based on their experiences, using these to make predictions about future events (Kelly, 1955). These are bipolar and are arranged within the personal construct system, revised based on feedback from experiences. This represents the individuals' belief-system. Repertory grids are a structured interviewing technique developed from this theory, exploring how participants organise their constructs, which may be more difficult to communicate in semi-structured interviews (Fransella, Bell & Bannister, 2004). The primary aim is to make underlying patterns of thinking clearer (Leach, Freshwater, Aldridge & Sunderland, 2001).

They consist of four parts: topic, elements, constructs and ratings (Jankowicz, 2004). The topic was 'trauma work'. Elements are examples of the topic, generally taking the form of people. These were provided, allowing comparisons

relevant to the research questions. These were ‘self-now’, ‘self before training’, ‘self coping well with trauma work’, ‘self struggling with trauma work’, ‘client struggling with trauma’, ‘client with posttraumatic growth’ and ‘non-trauma exposed, psychologically healthy individual’ (control). Participants were asked to think of a specific person for each ‘other’ element. Constructs can be supplied by the researcher; allowing greater statistical comparison between grids (Tan & Hunter, 2002). However, personal construct psychology is concerned with how people make sense of their world, so relying fully on supplied constructs counteracts the aims of the study, which were to explore how participants make sense of trauma work. Therefore, some constructs were supplied to ensure belief areas relevant to existing theory were explored, as well as eliciting some from participants. Supplied constructs included: ‘safe’, ‘trusting’, ‘powerful’, ‘dependent’, ‘kind’, ‘alienated’, ‘emotionally numb’, ‘confident’, ‘optimistic’, ‘fearful’, ‘energised’ and ‘spiritual’. Participants were asked to think of the opposite of each to elicit the implicit pole. The triadic method was used to elicit any further constructs the participants believed were important (Kelly, 1955). This was done by selecting three elements and asking participants to think of a way two were similar and therefore different from the third. This was done until no further constructs were elicited. They were then rated on a five-point Likert scale.

Secondary Traumatic Stress Scale (STSS; Bride, Robinson, Yegidis & Figley, 2004) – a 17-item self-report measure of symptoms rated on a 5-point Likert scale of frequency experienced (1= never, 5= very often). Higher scores indicate greater STS. It was developed in line with the STS model, assessing effects of indirect trauma exposure. There are three subscales: intrusion, avoidance and arousal. It has good validity and internal consistency for the total scale (.93), intrusion subscale (.80), avoidance subscale (.87) and arousal subscale (= .83) (Bride *et al.,* 2004).

TABS (Pearlman, 2003) – an 84-item self-report measure of disrupted beliefs related to ‘self’ and ‘other’ in the five CSDT areas; trust, safety, esteem, intimacy and control. Participants rate each item on a 6-point Likert scale; higher scores represent greater negative disruptions consistent with VT. The

total scale score has good validity and good internal consistency (=.96). Internal consistency of subscales ranges between .67 and .87 (Pearlman, 2003).

Professional Quality of Life (ProQOL) Scale (Stamm, 2010) – a 30-item self-report measure used to assess positive and negative effects of caregiving roles. It contains three subscales: compassion satisfaction (a positive experience), burnout and STS. Higher scores represent higher levels of each. Each item is rated on a 5-point Likert scale. It has good construct validity, each scale is distinct, with compassion satisfaction only sharing 2% of the variance with STS and 5% with burnout (Stamm, 2010).

Life Events Checklist (LEC) (Blake *et al.,* 1995) – this was used to measure participants' personal trauma experience of 15 traumatic events, with one item assessing any other event participants found traumatic, not already covered by the scale. Each is rated on a 5-point nominal scale (1= happened to me, 2 = witnessed, 3 =learned about it, 4 = not sure, 5 = does not apply). Frequency of traumatic events experienced by each participant was calculated as a measure of personal trauma. It has good convergent validity with established measures of trauma exposure and trauma-related distress (Gray, Litz, Hsu & Lombardo, 2004). As potentially traumatic event exposure is not a unidimensional concept, calculation of internal consistency is inappropriate (Netland, 2001).

Analysis

Repertory Grids – Repertory grids were analysed using Idiogrid (Grice, 2002) to calculate Double-Scaled Euclidean Distances between each element.

Interview Data – Interviews were transcribed by the primary researcher. Directive content analysis (Mayring, 2000) was used to analyse these, following a coding agenda mapping on to the five CSDT belief-areas. Each code was operationalised using CSDT, TABS subscales and previous research. They were split into 'self' / 'other' and 'positive' / 'negative', totalling 20 codes (Appendix J). Participants could have more than one comment for each; for example, they could discuss 'other-control' several times and each would be coded separately.

Two researchers coded two transcripts separately and discrepancies were discussed to reach a consensus. Most discrepancies involved one researcher coding something the other had left blank. There was 100% agreement on positive/negative valence. Frequencies of each were calculated for trainees and qualified therapists.

Psychometrics – Descriptive statistics were calculated for psychometric measures using SPSS (see Table 3).

Mixed Methods Synthesis – SPSS was then used to calculate Spearman's Rank Correlations for average total TABS scores and Euclidean distances for trainees and qualified staff. These were also calculated for frequency of each belief-area from qualitative content analysis and the corresponding TABS subscale e.g. frequency of 'self-safety negative' codes correlated with TABS 'self-safety' scale.[1]

Results

(see extended paper for additional information)

Repertory Grids

Double-scaled Euclidean distances were calculated using Idiogrid for each element (see Table 1): 0 indicates maximum dissimilarity, 1 indicates maximum similarity. This is the opposite scaling system to other Euclidean distance measures in the literature, where 0 usually represents maximum similarity. Trainees' most similar elements were 'self coping well with trauma work' and 'client with posttraumatic growth' with an Euclidean Distance of 0.78. This was similar to their Euclidean Distance for 'self-now' and 'client with posttraumatic growth'; suggesting their current-self was construed as coping well and not experiencing VT. Qualified therapists' most similar elements were 'self-now' and

[1] Non-parametric tests were run due to the data violating the assumption of normal distribution. This results in a loss of statistical power. It is noted that running multiple tests on the same data increases the chance of a Type I error being made (Benjamini & Hochberg, 1995). However, an adjustment to the significance value of 0.05 was not made as this is an exploratory, secondary analysis. Adjusting for multiple tests may miss important areas that could be followed-up in better powered further research.

‘self-coping well with trauma work’, with an Euclidean Distance of 0.83. The least similar elements for both groups were ‘self-now’ and ‘client struggling with trauma’, suggesting they were not experiencing negative beliefs consistent with VT.

The difference between the least similar Euclidean Distance ‘self-now & client struggling with trauma’ was compared with the Euclidean distance between ‘self-now & self coping well with trauma-work’ as this was the most similar Euclidean Distance for ‘self now’ ratings. The data was normally distributed therefore a paired T-Test was used. For qualified therapists this difference was significant; $t=-9.09$, $p < .05$. The same was found for trainees; $t=-4.83$, $p < .05$. The difference between ‘self-now & client struggling with trauma’ and ‘self-now & client with PTG’ was also compared for each group. The data for the Euclidean distance ‘self now & client with PTG’ was not normally distributed, therefore the non-parametric equivalent of a t-test was used, a Wilcoxon signed-rank test. For qualified therapists this difference was significant; $z=-2.81$, $p < .05$. The same was found for trainees; $z=-2.59$, $p < .05$.

Table 1. *Euclidean Distances between Elements*

Euclidean Distance Between Elements	**Mean – Trainee Clinical Psychologists**	**Mean – Qualified Psychological Therapists**
‘self-now’ & ‘self before training’	0.66	0.61
‘self-now’ & ‘self-coping well with trauma work’	0.77	0.83*
‘self-now’ & ‘self-struggling with trauma work’	0.59	0.65
‘self-now’ & ‘client struggling with trauma’	0.45*	0.34*
‘self-now’ & ‘client with posttraumatic growth’	0.71	0.75

'self-now' & 'non-trauma exposed healthy individual'	0.68	0.72
'self coping well with trauma work' & 'client with posttraumatic growth'	0.78*	0.78
'self struggling with trauma work' and 'client struggling with trauma'	0.71	0.51
'self before training' & 'client struggling with trauma'	0.45	0.51
'self before training' & 'client with posttraumatic growth'	0.68	0.66

** represents highest (most similar) and lowest (least similar) Euclidean distance for each group*

Directive Content Analysis

Data corresponding to the five CSDT belief-areas was extracted from interview transcripts. A summary is presented below (a *more detailed qualitative paper containing more examples is also going to be produced but this is beyond the scope of this paper*). Table 2 provides overall frequencies for each code and an interpretation of this in relation to whether it suggests VT or VPTG. Statistical analyses determined whether the difference between positive and negative codes in each belief-area was significant. Where data met the assumptions of normality, a paired-samples T-Test was run. Where data violated this assumption but met the assumption of symmetry, a Wilcoxon signed-rank test was run. When both these assumptions were violated, a paired-samples sign test was used.

Table 2. *Directive Content Analysis Belief-Area Coding Frequencies*

Belief	**Total Frequency Coded – Trainee Clinical Psychologists**	**Total Frequency Coded – Qualified Psychological Therapists**
Self-Control +	15	13
Self-Control -	16	14
PTG or VT?	Equal	Equal
Other-Control +	17	12
Other-Control -	31	21
PTG or VT?	VT	VT

Self-Esteem +	34	40
Self-Esteem -	4	2
PTG or VT?	VPTG*	VPTG*
Other-Esteem +	11	26
Other-Esteem -	11	8
PTG or VT?	Equal	VPTG*
Self-Intimacy +	18	18
Self-Intimacy -	2	4
PTG or VT?	VPTG*	VPTG*
Other-Intimacy +	27	29
Other-Intimacy -	28	19
PTG or VT?	Equal	VPTG
Self-Safety +	2	2
Self-Safety -	6	4
PTG or VT?	VT	VT
Other-Safety +	1	0
Other-Safety -	8	20
PTG or VT?	VT	VT*
Self-Trust +	8	21
Self-Trust -	14	14
PTG or VT?	VT	VPTG
Other-Trust +	0	0
Other-Trust -	7	13
PTG or VT?	VT*	VT*

**This difference between frequency of positive and negative codes was statistically significant (see extended results for statistical tests and results)*

Self-Control

Trainees and qualified therapists demonstrated an approximately equal balance of positive and negative beliefs, suggesting VT and VPTG occurred in parallel. Positive beliefs related to believing they could openly express their emotions: '*able to…be completely honest and open in how things have maybe impacted me. And that feeling ok'.* They also communicated feeling able to facilitate change in clients, which helped deal with beliefs about not being able to influence trauma happening in the world around them: '*I feel like I can influence…the impact of that for that person and make a difference'.*

Negative beliefs related to having to contain and hide emotions, feeling stuck and helpless with clients, unable to influence what has happened or facilitate change. One trainee noted that when she felt stuck with clients she was unable

to sit with this '*going into solution-focussed mode if someone's not doing well…you sort of get driven to want to suggest things or…rather than just sitting with it and having to tolerate it yourself*'. Several related negative beliefs related to an inability to facilitate change in organisational factors: '*way services are going at the moment, and the difficulties there are in working in services…it can feel a little bit like fighting a losing battle'*.

Other-Control

Both groups communicated more negative other-control beliefs. This suggests there was more belief-disruption consistent with VT although this difference was non-significant for trainees and qualified therapists. VPTG did still occur alongside this. Trainees' positive beliefs mainly centred around working collaboratively with clients and encouraging them to make changes to their lives: '*able to see themselves differently…see their own...competence to deal with things….it makes you feel hopeful…it's a two-way process, you're giving and they're giving'.* Similar beliefs relating to feeling in control of the therapy process and facilitating changes were communicated by qualified therapists: *'facilitator of change…being able to, kind of, guide people or umm (2) develop insight in people to allow themselves to get out of it'.*

Negative beliefs mainly referred to feeling unable to facilitate change, leading to frustration and sense of responsibility in both groups: *'incredible reluctance to consider it umm I found really frustrating…because I want to be able to, kind of facilitate change umm and it didn't…it felt like my hands were tied and…you know, at the time I felt…really quite irritated that I couldn't do more'* and *'I just feel like I can't get through, it's really hard and I feel like I'm not doing a good job. I think I probably internalise and think I'm not helping them because I can't get them to be confident'.*

Self-Esteem

Both groups communicated significantly more positive self-esteem beliefs, suggesting more VPTG. Positive self-esteem mainly related to believing others viewed their profession as worthwhile: '*some people think it's amazing and are*

really interested' and '*lot of respect towards you, that you've kind of chosen to do it and you're able to help people'*. Others mentioned feeling privileged when clients share their trauma: '*the honour of being in someone's most vulnerable moment…they're trusting me with it and (8) just being grateful for that*'. Many believed they had become more understanding of people and less judgemental, often linked to increased empathy: '*more empathy and understanding and just being a bit more careful to judge people umm when…even when they do bad things that's what's changed for me. So I think I'm a lot less judgemental (laughs) which is good'*

Negative beliefs were scarce in both groups, but when these were coded they related to feeling incompetent and guilty when clients continue struggling: '*sense of criticism or could of done more…how would my supervisor have dealt with this better'* and *'come out of the session feeling like not a particularly good or competent therapist'*. This had some over-lap with 'other-control'. Codes directly related to a negative view of self were coded as 'other-esteem', whereas those relating to therapeutic skills specifically, rather than a global view of self, were coded as 'other-control'.

Other-Esteem

Trainees communicated equal numbers of positive and negative other-esteem beliefs, suggesting VT and VPTG occurred in parallel. Qualified therapists experienced significantly more positive beliefs, suggesting they were experiencing VPTG in other-esteem. Both groups had similar positive other-esteem beliefs, relating to acknowledgement of others' resilience: '*the biggest thing actually is just thinking how resilient people are*' and '*I'm often quite kind of amazed by how, these people have kind of got through these, kind of experiences*'. Some beliefs over-lapped with self-esteem when participants felt less judgemental. This led to them seeing others more positively, even if they behaved negatively, as they understood that it is impossible to know what that person had been through: '*I never judge people umm (3) but I guess more and more so just you know, never reading a book by its cover and how trauma can come in so many different forms and can be so hidden'.*

Negative beliefs centred around a generally more pessimistic view of the world and realisation of the horrible things some people do: '*there can be just such awful people in the world. and…it kind of that in itself is kind of like a sad thought and it makes me feel frustrated umm (2) that there are people that can do mean things'* and *'shakes me to the core in terms of thinking how other humans can do vile things to other humans'*.

Self-Intimacy

Both groups communicated significantly more positive self-intimacy beliefs, suggesting they were experiencing more VPTG in this domain. Positive beliefs related to using time alone to sit with emotions and improved self-awareness. Some spoke about the importance of reflecting on emotions aroused by trauma work: '*feel umm…affected by it I'd probably just stay, like notice it because I think that can be an important thing to tune into your own responses as a therapist and to use it to reflect further'*. Some felt this ability improved with experience '*if stuff does play on my mind I'll think about why that is. So…I'm a bit more reflective I think than I used to be'*. Interestingly, several trainees spoke about initial trauma work experiences bringing up personal experiences, leading some to access personal therapy or supervision to improve self-awareness: '*going to therapy myself and I think that's been really helpful just to understand myself more so that I can be with people a bit better'* and *'when I was first faced with it …triggers off your own memories of sort of things that have happened… have to work on that…just so I could be there for the client…when I knew that that potential was there'.*

Negative self-intimacy was rarely coded but when it was both groups reflected on believing they lacked self-awareness prior to starting trauma work: *'before I might have been aware of those sensations…knew they were telling me something, but I wouldn't be quite sure what. So it was that, kind of, umm…that…that would be unprocessed in a way'.*

Other-Intimacy

Trainees communicated an equal balance of positive and negative other-intimacy beliefs. Qualified therapists communicated more positive beliefs, suggesting VTPG in this area, although this difference was non-significant. Positive beliefs covered feeling supported by colleagues due to shared understanding: '*support that we have with each other here is so important...being able to pick yourself up by having a supportive colleague'* and *'being able to say…'that stuff that happened on the wards today that was really horrible' like having that kind of sense of umm a shared experience rather than it was just me who saw that, it was really helpful'.* Often this related to off-loading the emotional impact of trauma work and have somebody validate that: *'just offloading it to someone is helpful, even if they've not got any answers just…letting somebody else hear it and say 'oh that sounds really difficult*'*.* Several trainees and qualified therapists felt connected with loved ones. Despite limits of confidentiality they felt supported by loved ones: '*If I've had a rough day my other half's amazing. But…that's (2) I can't go into the details particularly, I'll just say 'I've had a rough day. I've had a rough session' (2) he might ask a bit more…he might know I can't answer'.* Intimacy with peers was different, involving 'dumping' trauma onto somebody who understood it based on shared experiences. Some were able to feel understood by loved ones, without having to share trauma, suggesting different types of positive other-intimacy exist based on relationship contexts.

Negative beliefs were similar for both groups, most talked about others lacking understanding: '*a lot of people express this thing of they wouldn't be able to do it, they wouldn't be able to listen. Almost that…that denial of no those kind of things don't happen to people'*. Many worried about the effects talking about work would have on others, *'my husband…I'm just like, 'I've had a rough day, just give me some space' and I know he'll say we can talk about it but I actually don't want to then traumatise him'.*

Self-Safety

Self-safety was the least frequently coded belief-area. Both groups showed slightly more VT beliefs but this was non-significant. Positives for qualified staff centred around having increased awareness of danger but believing they had coping skills to keep themselves safe: '*having those skills yourself like the umm mindfulness and all the other things that you do to keep yourself safe. They're skills that if something did happen that was unpleasant to you, you've got those skills*'. This could be conceived as VT, as the therapist believes she needs to have these skills due to an increased awareness of personal vulnerability. However, she viewed it as a positive aspect of keeping herself safe so it was coded as positively. Trainees spoke about how experience had led them to feel safer working with people who have harmed others: '*actually when I started working with them…they weren't these…scary people that I probably made out in my head to be. Dangerous and obviously you had to be mindful and careful, but…probably not as dangerous as I'd made out'*.

Negative beliefs focused on increased awareness of danger in the world, resulting in feeling more vulnerable '*You do start to see the world as a…less safe. That…you know, that sort of like the PTSD symptoms of hypervigilance and kind of being aware*'.

Other-Safety

Both groups communicated more negative other-safety, suggesting this area experienced more VT. However, this difference was only significant for qualified therapists. The only positive belief related to observing posttraumatic growth and how this increases clients' sense of safety: '*it's changes their engagement with the world and they...I think they transition, as I see it, to a place of safety, intra-psychically they feel safe'*.

Negative beliefs related to a general sense of the world being less safe and trauma being something which can affect anyone: '*trauma can affect everyone…therefore I think I view the world as (2) kind of like crueller or more unsafe*'. Two qualified therapists discussed specific concerns about their own

children linked to increased awareness of child-abuse; '*90% of our caseload…have experienced childhood trauma. Umm so it makes me, I'm more mindful I guess of the children that are in my life and how to protect them …would be uncomfortable with the children in my life staying at a stranger's house…so I think it's influenced some of the decisions I would make'*.

Self-Trust

Trainees communicated more negative self-trust beliefs. Qualified therapists had more positive beliefs. This suggests an opposite effect in each group: trainees experienced more VT, although both VT and VPTG beliefs occurred in parallel. Positive beliefs mainly related to confidence in their skills and therapeutic judgements: '*holding onto the fact that I do have some expert skills and some knowledge that I can use'* and '*I can really help because I can see the progressing happening and I can, like I say, be the facilitator of that…my knowledge of the therapy… I can help people with that'*.

Negative beliefs related to doubting their skills and questioning themselves; several participants related this to worries about re-traumatising clients: '*you have an internal dialogue with yourself of umm is this…is this too much? Because of course very quickly somebody could go back into a trauma and potentially stay there'* and *'I've opened this stuff up and now I don't know what I'm going to be able to do to…put the lid back on to…or to process it. What…are we just going to cope by putting the lid back on? Will the lid go back on? Are…are we going to end up in a bad situation'*. Some trainees related this to questioning their skills due to not yet being qualified: '*you do get that sense of ''oh what impact am I really going to have as a trainee?''…thinking 'what can I do?*'.

Other-Trust

Positive other-trust was not coded at all in both groups. This suggests VT was impacting this belief-area. Negative other-trust was linked to believing you can never really know people and a general distrust of others: '*more…kind of like alert to people…more aware of who's around and the fact that I don't know*

them…they might be…kind of perpetrators of kind of traumatic experiences. Umm so…I think it has changed a little bit in terms of kind of being aware of safety things' and *'historically I would have possibly been more trusting…umm (3) and…yeah somehow having heard a lot of difficult…stuff (laughs) has made me a bit more (2) cautious…sometimes find myself just…questioning people more'.*

Psychometrics

On average, neither trainees or qualified therapists scored above the cut-off for disrupted beliefs on the TABS. Trainees fell within the mild range for STS symptoms, whereas qualified therapists fell below this cut-off, suggesting trainees were slightly more distressed due to trauma work. Similar results were found on the STS-subscale of the ProQOL, strengthening this finding. Both groups showed no burnout and high levels of compassion satisfaction on the ProQOL. This suggests overall there was limited distress experienced and each group were experiencing some positive effects of trauma work. On the LEC trainees had experienced an average of 1.6 personal traumatic events. Qualified therapists slightly more persona trauma experience with a mean of 2.5 events reported.

Table 3. *Psychometric Results – Trainees & Qualified Therapists*

Measure	**Trainees**	**Qualified Therapists**
STSS – Total	Mean = 29.2 Range = 19-37 S.D = 6.34 'Mild STS'	Mean = 25.0 Range = 17-31 S.D = 4.76 'No STS'
STSS – Avoidance	Mean = 11.4 Range = 7-14 S.D = 2.55	Mean = 10.2 Range = 7-12 S.D = 2.15
STSS – Intrusion	Mean = 9.4 Range = 5-13 S.D = 2.41	Mean = 8.1 Range = 5-12 S.D = 2.65

STSS - Arousal	Mean = 8.4 Range = 6-14 S.D = 2.55	Mean = 6.7 Range = 5-9 S.D = 1.34
LEC – Experienced	Mean = 1.6 Range = 0-4 S.D = 1.26	Mean = 2.5 Range = 0-5 S.D= 1.72
LEC - Witnessed	Mean = 1.4 Range = 0-3 S.D = .97	Mean = 2 Range = 0-8 S.D = 2.4
ProQOL – Compassion Satisfaction	Mean = 38.7 Range = 29-45 S.D = 5.6 Above cut-off	Mean = 41.1 Range = 36-47 S.D = 3.63 Above cut-off
ProQOL - Burnout	Mean = 22.3 Range = 17-26 S.D = 2.67 Below cut-off	Mean = 19.8 Range = 15-24 S.D = 2.82 Below cut-off
ProQOL – Secondary traumatic stress	Mean = 17 Range = 13-23 S.D = 3.05 At cut-off	Mean = 16.3 Range = 10-26 S.D = 4.47 Below cut-off
TABS – Total	Mean = 47.1 Range = 42-53 S.D = 3.51 Below cut-off	Mean = 43.9 Range = 29-57 S.D = 9.88 Below cut-off
TABS – Self-safety	Mean = 41.4 Range = 27-47 S.D = 7.76 Below cut-off	Mean = 39.7 Range = 20-57 S.D = 12.39 Below cut-off
TABS – Other-safety	Mean = 36.2 Range = 24-45 S.D = 6.83	Mean = 41.3 Range = 24-57 S.D = 10.26

	Below cut-off	Below cut-off
TABS – Self-trust	Mean = 55.9 Range = 39-66 S.D = 8.32 Below cut-off	Mean = 45 Range = 28-57 S.D = 7.85 Below cut-off
TABS – Other-trust	Mean = 39.2 Range = 32-50 S.D = 5.27 Below cut-off	Mean = 42.5 Range = 20-67 S.D = 12.75 Below cut-off
TABS – Self-esteem	Mean = 50.5 Range = 44-63 S.D = 6.19 Below cut-off	Mean = 47.3 Range = 37-62 S.D = 6.73 Below cut-off
TABS – Other-esteem	Mean = 47.1 Range = 37-60 S.D = 7.11 Below cut-off	Mean = 47.4 Range = 35-73 S.D = 12.6 Below cut-off
TABS – Self-intimacy	Mean = 48.9 Range = 24-68 S.D = 11.84 Below cut-off	Mean = 40.7 Range = 24-49 S.D = 9.68 Below cut-off
TABS – Other-intimacy	Mean = 45.7 Range = 33-57 S.D = 8.37 Below cut-off	Mean = 43.4 Range = 28-58 S.D = 10.6 Below cut-off
TABS – Self-control	Mean = 50.2 Range = 41-61 S.D = 5.96 Below cut-off	Mean = 43.7 Range = 25-66 S.D = 12.48 Below cut-off
TABS – Other-control	Mean = 44.2 Range = 33-51 S.D = 7.08	Mean = 45.8 Range = 31-61 S.D = 12.48

	Below cut-off	Below cut-off

Synthesising Data

TABS & Euclidean distances

Non-parametric correlations were calculated because data was not normally distributed. Relationships were explored between the TABS and Euclidean distances. Strong correlations were expected as both measures theoretically measured VT. A Spearman's rank-order correlation exploring the relationship between total TABS score and Euclidean distance between 'self-now' and 'client with posttraumatic growth' found a weak positive relationship, the correlation co-efficient was R = .068, this was non-significant (p=.777). This is the opposite direction of what would be expected, suggesting that as TABS scores increase (more VT) there is greater similarity in the way participants construe themselves and clients with posttraumatic growth. There should be a negative correlation with TABS scores, as higher scores suggest more negative beliefs.

There was almost no relationship between total TABS score and Euclidean distance between 'self-now' and 'client struggling with trauma'; R = .002. Again this was an unexpected result. As the Euclidean Distance increases between 'self-now' and 'client struggling with trauma' this would suggest VT is occurring as participants construe themselves as more similar to clients struggling with trauma. A positive correlation was expected with the TABS as higher TABS scores are thought to represent more VT and larger Euclidean distances should also represent VT. This is problematic, suggesting that the repertory grids and the TABS are measuring unrelated constructs.

TABS & Coding frequencies – correlations & interpretations

Non-parametric tests were run to explore the relationships between positive and negative coding frequencies for each belief area with the corresponding TABS subscale scores. These measures were completed with the same participants and are thought to measure VT, so a positive correlation was expected between

frequency of negative codes and the corresponding TABS subscale. Higher TABS scores and more negative codes represent VT beliefs. A negative correlation was expected with positive codes and TABS scores as higher positive codes should be related to less belief disruption and lower TABS scores. Table 4 provides the correlations and interpretation of whether these were in the expected direction.

The study lacked power to detect significant correlations so the direction is focused on. However, one relationship reached statistical significance. Negative self-intimacy codes had a moderate negative correlation with the TABS self-intimacy subscale. This is problematic as if the measures were measuring the same construct, a positive correlation was expected. There were seven other relationships which occurred in the opposite direction to what was expected.

Table 4. *Correlations Between TABS and Coding Frequencies by Belief-Area*

Relationship explored	**Correlation**
Positive self-control codes & TABS self-control score	R = .013 p = .955
	Unexpected direction – should be negative
Negative self-control codes & TABS self-control score	R = .159 p = .503
	Expected direction – weak positive
Positive other-control codes & TABS other-control score	R = -.175 p = .461
	Expected direction – weak negative
Negative other-control codes & TABS other-control score	R = .244 p = .300
	Expected direction – weak positive
Positive self-esteem codes & TABS self-esteem score	R = .205 p = .387
	Unexpected direction – should be negative
Negative self-esteem codes & TABS self-esteem score	R = -.162 p = .494
	Unexpected direction – should be positive
Positive other-esteem codes & TABS other-esteem score	R = -.275 p = .241
	Expected direction – weak negative
Negative other-esteem codes & TABS other-esteem score	R = -.005 p = .983
	Unexpected direction – weak negative

Positive self-intimacy codes & TABS self-intimacy score	R = -.150 p = .529
	Expected direction – weak negative
Negative self-intimacy codes & TABS self-intimacy score	R = -.467 p = .038 *
	Unexpected direction – should be positive
Positive other-intimacy codes & TABS other-intimacy score	R = .324 p = .164
	Unexpected direction – should be negative
Negative other-intimacy codes & TABS other-intimacy score	R = .089 p = .711
	Expected direction – weak positive
Positive self-safety codes & TABS self-safety score	R = -.011 p = .963
	Expected direction – weak negative
Negative self-safety codes & TABS self-safety score	R = .048 p = .840
	Expected direction – weak positive
Positive other-safety codes & TABS other-safety score	R = -.281 p = .229
	Expected direction – weak negative
Negative other-safety codes & TABS other-safety score	R = .209 p = .377
	Expected direction – weak positive
Positive self-trust codes & TABS self-trust score	R = -.408 p = .074
	Expected direction – moderate negative
Negative self-trust codes & TABS self-trust score	R = -.315 p = .176
	Unexpected direction – weak negative
Positive other-trust codes & TABS other-trust score	No correlation as no positive other-trust codes in this sample
Negative other-trust codes & TABS other trust score	R = .206 p = .384
	Expected direction – weak positive

* *represents correlations that reached statistical significance at the p <.05 level*.

Conclusion

Triangulating data from repertory grids, psychometrics and interviews revealed some inconsistencies. Repertory grids suggested overall greater VPTG in both groups. Directive content analysis suggested both VT and VPTG beliefs occurred in parallel and variation occurred for belief areas. Other-control, self-safety, other-safety and other-trust demonstrated more evidence for VT in both

groups, whereas self-esteem and self-intimacy demonstrated more evidence for VPTG. There were some differences in trainees and qualified therapists; other-intimacy had an equal balance for trainees but qualified therapists showed VPTG. Self-trust was more negatively disrupted for trainees, whereas qualified experienced VPTG. Overall, VT appeared higher for trainees as they experienced this in five belief areas and VPTG in two, compared to qualified therapists who experienced VT in four belief areas and VPTG in five. This may relate to the findings that trainees displayed 'mild' STS, whereas qualified therapists did not demonstrate evidence of STS on quantitative measures.

There seems to be difficulties with the measures showing no relationships or relationships in unexpected directions, which would suggest they are measuring different constructs. TABS scores failed to show belief disruption consistent with VT for either group, despite qualitative evidence for this from the same sample. The lack of relationship between the repertory grid measure of VT and TABS scores, and the weak positive correlation with the repertory grid measure of VPTG is problematic as it suggests the TABS is not measuring VT and is more linked to a measure of VPTG. This was partially supported by the significant negative correlation between negative self-intimacy codes and the TABS self-intimacy score, which was in the opposite direction to what would be expected if the TABS was measuring negative beliefs. The weak correlations which occurred in the expected direction between belief-area codes and TABS scores, as well as seven correlations in an unexpected direction, add further speculation to the claim that the TABS may not measure VT.

Discussion

(see extended paper for additional information)

This was the first British study comparing qualified therapists' and Trainee Clinical Psychologists' trauma work experiences. It had three aims, each is discussed.

Firstly, repertory grids measured how similarly they construed themselves to clients with trauma experiences. This is the first study using repertory grids to measure VT. Participants construed themselves as least similar to clients

struggling with trauma, suggesting they perceived themselves as having different beliefs. Trainees construed themselves as most similar to clients with posttraumatic growth. Qualified therapists construed 'self-now' as most similar to themselves coping well with trauma work. This suggests both were experiencing more positive effects. Westphal and Bonnano (2007) imply therapists may report positive changes to help them cope with the threat distress resulting from trauma work may pose to their identity. However, repertory grids have low face validity, so are less likely affected by social desirability. This supports previous reviews concluding trauma therapists generally cope well (Kadambi & Ennis, 2004; Elwood, Mott, Lohr & Galovski, 2011).

Secondly, a deductive analysis explored whether therapists experience beliefs consistent with CSDT. Evidence was found for all, but some occurred more. Other-intimacy was communicated by all participants and self-esteem and other-esteem were communicated by 19; whereas self-safety was only communicated by seven. As open questions about trauma work in general were used, not finding some belief areas within some transcripts could be argued to reflect participants not being directly asked like they were in previous research exploring CSDT beliefs in judges (Miller, Flores & Pitcher, 2010). However, the openness suggests participants were communicating beliefs most relevant to their perception of trauma work. It is possible that some areas were seen as less important. It is interesting that safety was the least reported as past studies have shown it to be a primary area disrupted in direct and vicarious trauma (Engelhard *et al.,* 2001; Iliffe & Steed, 2000; Janoff-Bulman, 1992); arguing an event cannot be experienced as traumatic without threat of safety to self or others. When safety beliefs were found, they tended to be negative, suggesting this area was more susceptible to VT in this sample.

Interestingly, positive and negative beliefs appeared alongside each other for most belief areas. This supports past studies which suggest the processes are not mutually exclusive (Cohen & Collens, 2013; Gill, 2015), growth can occur whilst experiencing some distress. Distress is part of the post-trauma experience and may be a precursor to VPTG (Abel, Walker, Samios &

Morozow, 2014). Overall, there were slightly more areas showing VPTG than VT for qualified therapists, whereas trainees had more areas showing VT. This contradicts repertory grid results, where trainees demonstrated VPTG. One area of difference between trainees and qualified therapists was self-trust. Trainees may doubt themselves more as they were less experienced and observed less client growth due to short placements. This is supported by Knight (2010), who found social work trainees with less experience had more disrupted self-trust. There was overlap between self-trust and self-esteem, also found in previous qualitative studies (Arnold *et al.,* 2005; Pistorius *et al.,* 2008) with participants feeling more self-confident over time. This is problematic for the TABS, which treats each area as distinct (Pearlman, 2003). Trainees and qualified therapists both experienced significantly more positive self-esteem beliefs, generally feeling satisfied in their work. Despite trainees experiencing more self-doubt, they experienced job satisfaction and confidence alongside negative self-trust beliefs.

Thirdly, repertory grid, interview and psychometric data was triangulated to explore consistency between methods all aiming to measure VT. There was some consistency, trainees showed higher STS and more negatively coded belief areas. This supports previous studies finding those with less experience experienced more distress from trauma work (Bober & Regher, 2006; Knight, 2010; Racanelli, 2005; Sprang *et al.,* 2007). However, there were some inconsistencies with the TABS. Lack of correlations with repertory grids, and small, non-significant and occasionally opposite to expected correlations with coding was problematic as meaures should be measuring the same construct. This may be related to the lack of power in the study to detect significant correlations, but this does not explain the unexpected directions of some correlations. Trainees and qualified therapists fell below the cut-off for belief-disruption on the TABS, similar to previous research (Makadia *et al., in press*; Baird & Jenkins, 2003; Kadambi & Truscott, 2003). However, there was evidence of some negative beliefs within interviews, suggesting the TABS may not be sensitive enough to detect these.

Limitations and Future Directions

This study is exploratory and generalisability was not the aim. Statistical analyses lack power due to the small sample, so caution should be taken when interpreting results. However, the sample was heterogeneous. Trainees were fairly equally split between year of training (30% first, 30% second, 40% final) and qualified staff varied in their role. Qualified staff had a wide range of experience, from 0.5 to 30 years. Although potentially increasing generalisability, caution must be taken due to the small sample.

Relating it to previous samples can help establish generalisability. Makadia *et al.* (*in press*) used a sample of British Trainees with a mean age similar to this study. This is positive as younger age has previously been related to more disrupted beliefs (Bober & Regehr, 2006; Way *et al.,* 2007). Some studies have found less experience is linked with more disrupted beliefs (Badger *et al.,* 2008; Sprang *et al*., 2007). This study had a slightly more experienced sample, however both studies fell below the cut-off on the TABS. Most research on qualified therapists is American, the only British sample did not specify the professional roles of their participants (Brockhouse, Msetfi, Cohen & Joseph*.,* 2011). Their sample was older but similar in terms of gender and average weekly hours working with trauma. They also compared their sample to previous American studies and found no significant differences, increasing generalisability of this sample.

Comparisons made between groups may also be limited. There was a gender difference between groups; all trainees were female, whereas 30% of the qualified staff were male. Some studies have found females are more likely to experience VT (Brady, Guy, Poelstra & Brokaw, 1999; Resick, 2000), potentially explaining the greater VT beliefs and STSS scores in the trainee group. All trainees were training in clinical psychology, but there was heterogeneity in the professional training of the qualified therapists, including psychiatry, nursing and social work. All participants construed themselves as ‘trauma therapists’ engaged in trauma-focussed work, allowing a broad range of views to be explored. However, it is unclear how differences in professional training may

have impacted results. It was also assumed that qualified therapists would have more experience than trainees due to being qualified, however the range of time since qualifying ranged from 0.5 to over 30 years. Participants were not asked about experience of trauma work prior to training. It is possible that some trainees may have had experience before training, potentially giving them more trauma-work experience than some of the qualified participants. This may limit the conclusions that can be made regarding differences between groups being due to experience.

The sample may be subject to self-selection bias. This could have two opposing effects: those negatively affected may have a vested interest to have their voice heard, resulting in a more distressed sample; or they may have been more stressed or even left the field, resulting in a less distressed sample. As the sample scored relatively low on measures of distress and high on compassion fatigue, the first explanation is more likely. One qualified therapist discussed past experiences of working within forensic settings and choosing to leave as she noticed herself becoming more cynical of others. A trainee also mentioned feeling more burnout during a forensic placement. There is possibly more distress related to working with perpetrators, suggesting type of trauma work could have different impacts. Due to the small sample this could not be explored. Future research could compare VT between different types of trauma work. Some have found no difference in belief disruption between those working with sexual violence or cancer (Kadambi & Truscott, 2003) and those working with sexual abuse perpetrators or victims (VanDeusen & Way, 2006). However, these are quantitative studies so it would be useful to explore this qualitatively due to issues highlighted with quantitative measures by this study. Research could explore why therapists chose to leave the field. However, this may be more ethically sensitive.

This study might be criticised for the use of mainly supplied constructs. Supplied constructs were used due to the deductive nature of the study aims, ensuring all areas of CSDT were covered within repertory grids. Although participants were given the emergent pole, they were asked to define the implicit pole by asking for the opposite of the supplied construct, so there was an element of them

applying their personal meaning system to supplied constructs. Some evidence suggests elicited constructs are more personally meaningful to participants than supplied constructs (Oswalt, 1974; Landfield, 1971). However, some argue it is impossible to supply a construct as the label is still subject to individual interpretation (Bell, 1990). Some studies show no difference between supplied and elicited constructs (Bieri, 1966; Warr & Coffman, 1970). It is unlikely that this significantly affected results, although some research has found elicited constructs are rated more extremely, suggesting increased meaningfulness (Landfield, 1971) so it may have been useful to explore differences in rating extremity between supplied and elicited constructs used in this study.

A methodological strength was the measure of personal trauma as previous research has found this can increase VT (Pearlman & MacIan, 1995; Cunningham, 1997). Previous samples estimate about a third have experienced personal trauma (Adams & Riggs, 2008; Linley & Joseph, 2007). However, 80% of trainees and 90% of qualified therapists in this sample reported at least one personal trauma. This means results must be interpreted with caution as it is impossible to ascertain whether belief changes relate to personal or vicarious trauma. Whilst the interview and repertory grids asked participants to reflect on their beliefs related to exposure to client trauma, it is difficult for them to know which beliefs relate to their own trauma. Steed and Downing (1998) found some participants could not differentiate the effects of trauma work from personal issues within their interviews. Some participants in this study believed trauma work increased their awareness of personal issues which needed to be processed to enable them to cope. Exposure to client trauma may exacerbate underlying beliefs related to personal trauma. Longitudinal research recruiting therapists prior to starting trauma work is needed to establish the impact of personal trauma, as it is impossible to separate the impact.

Previous research is limited by being cross-sectional. Although this study used repertory grids as an implicit measure of belief change between current-self and self before trauma work it is still retrospective and may be limited by recall and reconstructive biases (Park & Lechner, 2006), further increasing the need for longitudinal designs.

Implications

This study is the first to triangulate qualitative and quantitative data and supports findings from reviews which highlight a discrepancy between studies using different methods. Sabin-Farrell & Turpin (2003) found more evidence for belie change in qualitative studies than those using the TABS. As this study uses the same sample, the difference between methodologies cannot be attributed to participant differences. It is possible that the TABS is not sensitive enough to detect some of the negative beliefs found qualitatively. It was also developed for direct trauma (Pearlman, 2003), using global statements like 'I don't trust my instincts' which may not apply to the specific examples participants spoke about in relation to trauma work. It only focuses on negative beliefs, ignoring the positive belief changes found alongside negative beliefs. Although exploratory, this may have implications for quantitative VT measures, refinements could be made to include all effects of trauma work, including positive beliefs. The TABS is inferential, based on comparison to norms developed from a self-selecting sample of therapists at a trauma workshop, rather than representing mental health professionals in general, possibly inflating the normative scores (Kadambi & Ennis, 2004). Therefore, any developments to quantitative measures should be tested using a more representative sample, comparing those working with trauma to those working with other presentations (Kassam-Adams, 1995).

Kadambi and Ennis (2004) argue VT has been embraced by the mental health community, and research into coping with it has preceded empirical evidence of its occurrence, which remains largely inconsistent. Many studies have advocated training and supervision to prevent VT (Catherall, 1995; Pearlman & MacIan, 1995; Rudolph & Stamm, 1999; Cunningham, 2003) but this may be premature without consistent evidence. This study found one key difference in levels of VT and VPTG between trainees and qualified therapists in self-trust. This related to confidence in therapeutic skills, as many felt more confident in their skills with experience. Some talked about using supervision to normalise small changes seen in trauma work and learning to see this as positive. Supervision was also mentioned in other-intimacy, where positive beliefs related

to normalising and understanding distress. Although exploratory, this process of normalising within supervision and training, which highlights distress as an expected part of trauma work, may help therapists make meaning of their reactions to client trauma. Distress is part of the post-trauma experience and may be a precursor for VPTG (Calhoun & Tedeschi, 2006). Further research should explore how supervision impacts this process.

Conclusion

This study adds to VT literature, demonstrating evidence for VT and VPTG beliefs consistent with CSDT in trainee and qualified staff. Negative and positive beliefs appear to co-occur, but despite some distress generally both groups felt they were coping well and experienced satisfaction from trauma work. Quantitative measures may not wholly capture the experience of therapists, which has implications for their development.

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References

Abel, L., Walker, C., Samios, C., & Morozow, L. (2014). Vicarious posttraumatic growth: predictors of growth and relationships with adjustment. *Traumatology: An International Journal, 20(1),* 9-18.

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

Arnold, D., Calhoun, L. G., Tedeschi, R., & Cann, A. (2005). Vicarious posttraumatic growth in psychotherapy. *Journal of Humanistic Psychology, 45(2)*, 239-263.

Badger, K., Royse, D., & Craig, C. (2008). Hospital social workers and indirect trauma exposure: An exploratory study of contributing factors. *Health & Social Work, 33(1),* 63-71.

Baird, S. A., & Jenkins, S. R. (2003). Vicarious traumatization, secondary traumatic stress, and burnout in sexual assault and domestic violence agency staff. *Violence and Victims, 18(1),* 71-86.

Benjamini, Y., & Hochberg, Y. (1995). Controlling the false discovery rate: a practical and powerful approach to multiple testing. *Journal of the Royal Statistical Society Series B (Methodological), 57(1),* 289-300.

Bieri, J. (1966). Cognitive complexity and personality development. In O.J. Harvey (Ed.), *Experience, structure, and adaptability* (pp. 13-37). New York, NY: Springer.

Blake, D. D., Weathers, F. W., Nagy, L. M., Kaloupek, D. G., Gusman, F. D., Charney, D. S., & Keane, T. M. (1995). The development of a clinician-administered PTSD scale*. Journal of Traumatic Stress, 8(1),* 75-90.

Bober, T., & Regehr, C. (2006). Strategies for reducing secondary or vicarious trauma: do they work? *Brief Treatment and Crisis Intervention, 6(1),* 1-9.

Brady, J. L., Guy, J. D., Poelstra, P. L., & Brokaw, B. F. (1999). Vicarious traumatization, spirituality, and the treatment of sexual abuse survivors: a national survey of women. *Professional Psychology: Research & Practice, 30(4),* 386-393.

Bride, B. E., Robinson, M. M., Yegidis, B., & Figley, C. R. (2004). Development and validation of the Secondary Traumatic Stress Scale. *Research on Social Work Practice, 14(1),* 27-35.

Brockhouse, R., Msetfi, R. M., Cohen, K., & Joseph, S. (2011). Vicarious exposure to trauma and growth in therapists: the moderating effects of sense of coherence, organizational support, and empathy. *Journal of Traumatic Stress, 24(6),* 735-742.

Calhoun, L. G., & Tedeschi, R. G. (2006). The foundations of posttraumatic growth: An expanded framework. In L. G. Calhoun & R. G. Tedeschi (Eds.), *Handbook of posttraumatic growth: Research and practice* (pp. 1–23). Mahwah, NJ: Erlbaum.

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

Cohen, K., & Collens, P. (2013). The impact of trauma work on trauma workers: a metasynthesis on vicarious trauma and vicarious posttraumatic growth. *Psychological Trauma: Theory, Research, Practice, and Policy, 5(6),* 570-580.

Cunningham, M. (1997). Vicarious traumatization: Impact of trauma work on the clinician. *Dissertation Abstracts International, 57(9-A),* pp. 4130. (UMI No. 9705502).

Cunningham, M. (2003). Impact of trauma work on social work clinicians: Empirical findings. *Social Work, 48*(4), 451-459.

Elwood, L. S., Mott, J., Lohr, J. M., & Galovski, T. E. (2011). Secondary trauma symptoms in clinicians: a critical review of the construct, specificity, and implications for trauma-focussed work. *Clinical Psychology Review, 31,* 25-36.

Engelhard, I. M., Macklin, M. L., McNally, R. J., van den Hout, M. A., & Arntz, A. (2001). Emotion- and intrusion-based reasoning in Vietnam veterans with and without chronic posttraumatic stress disorder. *Behaviour Research and Therapy, 39(11)*, 1339–1348.

Figley, C. R. (1995). Compassion fatigue as secondary traumatic stress disorder: An overview. In: Figley, C. R. (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatised*, (pp. 1-20). New York, NY: Brunner/Mazel Publishers.

Fransella, F., Bell, R., & Bannister, D. (2004). *A Manual for Repertory Grid Technique*. Chichester, UK: John Wiley and Sons Ltd.

Gill, S. (2015). Is secondary traumatization a negative therapeutic response? *Journal of Loss & Trauma, 20(5)*, 410-416.

Gray, M.J., Litz, B.T., Hsu, J.L., & Lombardo, T.W. (2004). Psychometric properties of the Life Events Checklist. *Assessment, 11(4),* 330-341.

Grice, J. W. (2002). Idiogrid: Software for the management and analysis of repertory grids. *Behavior Research Methods, Instruments, & Computers, 34(3)*, 338-341.

Harrison, R. L., & Westwood, M. J. (2009). Preventing vicarious traumatization of mental health therapists: identifying protective factors. *Psychotherapy Theory, Research, Practice, & Training, 46(2),* 203-219.

Iliffe, G., & Steed, L. G. (2000). Exploring the counsellor's experience of working with perpetrators and survivors of domestic violence. *Journal of Interpersonal Violence, 15(4)*, 393–412.

Jankowicz, D. (2004). *The easy guide to repertory grids*. Chichester, UK: John Wiley & Sons.

Janoff-Bulman, R. (1992). *Shattered assumptions: Towards a new psychology of trauma.* New York, NY: The Free Press.

Joseph, S., & Linley, A. P. (2008). *Trauma, recovery and growth: Positive psychology perspectives on posttraumatic stress*. Hoboken, NJ: Wiley.

Kadambi, M. A., & Truscott, D. (2003). Vicarious traumatisation and burnout among therapists working with sex offenders. *Traumatology, 9(4),* 216-230.

Kadambi, M. A., & Ennis, L. (2004). Reconsidering vicarious trauma. *Journal of Trauma Practice, 3(2),* 1-21.

Kassam-Adams, N. (1995). The Risks of Treating Sexual Trauma: Stress and Secondary Trauma in Psychotherapists. In B. H. Stamm (Ed.) *Secondary Traumatic Stress: Self Care Issues for Clinicians, Researchers and Educators,* (pp.37-47). Lutherville, MD: Sidran Press.

Kelly, G. A. (1955). *The Psychology of Personal Constructs - Volume 1: A Theory of Personality & Volume 2: Clinical Diagnosis and Psychotherapy*. New York, NY: Norton.

Knight, C. (2010). Indirect trauma in the field practicum: secondary traumatic stress, vicarious trauma, and compassion fatigue among social work students and their field instructors. *The Journal of Baccalaureate Social Work, 15(1),* 31-52.

Landfield, A. W. (1971). Personal construct systems in psychotherapy. Chicago, IL: Rand McNally.

Leach, C., Freshwater, K., Aldridge, J., & Sunderland, J. (2001). Analysis of repertory grids in clinical practice*. British Journal of Clinical Psychology, 40(3)*, 225–248.

Linley, P. A., & Joseph, S. (2007). Therapy work and clinician's positive and negative well-being. *Journal of Social and Clinical Psychology, 26(3),* 385–403.

Makadia, R., Sabin-Farrell, R. & Turpin, G. (In press). Indirect exposure to client trauma and the impact on trainee clinical psychologists: secondary traumatic stress or vicarious traumatization? *Clinical Psychology & Psychotherapy*.

Maslach, C. (1982). *Burnout, the cost of caring.* Englewood Cliffs, NJ: Prentice-Hall.

Mayring, P. (2000). Qualitative content analysis. *Forum: Qualitative Social Research, 1(2),* Art. 20. Retrieved from http://www.qualitative-research.net/fqs-texte/2-00/02-00mayring-e.htm

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

McCann, I. L., & Pearlman, L. A. (1992). Constructivist self-development theory: A theoretical model of psychological adaptation to severe trauma. In D. K. Sakheim & S. E. Devine (Eds). *Out of Darkness: Exploring Satanism and Ritual Abuse* (pp. 185-206). New York: Lexington Books.

Miller, M. K., Flores, D. M., & Pitcher, B. J. (2010). Using constructivist self-development theory to understand judges' reactions to a courthouse shooting: an exploratory study. *Psychiatry, Psychology and Law, 17(1),* 121-138.

Munroe, J. F. (1999). Ethical issues associated with secondary trauma in therapists. In B. H. Stamm (Ed.). *Secondary Traumatic Stress: Self Care Issues for Clinicians, Researchers, and Educators* (pp. 221-229). Lutherville, MD: Sidran.

Najjar, N., Davis, L. W., Beck-Coon, K., & Doebbeling, C. C. (2009). Compassion fatigue: A review of research to date and relevance to cancer providers. *Journal of Health Psychology, 14(2)*, 267−277.

Netland, M. (2001). Assessment of exposure to political violence and other potentially traumatizing events. *Journal of Traumatic Stress, 14(2)*, 311-326.

Oswalt, R. M. (1974). Person perception: Subject-determined and investigator-determined concepts. *Journal of Social Psychology, 94(2),* 281-285.

Park, C. L., & Lechner, S. C. (2006). Measurement issues in assessing growth following stressful life experiences. In L. G. Calhoun & R. G. Tedeschi (Eds.), *Handbook of posttraumatic growth: Research and practice* (pp. 47–67). Mahwah, NJ: Erlbaum.

Pearlman, L. A. (1996). Psychometric review of the TSI Belief Scale, Revision-L. In B. H. Stamm (Ed.), *Measurement of Stress, Trauma, and Adaptation* (pp. 415-418). Lutherville, MD: Sidran Press.

Pearlman, L. A. (2003). *The Trauma Attachment Belief Scale manual*. Los Angeles, CA: Western Psychological Services Inc.

Pearlman, L. A., & MacIan, P. S. (1995). Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. *Professional Psychology: Research and Practice, 26(6*), 558-565.

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

Pistorius, K. D., Feinauer, L. L., Harper, J. M., Stahmann, R. F., & Miller, R. B. (2008). Working with sexually abused children. *The American Journal of Family Therapy, 36(3),* 181-195.

Racanelli, C. (2005). Attachment and compassion fatigue among American and Israeli mental health clinicians working with traumatized victims of terrorism. *International Journal of Emergency Mental Health, 7(2),* 115-124.

Resick, P. (2000). *Stress and trauma.* Hove, UK: Psychology Press.

Rudolph, J. M., & Stamm, B. H. (1999). Maximizing human capital: Moderating secondary traumatic stress through administrative and policy action. In B. H. Stamm (Ed.), *Secondary traumatic stress* (2nd ed., pp. 277-290). Letherville, Maryland: Sidran Press.

Sabin-Farrell, R., & Turpin, G. (2003). Vicarious traumatization: implications for the mental health of health workers? *Clinical Psychology Review, 23(3),* 449-480.

Sermpezis, C., & Winter, D. A. (2009). Is trauma the product of over- or under-elaboration? A critique of the personal construct model of posttraumatic stress disorder. *Journal of Constructivist Psychology, 22(4),* 306-327.

Sewell, K. W. (1997). Posttraumatic stress: Towards a constructivist model of psychotherapy. In G. N. Neimeyer & R.A. Neimeyer (Eds.), *Advances in personal construct psychology* (pp. 207–235). Greenwich, CT: JAI Press.

Sewell, K. W., Cromwell, R. L., Farrell-Higgins, J., Palmer, R., Ohlde, C., & Patterson, T. W. (1996). Hierarchical elaboration in the conceptual structure of Vietnam veterans. *Journal of Constructivist Psychology*, *9*, 79–96.

Shamai, M., & Ron, P. (2009). Helping Direct and Indirect Victims of National Terror: Experiences of Israeli Social Workers. *Qualitative Health Research, 19(1),* 42-54.

Splevins, K. A., Cohen, K., Joseph, S., Murray, C., & Bowley, J. (2010). Vicarious posttraumatic growth among interpreters. *Qualitative Health Research, 20(12),* 1705-1716.

Sprang, G., Clark, J. J., & Whitt-Woosley, A. (2007). Compassion fatigue, compassion satisfaction, and burnout: Factors impacting a professional's quality of life. *Journal of Loss and Trauma, 12(3),* 259-280.

Stamm, B.H. (2010). *The Concise ProQOL Manual* (2rd ed.). Pocatello, ID: ProQOL.org.

Stamm, B. H., Varra, E. M., Pearlman, L. A., & Giller, E. (2002). *The Helper's Power to Heal and to be Hurt – Or Helped – By Trying.* Publication of the National Register of Health Service Providers in Psychology. Washington, DC.

Steed, L. G., & Downing, R. (1998) A phenomenological study of vicarious traumatization amongst psychologists and professional counsellors working in the field of sexual abuse/assault. *The Australasian Journal of Disaster and Trauma Studies, 2*. Retrieved from http://www.massey.ac.nz/~trauma/issues/1998-2/steed.htm.

Tan, F. B., & Hunter, G. M. (2002). The repertory grid technique: A method for the study of cognition in information systems. *MIS Quarterly*, *26(1)*, 39-57.

Trippany, R. L., White Kress, V. E., & Wilcoxin, S. A. (2004). Preventing vicarious trauma: What counselors should know when working with trauma survivors. *Journal of Counseling and Development, 82(1),* 31– 37.

VanDeusen, K. M., & Way, I. (2006). Vicarious trauma: An exploratory study of the impact of providing sexual abuse treatment on clinicians' trust and intimacy. *Journal of Child Sexual Abuse, 15(1),* 69-85.

Warr, P. B., & Coffman, T. L. (1970). Personality, involvement and extremity of judgement. *British Journal of Social and Clinical Psychology, 9(2),*108-121.

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

Way, I., Van Deusen, K. M., & Cottrell, T. (2007). Vicarious trauma: Predictors of clinicians' disrupted cognitions about self-esteem and self-intimacy. *Journal of Child Sexual Abuse, 16(4),* 81-98.

Westphal, M., & Bonnano, G. M. (2007). Posttraumatic growth and resilience to trauma: Different sides of the same coin or different coins? *Applied Psychology: An International Review, 56(3),* 417-427.

EXTENDED PAPER

1. Extended Background

This section is intended to provide further explanation of theory and previous research related to those discussed within the journal paper. An overall summary of the literature is provided along with the rationale for the present study.

1.1 Effects of Exposure to Client Trauma: Concepts

Within the literature, there are multiple terms used to describe the effects on therapists who are exposed to client trauma within their role. This forms one of the key methodological difficulties when researching the effects of exposure to indirect trauma due to lack of consistency and terms used interchangeably (Najjar, Davis, Beck-Coon & Doebbeling, 2009). Terms used in the literature include VT, STS, 'compassion fatigue', 'countertransference' and 'burnout'. Each differs slightly in focus on how individuals exposed to indirect trauma are affected and their theoretical basis.

STS

This term focuses on the symptomatic effects of exposure to indirect trauma, specifically through listening to client trauma accounts (Figley, 1995). The construct was first noted when symptom patterns were observed in those empathising with client trauma within their roles. Figley (1995) suggests it can occur from a single exposure to indirect trauma accounts and with more exposure the degree of STS increases. It is not underpinned by a unique psychological theory, instead it relates to diagnostic criteria for Posttraumatic Stress Disorder (PTSD) (DSM-IV, American Psychiatric Association (APA), 2000), including hyperarousal, avoidance and re-experiencing client trauma. The DSM-V has recently been updated to include indirect trauma as a precipitating factor for PTSD (APA, 2013). This causes difficulties for the construct of STS, as it may now be conceptualised as PTSD. This risks pathologising what may be a normal part of therapists' experience within trauma work.

Compassion Fatigue

This term is thought to develop through empathising with client distress (Figley, 1999). It is used interchangeably with STS, and some researchers argue it refers to the same phenomenon (Bride, Radey & Figley, 2007). However, it can develop through any type of healthare, whereas STS is specifically related to trauma work (Sabin-Farrell & Turpin, 2003). It is rooted in a stress-process framework (Figley, 2002). This model postulates that empathy and emotional energy are required in the formation of therapeutic rapport. Empathising with a client's distress may result in compassion stress due to use of emotional energy. Risk increases if exposure to distress is ongoing and memories of client distress elicit an emotional response. A limitation of this model is it is binary, suggesting compassion fatigue is either present or absent, rather than recognising varying degrees of response which may depend on contextual factors.

Burnout

Similarly, burnout can occur with any type of work and is not just specific trauma. It is even more general, encompassing a range of symptoms including fatigue, emotional exhaustion, irritability, anxiety, guilt, pessimism, hopelessness, social withdrawal and work-related behaviours such as leaving the role, reduced role performance and depersonalisation (Maslach, 1982). It is thought to develop from chronic exposure to emotionally-demanding work (Pines & Aronson, 1988), so can apply to any profession, not just those which involve listening to client trauma (Leiter & Schaufeli, 1996).

VT

This concept builds on the previous terms to include not only STS symptoms but changes in the therapists' identity; including their frame of reference, self-capacities, ego resources, psychological needs and schemas which interact with memory and perception (Pearlman & Saakvitne, 1995). Therapists may experience much of what their clients experience, but at subclinical levels (Pearlman & Saakvitne, 1995). It is rooted in Constructivist Self-Development

Theory (CSDT), which explains the psychological and interpersonal effects of trauma-exposure, both direct and indirect through trauma work. It is an integration of psychoanalytic and cognitive-developmental learning theories which identifies areas of the self which are impacted by disrupted belief systems following exposure to trauma (Pearlman & Saakvitne, 1995). A key point made is that VT reactions are normal and adaptive in emotional regulation. It is a natural response to demanding work, developing a way to protect themselves from repeated exposure to client trauma (Pearlman & Saakvitne, 1995). The meaning ascribed to trauma exposure is influenced by complex relations between the individual, the event and the wider context (McCann & Pearlman, 1990).

Frame of reference refers to the cognitive structure individuals use to make sense of themselves and the world around them. It includes worldview, spirituality and identity (McCann & Pearlman, 1990). Exposure to client trauma can result in distressing changes to the therapist's frame of reference, which may negatively impact the therapeutic relationship (Pearlman & Saakvitne, 1995).

Self-capacities refer to inner processes that maintain a stable and coherent self-identity. When this is disrupted through exposure to client trauma, the therapist may struggle with tolerating and regulating their emotions, relating to others and maintaining a positive view of themselves (Pearlman & Saakvitne, 1995).

Ego resources are related to the therapist's ability to connect interpersonally and meet their psychological needs. They include the capacity to empathise, self-reflect and establish boundaries, all of which may be negatively affected through exposure to client trauma which can impact therapeutic relationships (Pearlman & Saakvitne, 1995).

People construct their realities using cognitive schemas. These are cognitive models which shape information-processing and develop through experience. New information usually integrates into existing schemas through assimilation. This occurs when new information is similar to previous experiences so previous information is used to make sense of it (Berger, 2008). Traumatic

material communicated by clients may be very different to therapists' existing schemas, potentially leading to schema disruptions. This occurs through accommodation, where existing schemas are altered to accommodate new information. This usually results in therapists' schemas becoming more negative, accommodating client trauma and distress into their own belief-system (McCann & Pearlman, 1990). Disruptions are thought to occur in the five main psychological need areas; safety, esteem, intimacy, trust and control. These beliefs are both self and other-focused. These areas are thought to be the most vulnerable to disruption following exposure to trauma and can impact negatively on the individual's spirituality in terms of reduced hope and becoming more cynical. These disrupted beliefs can also result in symptomatic changes such as emotional numbing, withdrawal, dissociation and sensory changes in memory including flashbacks, intrusive images and hyperarousal (McCann & Pearlman, 1990). This parallels some of the symptoms accounted for by STS but builds on this term using psychological theory to account for the inner changes in the therapists' sense of self resulting from indirect exposure to trauma.

The changes are proposed to be pervasive; impacting all aspects of the therapists' life including that outside of work, and cumulative; suggesting the more exposure to client trauma a therapist has the more affected they will be as each experience will reinforce the schematic changes (Trippany, White Kress & Wilcoxin, 2004).

Countertransference

This term describes the physical, emotional, behavioural and cognitive responses a therapist has towards their client, as well as their conscious and unconscious defences towards the associations and intrapsychic conflicts aroused by these (Pearlman & Saakvitne, 1995). Therapists reactions can parallel their client's, which relate to their own previous experiences and psychological defences (Neumann & Gamble, 1995). Countertransference can occur in all therapies, not just those focussed on trauma, therefore it is a broader concept than VT. It also refers specifically to the client-therapist dyad,

failing to address the cumulative effect of working with many traumatised clients, which VT theory accounts for. However, Danieli (1994) introduced the term ‘event countertransference’ which specifically refers to the psychological reactions therapists experience as being related to the clients’ trauma stories, rather than unresolved neurotic conflicts of the therapist.

VT is also thought to have a pervasive effect on the therapist, within and outside of therapy in their personal lives, whereas countertransference is a temporary reaction within the therapeutic relationship (Pearlman & Saakvitne, 1995). It is argued that unrecognised countertransference reactions can increase vulnerability to VT (Blair & Ramones, 1996). Although the two concepts are linked, they are distinct but can influence each other.

Summary

Within the literature the overlapping use of these terms and lack of conceptual clarity has created confusion (Elwood, Mott, Lohr & Galovski, 2011). For the purpose of this study, VT will be the term used, operationally defined as negative changes in the therapist’s sense of self including belief changes as well as symptoms similar to those experienced by their clients. It goes beyond terms like countertransference which are reactions specific to one client. Countertransference suggests therapists can experience parallel emotions to that of their client, influenced by their own psychological defences (Neumann & Gamble, 1995). These effects are temporary, linked directly to an event within the single therapeutic relationship. VT is more pervasive, as it takes place across the therapist’s career and impacts life outside of work (Pearlman & Saakvitne, 1995). Whilst there is some overlap with burnout, compassion fatigue and STS, in terms of the symptomatic effects, VT goes beyond these explanations to explain how symptoms result from internal changes to the therapists’ sense of self and belief-system. It is rooted in constructivist personality theory, focussing on the process of meaning-making and adapting to exposure to client trauma, rather than focussing on symptoms. Evidence for symptoms resulting from exposure to client trauma is more consistent (Sabin-Farrell & Turpin, 2003), therefore there is a need to explore the underlying

beliefs and process of meaning making in therapists working with trauma which is emphasised in VT theory.

1.2 VT: Five Belief Areas

As this study takes a deductive approach, specifically looking for evidence supporting beliefs related to the five psychological needs specified within CSDT, a detailed summary of each is provided. As schemas are shaped by the individual's experiences and associated with specific emotions, different people will experience different distortions depending on which needs are most salient to them (McCann & Pearlman, 1990). Therefore, one therapist may only experience distortions in their sense of safety with no disruptions to the other four areas.

Control

This need relates to the urge to control one's behaviour, emotions and thoughts or those of others. Distorted self-control beliefs may result in the therapist feeling helpless or unable to predict and direct their future (Pearlman & Saakvitne, 1995). Disruptions in other-control can either result in an excessive need to exert control over others, narrowing their world to increase sense of control; or alternatively it can lead to over-dependence and surrender of control in situations where control is possible.

Previous research found therapists supporting rape victims felt they had less control over themselves (Bober & Regehr, 2006; Goldblatt *et al*., 2009); some no longer felt shockable (Iliffe & Steed, 2000). Those working with sectioned clients and with less experience believed they had reduced self-control (Knight, 2010). Perceptions of having no control over other organisations involved in helping their clients was related to feeling powerless (Capri *et al.,* 2003; Schauben & Frazier, 1995) and greater burnout (Johnson & Hunter, 1997).

Esteem

People have a core need to feel recognised and valued by others. They also need to perceive the value and worth of others (Pearlman & Saakvitne, 1995). Therapists with disrupted self-esteem beliefs may question their worth, their

ability to help others or become more self-critical. Those with disrupted other-esteem may devalue others or dismiss them.

Research has demonstrated some therapists with personal trauma had more deleterious self-esteem beliefs (Pearlman & MacIan, 1995; Bober & Regehr, 2006). However, others felt more personal accomplishment through their work, despite suffering higher emotional exhaustion (Baird & Jenkins, 2003) or felt helping clients helped them heal from personal victimisation (Schauben & Frazier, 1995). Some professionals doubted their clinical efficacy, especially in clients where change was slow (Arnold *et al.,* 2005). This occurred more in less experienced professionals (Pearlman & MacIan, 1995; Iliffe & Steed, 2000; Knight, 2010) who felt they lacked skills (Robinson, Clements & Land*,* 2003). Some identified that crises of confidence led to using more negative self-talk (Steed & Downing, 1998). Those working with abused children doubted the efficacy of their parenting (Menashe, Possick, & Buchbinder*.,* 2014). Changes in 'other-esteem' included seeing others as evil (Schauben & Frazier, 1995; Steed & Downing, 1998; Bell, 2003; Pistorius *et al*., 2008; Ben-Porat & Itzhaky, 2009; Kita, 2015).

Intimacy

This relates to the need to feel connected to others in a meaningful way as well as connected to one's own emotions and thoughts (Pearlman & Saakvitne, 1995). When self-intimacy is disrupted the therapist may no longer enjoy their usual individual pursuits and spending time alone. They may also experience emotional numbing and emptiness. When other-intimacy is disrupted, therapists may feel alienated from others or loved ones may feel the therapist puts their work and clients before them. This may result in them withdrawing from others or feeling others do not understand them.

Previous research has found those with disrupted self-intimacy beliefs had less time for leisure activities (Bober & Regehr, 2006), had less peer support and less experience (Knight, 2010) or had experienced personal trauma (Pearlman & MacIan, 1995). These results are correlational, so cause and effect cannot be established. Qualitative findings suggested some domestic abuse counsellors

became so used to listening to trauma they were out of touch with themselves (Iliffe & Steed, 2000). Others noticed negative changes including lacking emotional availability (Ben-Porat & Itzhaky, 2009) or feeling isolated due to others not understanding or wanting to hear about their work (Capri *et al.,* 2003; Steed & Downing, 1998; Iliffe & Steed, 2000; Pistorius *et al.,* 2008; Jankoski, 2010; Kita, 2015). However, this led to increased feelings of support from colleagues with shared experiences (Capri *et al.,* 2003; Pack, 2010; Kita, 2015; Jankoski, 2010). Those not able to access peer support had more disrupted beliefs on the TABS (Knight, 2010), so peer support may buffer against some disconnection felt towards others. Negative beliefs surrounding physical intimacy impacted professionals' sexual relationships, specifically those working with abuse and domestic violence victims (Knight, 1997; Clemans, 2004; Pistorius *et al.,* 2008; Goldblatt *et al.,* 2009, Jankoski, 2010, Pack, 2010).

Safety

This relates to the need to feel secure and able to protect self and others from physical and emotional harm. There is a need to perceive the world and those in it as safe. When safety beliefs are negatively disrupted the individual may feel more fearful, vulnerable to harm and worried about loved ones (Dyregrov & Mitchell, 1992). It may also relate to behavioural changes such as becoming more vigilant and taking steps to protect themselves like avoiding going out at night or learning self-defence (Trippany *et al.,* 2004).

Previous studies have found therapists felt more vulnerable to harm due to their work (Iliffe & Steed, 2000; Cunningham, 2003; Arnold *et al.,* 2005, Kita, 2015). Some beliefs were linked to specific dangers related to their experience of client trauma. Rape counsellors felt more vulnerable to sexual violence, becoming hyper-vigilant and cautious (Clemans, 2004). Less experienced therapists (Devilly, Wright & Varker, 2009; Knight, 2010) and those seeing more sexually abused clients (Cunningham, 2003) had more negative safety beliefs and heightened distress. Rates of disrupted self-safety beliefs varied between studies: 27% (Knight, 1997) compared to 66% (Steed & Downing, 1998) felt more unsafe as a result of their work. Both were samples of therapists working

with sexual abuse survivors but one used questionnaires and the one finding greater disrupted beliefs used semi-structured interviews, so differences could be due to questioning or cultural influences. Seeing the world as dangerous led professionals to be over-protective of their children (Benatar, 2000; Clemans, 2004; Jankoski, 2010; Menashe *et al*., 2014) or become more cynical about the safety of others' children, specifically worrying about the potential for abuse (Steed & Downing, 1998; Pack, 2010).

Trust

This refers to the need to be able to rely on self-perceptions and judgements as well as those of others, believing others will keep their promises and have good intentions (McCann & Pearlman, 1990). When this area is negatively distorted the therapist may feel suspicious or disappointed by others. They may anticipate betrayal or feel less confident in their decisions, decreasing independence (Pearlman & Saakvitne, 1995).

Previous research has found therapists with personal trauma experiences doubted their perceptions more (Pearlman & MacIan, 1995; Bober & Regehr, 2006) and so did those with less experience and less support from supervisors (Dunkley & Whelan, 2006; Pearlman & MacIan, 1995; Knight, 2010). Those with personal trauma experience were also more distrustful of others (Pearlman & MacIan, 1995; VanDeusen & Way, 2006). It is difficult to establish whether this is related to their personal experiences of trauma or VT, which is why it is important for studies to measure personal trauma as a way of providing context to interpret findings. VT theory suggests personal trauma may impact the disruption of cognitions, hypothesising more negative disruptions in belief systems if therapists have experienced their own trauma (Pearlman & MacIan, 1995). Sexual abuse therapists felt more suspicious of others (Capri *et al*., 2003; Cunningham, 2003; Pistorius *et al*., 2008; Jankoski, 2010; Menashe *et al*., 2014) and had a darkened view of society and its denial of sexual violence (Benatar, 2000). Domestic violence counsellors felt sceptical over existence of non-abusive relationships (Clemans, 2004; Goldblatt *et al*., 2009).

1.3 Factors Contributing to VT

A large body of research has attempted to identify factors which increase the risk of developing VT. A review of these is necessary for this study as it helped inform the information collected from participants.

Experience

CSDT suggests VT effects are cumulative, with more exposure to client trauma over time increasing VT (McCann & Pearlman, 1990). Trainee Clinical Psychologists are likely to be exposed to client trauma accounts through their experiences on placement, but their experience of this is likely to be less than qualified therapists due to limited numbers of days on placement, smaller caseloads and less time spent in the field. Therefore, according to CSDT, VT should be less in trainees when compared to qualified therapists with more experience. However, some research has found VT is greater in less experienced qualified therapists (Bober & Regher, 2006; Knight, 2010; Racanelli, 2005; Sprang, Clark & Whitt-Woosley, 2007, Way *et al*., 2004). This association is suggested to be due to those experiencing high levels of distress related to trauma work leaving the profession. Studies have found those with greater VT were more likely to express a desire to leave (Bride *et al.,* 2007).

There is only one published study assessing VT in trainee therapists. Adams and Riggs (2008) studied Trainee Clinical and Counselling Psychologists in America, finding those with less experience working with trauma reported more disrupted beliefs. This conflicts with the cumulative premise of the theory. An unpublished study of British Trainee Clinical Psychologists found no link between trauma work and disrupted beliefs. However, it did find a link between levels of stress in clinical work and quality of trauma training with STS symptoms (Makadia *et al*., *in press*). These conflicting findings related to disrupted beliefs between American and British samples warrants further research in this area. Both these studies were quantitative, using the TABS as a measure of belief disruption. Therefore, qualitative research with Trainee Clinical Psychologists may allow deeper exploration of their experiences related to disrupted beliefs.

There is no previous research comparing VT effects in qualified and trainee therapists, providing a rationale for this study's sample. Comparing trainee and qualified staff will help determine whether VT is cumulative and chronic, as qualified staff will have more experience of indirect trauma exposure. Therefore, if the effects are cumulative, they should be greater in more experienced therapists. It is also important to determine whether VT is a risk for those training as therapists in the UK, as this will have implications for their wellbeing and ability to practice.

Exposure Level

Existing literature has struggled with measuring therapists' exposure to indirect client trauma (Elwood *et al.,* 2010). Some have used hours per week working with trauma, percentage of trauma clients on caseload or years working with trauma clients. This makes it difficult to compare results between studies and establish whether more exposure to client trauma is related to increased VT. Research identified the primary predictor of VT was hours spent working with traumatised clients, suggesting balancing caseloads with non-trauma work is important in reducing the negative impact of VT (Brady, Guy, Poelstra & Brokaw*,* 1999; Kassam-Adams, 1995; Harrison & Westwood, 2009; Sprang *et al.,* 2007). However, others failed to find a link with percentage of trauma clients on therapist caseloads (Boscarino, Figley & Adams, 2004; Cunningham, 2003; Devilly *et al.,* 2009; Perron & Hiltz, 2006), some even found those seeing more trauma clients reported less distress (Baird & Jenkins, 2003). Findings have offered more support for an increase in STS symptoms than disrupted beliefs following more exposure to client trauma on therapist caseloads (Betts-Adams, Matto & Harrington, 2001; Bober & Regher, 2006, Linley, Joseph & Loumidis*,* 2005)

Trauma Type

Client trauma is defined as their exposure to any event involving experiencing, witnessing or learning about actual or threatened death or serious injury to themselves or others; or threatened sexual violation (APA, 2013). Client trauma studied within existing literature has included childhood sexual abuse, domestic

violence, torture, physical assault and rape (Bell, 2003; Ben-Porat & Itzhaky, 2009; Clemans, 2004; Engstrom, Hernandez & Gangsei, 2008; Knight, 1997). Some researchers suggest when trauma is inflicted by another human being, such as abuse, it is more devastating (Herman, 1992; McCann & Pearlman, 1990). This is supported by studies comparing therapists working with victims of sexual abuse and those working in oncology, finding greater VT in those working with sexual abuse (Cunningham, 2003). Other studies have failed to replicate these findings, demonstrating no difference in VT related to the type of trauma therapists predominately work with. Kadambi and Truscott (2003) found no differences in TSI-beliefs scale scores between therapists treating sexual offenders and a control group of general mental health professionals. However, this study did find differences in therapists' perceptions of how traumatising their work was, despite failing to find differences on quantitative measures of disrupted beliefs. Those treating sex offenders viewed their work as more stressful This questions the sensitivity of these measures in picking up VT, providing rationale for qualitative research where therapist experience can be explored in depth. Other factors may also be accounting for the differences in VT previously found. Oncology therapists had higher caseloads, so those working with abuse may have seen clients for longer and had less turnover and variety on their caseloads (Cunningham, 2003).

Trauma Training

It is argued that without access to trauma-specific training, particularly addressing VT, therapists have no way of making sense of their experiences (Pearlman & Saakvitne, 1995). Access to training for both new and experienced therapists working with trauma is thought to reduce VT (Chrestman, 1999; Ortlepp & Freidman, 2002; Pearlman & MacIan, 1995). An unpublished study examining the effects of vicarious resiliency training, which promotes awareness of VT, found 72% of professionals reported a decrease in their symptoms 4-weeks later (Shew, 2010). However, this was based on a small sample, reducing generalisability.

Personal Trauma

Therapists who have personal experience of traumatic events may be more susceptible to VT (Pearlman & MacIan, 1995). Estimates vary between studies, but more than a third of therapists have reported personal trauma (Adams & Riggs, 2008; Linley & Joseph, 2007). However, research has demonstrated conflicting results regarding whether this increases VT. Some have found more disrupted beliefs in those who have experienced personal trauma, particularly in safety, trust and other-intimacy (Pearlman & MacIan, 1995) and in esteem (Cunningham, 1997). Others have found therapists with personal history were not more affected than those without this exposure (Kadambi & Truscott, 2003; Schauben & Frazier, 1995; Way *et al*., 2004; Young, 2000). It is argued that VT may not be a distinct construct if it is consistently linked to persona trauma exposure, as it is difficult to distinguish whether effects are related to direct or indirect exposure to trauma (Elwood *et al.,* 2011). Creamer and Liddle (2005) failed to find a link between personal trauma experience and STS symptoms, but did find a link with therapists who had accessed therapy for their personal trauma. This suggests that those who are more distressed by their personal experiences of trauma may be more susceptible to scoring higher on secondary trauma measures, suggesting lack of distinction between indirect and direct exposure. This is supported by the finding that therapists who felt their personal trauma experiences were unresolved scored higher on secondary trauma measures (Hargrave, Scott & McDowell, 2006).

Defence and Coping Style

Listening to client trauma accounts can be emotionally overwhelming, promoting the use of psychological defences by the therapist to protect themselves from these emotions (Herman, 1992). They may use denial, withdrawal or dissociation, which prevents them working through the emotions, prompting symptom development (Pearlman & Saakvitne, 1995). Self-sacrificing defence styles have been linked with more VT symptoms (Adams & Riggs, 2008). These individuals are highly motivated to help others, which may increase vulnerability to VT.

Therapists who use active coping strategies to work through the emotions elicited through listening to client trauma have been shown to be less affected by VT. These strategies include instrumental support, problem-focussed coping and humour (Schauben & Frazier, 1995, Weaks, 2000)

Supervision

Therapists need to engage in a process of integrating their experience of client trauma, in a similar way clients do within therapy (McCann & Pearlman, 1990). Studies have found quality and quantity of supervision influences VT (Sabin-Farrell & Turpin, 2003). Those not receiving adequate supervision were found to have more disrupted beliefs (Pearlman & Saakvitne, 1995). Peer supervision can provide therapists with social support from those with shared experiences and understanding, helping normalise VT (Trippany *et al.,* 2004). However, some found the amount of supervision received was not linked to VT (Meldrum, King & Spooner, 2002). Inconsistency in findings may be linked to different measures used in these quantitative studies. Qualitative research has identified that therapists value the use of supervision for allowing them to process client trauma, specifically due to the shared understanding provided by supervisors and peers who have similar experiences of trauma work. This mixed method study found use of supervision was also linked to lower work stress (Killian, 2008).

Others have reported positive changes in therapists receiving more supervision, such as increased spirituality (Brockhouse, Msetfi, Cohen & Joseph, 2011). It may be that supervision and perceived support from others is more relevant to VPTG, as this has been found in those directly exposed to trauma (Borja, Callahan & Long, 2006).

It is worth noting that most these studies were conducted in the United States of America, where supervision requirements differ greatly to those in Britan, reducing applicability to British therapists (Chouliara, Hutchinson & Karatzias, 2009).

1.4 Implications of VT

The negative impact of VT has the potential to affect therapists in numerous ways. It poses a risk factor for mental health difficulties including anxiety and depression (Clark & Giorio, 1998; Steed & Downing, 1998). It also has implications for job performance, being associated with increased absence, reduced morale and productivity, increased lateness and decreased use of supervision (Dutton & Rubinstein, 1995; Stamm, Varra, Pearlman & Giller, 2002). Therapists may make efforts to avoid working with clients' traumatic material (Figley, 1995; Munroe, 1999). Those who question their clinical efficacy may lose sight of client strengths and improvements (Herman, 1992), which is likely to negatively impact therapeutic interventions. It is argued that if the therapist is suffering from similar distorted views to their client then they cannot provide reasonable care (Lonergan, O'Halloran & Crane, 2004), with 36.7% admitting negative impacts on the care they provided (Guy, Poelstra & Stark, 1989). Research also suggests therapists affected by VT make poorer professional judgements, such as misdiagnosis and poor treatment planning (Munroe, 1999; Hesse, 2002). Therapists who question their clinical efficacy, related to disruptions in self-esteem beliefs, may discount client strengths and improvements. There are also implications for therapists' personal relationships, related to increased suspicion of others and disruptions in sexuality (Rich, 1997).

Despite research highlighting the significant effects VT may have on therapist wellbeing, others have suggested the impact is much less than that caused by direct trauma exposure, resulting in chronic, milder distress (Motta *et al.,* 1997). This may result in it being concealed as therapists are still functioning well (Lerias & Byrne, 2003). This is complicated by research and theory not providing a clear cut-off between what constitutes a normal, temporary response to trauma work and a pervasive VT response (Elwood *et al.,* 2011). Common measures of VT and STS vary in terms of the time periods covered, some leaving it unspecified (Elwood *et al*., 2011) and the cross-sectional nature of most existing research makes it difficult to determine chronicity of these effects. Without clarity regarding this, as well as inconsistent evidence regarding

the occurrence of theorised belief shifts in therapists working with trauma, developing interventions for VT is premature, as it is unclear whether symptoms may resolve naturally. If these effects are part of a normal response to trauma work, interventions may even be damaging, potentially leading to self-fulfilling prophecies and increasing therapist distress (Elwood *et al.,* 2011).

1.5 Methodological Difficulties

Much of the quantitative research using measures such as the TABS (Pearlman, 2003) is limited by cross-sectional designs, measuring belief disruptions at one time-point. As there are no baseline measures of therapists' beliefs prior to starting trauma work, it is difficult to determine whether the disrupted beliefs measured by the TABS are a result of trauma work or were pre-existing based on the therapists' life experiences. There is also the difficulty of the TABS purporting to measure belief disruption without a baseline comparison to beliefs before exposure to trauma work. Therapists will all have individual differences in their belief systems prior to commencing trauma work, as schemas are formed on the basis of individual life experiences. Therefore, a measure based on norms may be misleading without a baseline measure, as therapists' belief systems may have fallen into the disrupted range prior to starting trauma work due to other personal experiences.

Also therapists have reported difficulties remembering their beliefs prior to starting trauma work (Steed & Downing, 1998), adding difficulty to qualitative designs which ask therapists about changes resulting from trauma work. This highlights a need for longitudinal designs, as without this the trajectory of VT is unclear. It may be an acute effect which therapists are able to recover from (Chrestman, 1999), possibly explaining why some cross-sectional studies have found no evidence of VT. Cross-sectional studies also suffer from sampling biases, as they cannot explain the experiences of those who choose to leave the field. Those who are suffering with the negative effects of trauma work may leave, offering another explanation for why some studies fail to find VT effects, as those who are more distressed may not be represented. Longitudinal research could capture those who do leave and explore reasons for this

decision. However, there are practical issues with longitudinal designs such as the time required from busy therapists resulting in potentially high attrition rates. Measures which try to capture change by asking therapists to reflect on different stages of their career using more implicit techniques such as that used in repertory grids may help address some of the difficulties associated with existing research. People code and organise information within their memory as cognitive structures which limit the input of information from the environment (Kelly, 1955). The way information is stored is implicit, often used in an automatic way when making sense of events, so is therefore difficult to elicit through introspection (Björklund, 2008). To elicit this information, interviews are not appropriate as it is not stored in a verbal form. This relates to personal construct psychology, which attempted to explain why people have different views (Kelly, 1955). Through experience people develop constructs which they use to make meaning from their world. Repertory grids developed from this (Bannister & Fransella, 1986), providing a way of identifying perceptions, associated feelings and intuitions about a given topic which may not be consciously accessible.

Within the field, there is limited research exploring the hypothesised causal mechanisms behind VT. CSDT uses cognitive theory to explain how changes in beliefs occur, through therapists accommodating client trauma into their own schemas (McCann & Pearlman, 1990). However, conflicting research results have questioned central premises of this theory. Some researchers have found schema disruptions consistent with the theory in therapists working with trauma (Pearlman & MacIan, 1995) whereas others, using the same measure, did not (Kadambi & Truscott, 2003; van Minnen & Keijsers, 2001). Research which has identified belief disruptions and symptoms related to trauma work also tends to yield weak correlations and scores below the subclinical level (Sabin-Farrell & Turpin, 2003). This could be due to measures lacking sensitivity to detect differences between therapists working with trauma and those that do not. However, other factors may also explain weak correlations and null findings. For example, sampling biases may influence results as those struggling may

choose not to participate or leave the field due to stress. If this was the case, levels of VT would be underrepresented by the samples used.

The theory also suggests effects are cumulative, but research has shown inconsistent findings regarding this. Some have found more exposure to client trauma is linked to more schema disruptions (Schauben & Frazier, 1995), others have failed to demonstrate this (Brady *et al.,* 1999). Research has mainly focused on measuring prevalence rates and risk factors for the development of VT. Therefore, more research is needed investigating the mechanisms underlying the effects.

The interchangeable use of terms related to VT, such as STS and compassion fatigue, many of which are poorly operationalised within individual studies, makes it difficult to directly compare results between studies. Also no measure exists which measures VT as a whole (Sabin-Farrell & Turpin, 2003), as this must include belief changes, symptoms, spirituality, worldview, affect and interpersonal relationships. The TSI-Beliefs scale (Pearlman, 1996) was the first measure developed to assess the five belief areas hypothesised within VT theory to be affected by exposure to trauma. It has been criticised for lacking construct and divergent validity (Betts-Adams *et al.,* 2001). Also normative data for the measure is based on a sample where trauma exposure and therapists' personal trauma is unclearly reported, so the norms may be inflated (Kadambi & Truscott, 2003). This highlights a difficulty with quantitative research, as the focus of the research is predetermined by the measures used, potentially missing important aspects of therapists' experience of trauma work. Previous qualitative research has identified positive aspects of therapists' experiences alongside the negatives included in existing quantitative measures (Arnold *et al.,* 2005; Steed & Downing, 1998).

1.6 VPTG

VT only focusses on negative aspects of therapists' experience of trauma work. This may partially be accounted for by the large body of quantitative research, using measures of VT and STS which only measure these negative effects. It is suggested that positive changes can also occur following direct exposure to

trauma in five areas: improved relationships, increased personal strength and appreciation for life, spiritual changes and discovering new possibilities (Tedeschi & Calhoun, 1996). Qualitative research discovered positive changes occurring alongside the negative in therapists exposed to indirect trauma, coining this VPTG (Arnold *et al*., 2005). These changes included improved self-perception, relationships and appreciation of life. Some have questioned whether this is a form of coping with VT or a separate outcome resulting from trauma work (Linley & Joseph, 2004). Models of posttraumatic growth suggest a process of meaning-making is required to integrate beliefs which may be challenged by exposure to trauma (Janoff-Bulman, 2004). Whilst clients engage in trauma-therapy they question the causes and implication of trauma, a process which is likely also done by the therapist. The depth of this meaning-making is thought to be an essential part of VPTG (McCullough, Root & Cohen, 2006).

Constructivist self-development theory may also be able to account for positive changes, despite the focus on negative effects. Saakvitne, Tennen & Affleck (1998) argue that the theory postulates frame of reference as the main determinant of change following exposure to trauma, resulting in changes to identity, spirituality and worldview. They argue these map onto the five areas of posttraumatic growth (Tedeschi & Calhoun, 1996): new possibilities (identity, worldview, spirituality), improved relationships (worldview), personal resilience (identity), spiritual change (spirituality), and appreciation of life (spirituality). Growth occurs if the therapist is able to make sense of the traumatic event and incorporate the associated emotions, beliefs and distress into their past experiences.

Cohen and Collins (2013) conducted a meta-synthesis of the qualitative literature on VT and VPTG, using this to develop an explanatory model of how indirect exposure to trauma may lead to growth. They found that therapists experience both positive and negative effects of trauma work alongside each other, suggesting both stem from empathic engagement with client trauma which leads to adaptation of therapist schemas. The self is multi-faceted so some aspects are accommodated positively, and others negatively (Joseph &

Linley, 2008) so VT and VPTG can lead to different outcomes for different schemas. If a therapist is shocked by the trauma clients report their schemas may be more likely to be negatively disrupted. However, they may also be surprised by the high resilience of clients to survive their trauma experiences, which may result in positive accommodation and VPTG. They suggest that mutually exclusive measurement of VT and VPTG using quantitative measures limits understanding of the effects of exposure to client trauma. The two may not be distinct as growth seems to occur alongside some level of distress (Cohen & Collens, 2013). This is supported by qualitative research finding trauma therapists reported negative belief changes related to their work but also more positive changes were reported alongside these compared to non-trauma therapists (van Minnen & Keijers, 2001).

Difficulties researching VPTG include no existing measure designed specifically for this. Previous research has used measures designed for use with direct exposure to trauma such as the Posttraumatic Growth Inventory (Tedeschi & Calhoun, 1996). This poses methodological difficulties as it is unclear whether indirect exposure through listening to client trauma will have similar effects. A review of the literature however identified that elements of VPTG were consistent with those identified in those with direct trauma exposure (Manning-Jones, de Terte & Stephens, 2015). This included qualitative studies, so does not appear to be just an artefact of using these measures as participants reported these effects when open-ended questions were used to explore their experiences of trauma work. Therapists reported changes in their values, spiritual growth, increased resilience and improved relationships (Barrington & Shakespeare-Finch, 2013a; Shamai & Ron, 2009). However, some subtle differences were noted to those experiencing direct trauma, suggesting VPTG is less integrated into therapists' self-concept (Manning-Jones *et al.,* 2015). There were also elements specific to their role as a therapist, such as feeling their job was valuable, they could make a difference to trauma clients and trauma work had increased their clinical skills (Barrington & Shakespeare-Finch, 2013a; Guhan & Liebling-Kalifani, 2011; Benatar, 2000; Satkunanayagam, Tunariu, & Tribe, 2010; Shamai & Ron, 2009; Splevins *et al.,* 2010).

Vicarious resilience is a similar term, but suggests therapists apply learning from client resilience to their own lives, allowing them to reframe and cope better with personal stressors (Engstrom, Hernandez & Gangsei, 2008). It differs slightly to VPTG, emphasising therapists need to observe client resilience to incorporate this into their own lives.

Empathy appears important in the development of VPTG. Those with more empathy reported more growth (Brockhouse *et al.,* 2011; Linley & Joseph, 2007). Therapists felt empathically engaging with client trauma allowed them to metaphorically apply this to their own lives, promoting a sense of growth (Shamai & Ron, 2009; Splevins *et al*., 2010). Supervision and peer support was also linked to the development of VPTG (Brockhouse *et al.,* 2011; Linley & Joseph, 2007; Satkunanayagam *et al*., 2010; Tehrani, 2010). This supports VT research demonstrating that inadequate supervision was linked to VT (Pearlman & Saakvitne, 1995), suggesting supervision may be a moderating factor influencing whether therapists develop VT or VPTG.

1.7 Personal Construct Psychology

As repertory grids form part of this study's methods, it is important to understand their underlying theory; personal construct psychology (Kelly, 1955). It is rooted in constructivism (Tindall, 1994), which believes reality is multi-faceted due to the many different ways in which the world can be constructed. What we may view as 'facts' are actually interpretations which vary among individuals. Humans are seen as 'human scientists', attempting to understand, predict and control events which happen in their lives (Kelly, 1955). People develop constructs based on their experiences, which they use to make sense of further experiences. Construing describes a dynamic search for personal understanding (Tindall, 1994). Understanding is achieved through examining things in relation to similarities and differences from previous experiences (Kelly, 1955). This is an active process, so constructs can be re-evaluated and change over time in light of new experiences. This is ongoing as people constantly try to understand the world around them and predict future events (Winter, 1992).

Personal construct psychology is based on the 'fundamental postulate': people develop constructs based on their experiences which link together to form a personal construct system, unique to each individual and a template through which they view the world. People behave in ways congruent with their predictions based on what they anticipate from this template (Kelly, 1955). For example, if the individual has a template of others as 'trustworthy', they are more likely to engage positively with others. Following from this is the 'construction corollary' which states people search for repeated themes in their experiences to allow them to make predictions of future experiences. If the individual's predictions are met then their constructs are validated, if not this may lead to changes in the personal construct system. However, too much invalidation can be disturbing as people tend to seek predictability (Kelly, 1955).

Some have questioned whether constructs can ever be invalidated, as events are always interpreted by the individual, so are probably understood in ways consistent with their existing constructs (Winter, 1992). However, Kelly (1955) argued people usually assess the outcomes of their expectations at a different level of construction of which they were formed, allowing adaptation if new events do not match expectations. This relates to the 'modulation corollary' which refers to the difference in permeability between individuals' personal constructs. If a person has permeable constructs these will allow new experiences that are not already construed within their framework to be integrated in (Winter, 1992). However, if they are more impermeable, they are unlikely to re-construe constructs based on conflicting experiences. Relating this to VT effects on therapists' belief-systems would suggest that those who have more permeable personal construct systems would be more amenable to changes in their beliefs following exposure to client trauma as these accounts are likely to conflict with their existing constructs of reality. This invalidation of their existing constructs may result in distress, linking this to symptomatic and affective responses seen in VT.

The 'dichotomy corollary' suggests personal construct systems are formed of a finite number of dichotomous constructs, meaning each construct is bipolar. The emergent pole indicates how events, or elements, are similar. The implicit pole

indicates how they differ from other elements. It is suggested that the implicit pole provides clear meaning to the construct (Fransella, Bell & Bannister, 2004).

Self-identity is explained through 'core constructs'; these control the maintenance of the individual's identity. The 'self' is part of the core construct system. It develops from the personal construct system, by observing others and defining the self as similar in some ways and different in others (Butt, 2004). Identity is not a single stable construct, but an evolving concept.

Personal construct psychology provides an ideal theoretical perspective for assessing changes in the way therapists construe different aspects of themselves related to trauma work and that of others they have worked with. It offers a structured interviewing technique to explore the structures people apply to their personal meaning systems, which are designed to make personal constructs that individuals use to make sense of their experiences more explicit. The way people make sense of their environment, themselves and others is guided by implicit theory which is based on prior experiences stored within these constructs (Jankowicz, 2004). When designing repertory grids for use in this study, an important corollary was the 'range of convenience' which argues each construct is applicable to only a finite set of events, therefore there will be some elements to which it does not apply (Kelly, 1955). This was important when developing rating scales for the repertory grids, as they needed to include an option for participants to rate the construct as non-applicable.

1.8 Study Aims

As this literature review has highlighted some key limitations in existing literature surrounding VT experiences, this study attempted to address these.

Firstly, research exploring the experiences of Trainee Clinical Psychologists and qualified therapists working in British mental health settings is lacking. A large body of the VT literature was conducted in America, which utilises a very different healthcare system from the National Health Service (NHS) and varied supervision requirements. Some studies have identified supervision and

organisational factors as potentially affecting VT (Sabin-Farrell & Turpin, 2003), therefore it is important to explore the effect of trauma work in British therapists where organisational factors are likely to differ from previous samples to determine whether it is applicable to therapists in this country. There are also conflicting findings regarding experience as a mediator variable, some finding those with less experience are more at risk of VT, conflicting with CSDT which argues VT is cumulative and increases with experience. By studying both trainee and qualified staff this offers an opportunity to compare whether they report similar experiences of trauma work effects, which can explore the effects of experience as trainees are less experienced. Using qualitative approaches is important here as it is not an area studied before, so open questions can allow a deeper exploration of trainee and qualified staff experiences and factors which they feel may be related to these.

Existing measures of VT have been criticised for lacking validity and not offering a full representation of all aspects of VT. Better evidence exists for STS symptoms than belief-change (Sabin-Farrell & Turpin, 2003) and therefore it is important to use alternative methods for exploring belief change. Qualitative research is criticised for participants struggling to recall their beliefs prior to starting trauma work, therefore triangulation of data was appropriate to help overcome some of the limitations of each approach and build a richer understanding of participant experiences. Repertory grids were used to try and tap into implicit beliefs and overcome some of the problems associated with recall. Semi-structured interviews then allowed a deeper exploration of participant experience. These were then triangulated with existing quantitative measures to determine whether the belief areas, suggested within CSDT and measured by the TABS, matched up with participant accounts and whether any other areas existed which were not covered by CSDT.

The qualitative aspects of the study also allowed exploration of both positive and negative aspects of trauma work experiences, whereas quantitative measures are biased towards the negative aspects of VT, limiting exploration of potential VPTG. Witnessing client posttraumatic growth was included in the repertory grids, allowing exploration of positive changes in therapists' beliefs as

well as negative. Again, this will add to existing literature as VPTG has not been explored in British samples.

The primary aim of the study was to explore potential belief changes in Trainee Clinical Psychologists and qualified therapists working in Britain. Repertory grids specifically looked for similarities between elements. If VT occurred in the current sample, greater similarity would have been expected between the therapists' construction of themselves now and a client suffering with trauma. However, if VPTG occurred there would have been greater similarity with a client with posttraumatic growth. Similarities between self- and client-ratings would suggest similar processes occur, with therapists accommodating client trauma experiences into their existing constructs, which would support the underlying mechanism of VT suggested within CSDT. Changes in the areas of esteem, control, intimacy, trust and safety were explored using a deductive analysis to determine whether participants' experiences support CSDT. An inductive approach explored additional areas not covered by CSDT which appeared important to the current sample.

The secondary aim was to triangulate data from repertory grids and interviews with quantitative measures to determine whether they revealed similar aspects of therapists' experiences. The final aim (not addressed by the journal paper) was employing an inductive analysis to explore anything related to trauma work that participants felt was important, but was not covered by CSDT.

2. Extended Method

Overview

This section expands on information presented in the method section of the journal paper, specifically detailing the epistemological position taken by the researcher, design rationale and the study procedure. The rationale for using mixed methods is initially addressed before relating this to the critical realist epistemological position. A brief summary of alternative qualitative approaches considered for this research will be discussed, before outlining the rationale for using thematic analysis (Braun & Clarke, 2006) and qualitative content analysis (Mayring, 2000). Finally, the study design, questionnaires, interview schedule development, sampling, inclusion criteria, ethical considerations, data collection and quality assurance procedures are outlined.

2.1 Epistemology

Qualitative and quantitative research methods align themselves with different underlying philosophical assumptions. Some argue these should not be combined within research, as they make opposing assumptions about reality and what can be claimed from data which may lead to incoherence (Teddlie & Tashakkori, 2003). These include epistemology' which questions how we come to know reality and ontology, the nature of reality (Scotland, 2012). Ontology refers to assumptions about what reality is, which impacts claims researchers can make from their findings (Benton & Craib, 2001). Epistemology also considers the relationship between the research and participants (Ponterotto, 2005) in terms of whether the researcher's established views, knowledge and experiences are independent from or form part of the research process.

It is important to clarify the researcher's epistemological and ontological assumptions as they relate to the methods used, the researcher's role and claims made about the information gained (Carter & Little, 2007). Every research study makes assumptions so explicitly acknowledging the researcher's position on reality is useful (Hanson *et al.,* 2005).

Quantitative approaches are established in positivist assumptions which argue reality is limited to observable facts (Bechtel, 2009) and is independent from the researcher (Pring, 2000). Findings are believed to be objective and bias is seen as controllable (Howitt, 2010). Positivist methodology is directed at explaining relationships, attempting to identify causes and associated effects; providing a basis for generalisation to a wider population than that studied (Creswell, 2009). Quantitative research tends to use experimental designs with large, representative samples to achieve its aims in generalising findings. This study rejected positivist assumptions, as the researcher believes subjective experience does impact what can be known from data collected.

In contrast, qualitative approaches stem from a constructivist stance, attempting to provide detailed descriptions of participants' experiences using methods like interviews (Harper & Thompson, 2012). Qualitative data is richer than data gained using quantitative methods, but is less easily generalised. However, this is not the aim of qualitative research, which seeks to describe phenomena within the context and meaning people bring to their experience of them (Denzin & Lincoln, 2011).

Pragmatism suggests qualitative and quantitative approaches can be combined. Paradigm issues are ignored, claiming methodology is independent of the epistemology it developed from (Patton, 1990). It aims to solve practical, real-life problems, rather than making assumptions about the nature of reality (Feilzer, 2010). It does this by choosing methods best suited to answering the research question but fails to provide a philosophical justification for their use (Hall, 2013), raising questions about reliability. Difficulties then arise during data interpretation when epistemology plays a role in determining what claims can be made (Hall, 2013).

Others argue researchers using mixed methods can draw from multiple assumptions across epistemological paradigms, with assumptions shifting with the methodology in current use (Morse, 2003; Cresswell & Plano-Clark, 2007; Agerfalk, 2013). However, difficulties arise in making clear which paradigms are mixed and how they have been mixed, especially when there is history of

incompatibility between paradigms (Hall, 2013). Again, this may impact reliability of claims made by researchers due to lack of transparency in research decisions made.

A single epistemological stance may be adopted which encompasses both quantitative and qualitative approaches (Hall, 2013), overcoming difficulties of mixing paradigms with conflicting assumptions of reality.

Critical Realism

This epistemological stance has been suggested as a single paradigm for combining qualitative and quantitative methods (Sayer, 2000). It developed within the post-modern movement, emphasising few situations exist which are independent of external factors (Bhaskar, 1975), addressing critiques of positivism which assumes reality is context-free. It integrates positivism and interpretivism, making assumptions that attempting to study reality through human participants is unlikely to represent reality in a pure form (Harper & Thompson, 2012). This is due to the researcher's experiences and interpretations, combined with the contexts of their participants, which will inevitably have an impact on the data analysed. A 'true' reality, independent to those observing it is accepted as being in existence, but knowledge of that reality is influenced by context, which encompasses the interactions between researchers and participants, beliefs of both researchers and participants and social-cultural factors (DeForge & Shaw, 2012). It does not seek to generalise findings or give in-depth accounts of individual experience, but attempts further understanding of the phenomenon studied through initial focus on individual experience then relating this back to underlying processes (Lipscomb, 2011). Critical realism is a subjectivist epistemology, viewing knowledge as context-dependent, co-constructed by participants and the researcher. Social constructionism is similar but assumes there are multiple realities rather than one 'true' reality which are historically, socially and linguistically determined (Willig, 2008). It focuses on how language influences the construction of social realities (Willig, 2008), which was not the aim of this study which focussed on participant experience. Critical realism provided the most appropriate paradigm

for the aims of this study, allowing qualitative and quantitative data to be combined to explore individual experience and relate this back to formal measures of underlying processes.

Epistemological position informs choice of methodology (Willig, 2008). Decisions regarding this will now be explained.

Methodology

This study took a dual approach to research aims. Evidence for existing theory on belief change in VT was explored through triangulation of three types of data. Any additional factors unaccounted for within constructivist self-development theory, which seemed important to participants' experience of trauma work, were also explored. The dual aims necessitated a mixed methods approach. Therefore, a deductive analysis, guided by theory was used to explore qualitative data, searching for support for the ten belief areas identified by the theory in participants' reported experiences. This was then triangulated with existing psychometric measures of the ten belief areas (TABS) and data from repertory grids, which offered a more implicit measure of beliefs related to trauma work. An inductive analysis of interview data allowed any further areas of importance, not covered by existing theory, to be extracted. A further aim of the research was to explore whether there were any differences between trainee and qualified therapists, as this is a previously unexplored area. Research on trainees is limited to quantitative explorations (Adams & Riggs, 2008) conducted in America, so it was important to explore the experiences of British Trainee Clinical Psychologists working with trauma as part of their training.

2.2 Mixed Methods Research

Mixed method research has been frequently debated in terms of integrating elements of research from varied paradigms (Bazeley, 2009). However, it is noted that choosing the best method to answer the research questions is important (Bryman, 2006). As the research question was exploratory, looking to explore similarities and differences in how trainee and qualified therapists

experience trauma work, an area only previously researched using quantitative methods, it was important to maximise chances of identifying between-group differences. Qualitative and quantitative methods each make significant contributions to research, and their strengths and limitations allow using different methods together to reveal other areas of the topic (Harper & Thompson, 2012). It is argued that combining approaches allows greater understanding of complex issues than either approach alone (Sale, Lohfeld & Brazil, 2002).

Belief change in VT has mainly been measured using the quantitative measure, Trauma and Attachment Beliefs Scale (TABS; Pearlman, 2003). This assesses the five belief areas theorised to be affected by exposure to VT in CSDT (McCann & Pearlman, 1990): control, esteem, intimacy, safety and trust. However, results from studies using the TABS were inconsistent, some finding no link between trauma work and TABS scores (Baird & Jenkins, 2003; Kadambi & Truscott, 2003). Qualitative research has identified evidence for negative changes in these belief areas, as theorised by Constructivist Self-Development Theory, as well as positive changes, framed as VPTG (Cohen & Collens, 2013). Therefore, a secondary aim of this research was to compare qualitative and quantitative data to determine whether there is consistency in belief areas identified within interviews and those scored on the TABS. This necessitated a mixed methods approach.

Mixed methods research is not without critique. Some argue it undermines qualitative aspects of the design, using it as subordinate to quantitative components (Teddlie & Tashakkori, 2011). However, qualitative approaches are important when samples include under-represented populations within the research field (Sweetman, Badiee & Creswell, 2010), which this study does by recruiting Trainee Clinical Psychologists, a population poorly represented in VT research. A further critique is that neither approach is analysed adequately due to time constraints of analysing two data types (Creswell, 2011). However, this can be overcome by combining approaches to answer specific research questions. It is not the aim of this study to provide rich accounts of individual experience, but to explore whether experiences discussed in qualitative data

reflect existing theory and quantitative measures based on existing theory. Mixed methods research is also criticised for researchers conflating practical methods with theoretical assumptions, resulting in a lack of transparency about what has been mixed (Giddings & Grant, 2007). This can be overcome by making it clear which methods have been mixed and which, if any, has been given more precedence (Tashakkori, 2009).

It is important to integrate methods at all stages, especially during data analysis, as conclusions can be misleading if integration is not achieved and risks representing 'multiple studies' (Yin, 2006). It is important to consider paradigm differences in methods when combing them (Harper & Thompson, 2012). Repertory grids are grounded in Personal Construct Theory (Kelly, 1955) (See section 1.7 for further detail). This stems from the epistemological stance of constructivism; assuming there are multiple ways of construing the world (Kelly, 1955). Personal meanings individuals make in their representations of themselves, others and the world are emphasised (Neimeyer & Raskin, 2000). Repertory grids are a tool to measure the ways an individual constructs their experience of reality. Similar to critical realism, an external reality is believed to exist, but it can only be experienced through an individual's construction of it (von Glaserfeld, 1995). Constructivism views identity as an evolving process, rather than a stable construct. Focus is placed on the individual's construction of reality, assuming those active in the research process impact the claims which can be made from data (Mertens, 2010). This is similar to critical realism which acknowledges the role researchers and participants have in research. A difference between the approaches is that constructivists assume there are multiple realities so no specific hypotheses are tested but general research questions shape exploration. This study seeks to test specific hypotheses based on existing theory, but is also exploratory and will be guided by the data to some degree in searching for potential factors not explained by existing theory.

The next method involved semi-structured interviews which were analysed using directive content analysis and inductive thematic analysis. Both of these qualitative approaches are not tied to specific epistemological stances so can

be approached from a critical realist stance (Braun & Clarke, 2006; Mayring, 2000). Focus is on the meaning individuals give to their experience but the role of the researcher in influencing the data is also acknowledged (Teddlie & Tashakkori, 2011). Constructivists would argue against generalisation across individuals, due to assuming multiple realities exist due to individual differences in construing. However, as a critical realist I assumed individual accounts may share some commonalities which could be highlighted across data. Therefore, data from interviews was compared to quantitative measures to look for support for existing theory as well as potential new areas missing from the theory.

Finally, questionnaire measures were used, which tend to be aligned with positivist epistemology. This assumes the data collected is a true representation of reality, free from influence of researcher or individual participant effects. As a critical realist I assume the reality measured is imperfect, as individuals will make varied interpretations of questions influencing self-reported data. Triangulating data from these measures with interview data attempts to acknowledge the differences in participant experience, giving more voice to their experiences.

It is acknowledged that both qualitative and quantitative approaches are limited by relying on observations that are either implicitly or explicitly influenced by existing theory (Barker, Pistrang & Elliott, 2002). To promote transparency in the interpretations made, pre-existing theories which are likely to influence claims made in this study are discussed in section 1.1.

2.3 Qualitative Methods

As the research was both descriptive and exploratory it benefitted from the use of mixed methods. Two methods of qualitative analysis were used: qualitative content analysis and inductive thematic analysis. Both of these are not tied to specific philosophical assumptions so fit with a critical realist approach (Braun & Clarke, 2006; Mayring, 2000).

Comparing qualitative data with data from psychometrics to explore whether relationships existed between formal measures and participants' accounts of

their experience formed the descriptive part of the study. The exploratory part was achieved using inductive thematic analysis to explore whether any new areas, not identified by existing theory or measured by available psychometrics, were part of participants' experiences of working with trauma. Other qualitative approaches were considered and an outline of these is given to provide rationale for the two approaches taken.

Grounded Theory

Grounded Theory is an iterative process for systematically analysing unstructured qualitative data (Glaser & Strauss, 1967). It takes an inductive approach not guided by existing theory as it aims to develop a theory based on what is held in the data (Tweed & Charmaz, 2012). It was not considered appropriate for this study's aims as there is a theory of VT and it is more useful when there is limited research and lack of understanding about a phenomenon (Cho & Lee, 2014). This study aimed to look for supporting evidence for the existing theory and to add to this using any additional themes identified as important unaccounted for by the theory, rather than develop a new theory from data collected.

Template Analysis

Template Analysis emerged from researchers familiar with Grounded Theory, so similarities between approaches are seen (Waring & Wainwright, 2008). It is not wedded to a specific epistemological stance so can be useful for a range of approaches. It involves coding large amounts of data so codes can be assembled to complete the interpretative process (King, 2004). It too can be deductive, using a-priori codes based on existing theory or inductive where codes are developed from the data. Codes are then refined and modified during the interpretative analysis stage (King, 2004). As a theory for VT exists and has not yet had all areas examined within qualitative research to determine whether support exists for all ten areas, it was considered better to examine these existing categories in the coding manual rather than modifying or deleting codes based on the data. Therefore, directive content analysis was deemed to be a

more suitable method than template analysis for this study's aim of looking for support for existing theory.

Interpretative Phenomenological Analysis (IPA)

IPA uses hermeneutic data interpretation from the researcher's perspective whereby the researcher uses their experiences to interpret participants' experiences, to explore social cognitions (Smith, Harré & Van Langenhove, 1995). It aligns itself with phenomenology, believing through explicit interpretation an individual's inner cognitive world can be accessed by looking at how they ascribe meaning to their experiences. It is therefore suited to research aiming to relate findings to biopsychosocial theories dominating current knowledge in healthcare professions (Smith, 2004). A strength of the approach is it makes explicit the researcher's interpretations of the participants' accounts (Osborn & Smith, 1998). Although this study was interested in participants' cognitions in relation to their experiences of trauma work, IPA starts with thematic analysis but goes beyond this to provide a detailed interpretative analysis of themes. This level of detail was beyond the scope of the current study, which primarily aimed to examine whether existing theory was supported by the data and to identify any potential themes not covered by existing theory.

Discourse analysis

Discourse analysis stems from social constructionism, focusing on the use of language to construct phenomena within social contexts (Willig, 2008). It focuses on the detail of the language participants use, opposed to the content of their comments. Although repertory grids also stem from social constructionism so would fit with this approach, research aims centred around describing participants' experiences of working with trauma and determining whether this fitted with existing theory. The aims were not analysing the language used in constructing these experiences, so discourse analysis was less appropriate in meeting specific research aims compared to qualitative content analysis.

Qualitative Content Analysis

Qualitative content analysis is a rigorous and systematic analysis system, best incorporated into a mixed methods design for triangulation or to add a further facet to research findings (Robson, 2002). It is defined as a method of subjective interpretation of text content through systematic coding and identifying of patterns (Hsieh & Shannon, 2005). It is seen as a useful method for summarising data whilst simultaneously preserving as many of participants' individual meanings as possible (Jankowicz, 2004). It focuses on the language used and contextual meaning of the text (Tesch, 1990). In itself, it aims to be a mixed methods approach starting from the methodological basis of quantitative content analysis but assigning categories to text in a qualitative-interpretive way (Mayring, 2014). Assignment of categories is qualitative and the analysis of category frequency is a quantitative step. It goes beyond just counting words by examining language to classify large amounts of text into categories signifying similar meanings (Weber, 1990). Conventional content analysis takes a more inductive approach, useful when existing theory is limited and research questions aim to describe a phenomenon. Therefore, pre-developed categories are not used, allowing these to flow from the data (Kondracki & Wellman, 2002). This was not suitable for the current study, where Constructivist Self Development Theory is well-researched and therefore defined categories pre-exist.

When an existing theory is available but would benefit from further description, directed content analysis is more appropriate (Hsieh & Shannon, 2005). This takes a deductive approach to data analysis, using existing theory as a guide to validate or extend the existing theoretical framework and determines the initial coding scheme (Mayring, 2000). Key concepts from existing theory form initial coding categories (Potter & Levine-Donnerstein, 1999). Operational definitions for each category are developed using the theory. Findings from this approach can offer supporting and non-supporting evidence for the theory and are presented using examples from the data with a descriptive account.

Strengths of this approach are supporting and extending existing theory, an aim of this study. It offers a flexible approach applicable to a range of research designs (Elo & Kyngäs, 2008). It explicitly identifies that researchers are unlikely to be naïve to existing research in the field and this guides analysis (Hsieh & Shannon, 2005). However, it can be criticised for researcher bias, as researchers may be more likely to find data supporting existing theory. Description of analysis may be problematic as the researchers' insights are difficult to put into words (Hsieh & Shannon, 2005).

Thematic Analysis

Thematic analysis is a qualitative method for identifying patterns of meaning across data (Braun & Clarke, 2006), producing a description of the data highlighting the most salient themes within the dataset (Joffe, 2012). A deductive thematic analysis is similar to content analysis as it is guided by existing theory (Silverman, 2011) but content analysis clearly operationalises coding categories and allows frequency counts which can be compared to quantitative data. Deductive thematic analysis allows initial codes to be expanded or removed to fully represent the data (Fereday & Muir-Cochrane, 2006), whereas directive content analysis sticks to codes identified within theory, so can determine whether the data fits existing theory or whether some parts of the theory are unsupported.

An inductive approach takes a 'bottom-up' stance, guided by the data to extract themes which capture something important to the research question (Boyatzis, 1998). This differs to inductive content analysis, which focuses on the frequency at which themes occur. As the inductive part of the study was exploratory, searching for any themes not covered by existing theory, thematic analysis was considered a better approach than inductive content analysis as content analysis can remove the category from the wider context (Namey, Guest, Thairu & Johnson, 2008).

Thematic analysis has been criticised for the interpretation involved on the researcher's behalf, so is less reliable than content analysis as different researchers may have varied interpretations (Namey *et al.,* 2008). However,

steps can be taken to improve rigour such as making the researcher's epistemological position clear (Braun & Clarke, 2006). Thematic analysis has also been criticised for splitting data and loosing individual meaning expressed by participants (Hollway & Jefferson, 2013). However, it does not set out to provide an in-depth analysis of one person's experience. Instead it allows valid meanings to be identified across the group, which this study aimed to do in order to potentially add to existing theory. Thematic analysis is also critiqued for its broad flexibility, some arguing it is undefined and lacks transparency (Antaki, Billig, Edwards & Potter, 2002) but this was dealt with by following the six-stage guidance for conducting thematic analysis (Braun & Clarke, 2006). This guidance aims to distinguish it as a distinct approach to other qualitative methods, outlining ways to conduct the analysis systematically to a good standard.

2.4 Repertory Grids

Repertory grids are a structured interviewing method, which can be analysed both qualitatively and quantitatively, making them suitable for mixed methods research. They are a cross-tabulation of elements against constructs (Banyard & Grayson, 2000) enabling participants' beliefs to be explored in terms of how they organise their understanding of elements within the grid. Repertory grids contain four components: the topic, constructs, elements and ratings (Jankowicz, 2004). The topic specifies the realm of discourse in which elements are constructed by the participant to make sense of a specific experience (Jankowicz, 2004). In this study the topic was 'trauma work', exploring participant views of how their therapeutic work with traumatised clients impacted them at different stages of their career and the way they perceived different clients affected by trauma.

Constructs refer to templates people use to make sense of their individual world. They develop through experience and are used to anticipate future events (Kelly, 1955). They represent a system individuals use to judge how things are similar as well as how they differ (Fransella *et al.*, 2004), thus making them bipolar in nature. People's constructions are placed on a continuum

between two poles (Jankowicz, 2004). Constructs are limited to a specific range of events, interactions or roles, which Kelly (1955) refers to as elements. It was decided that some constructs would be supplied by the researcher and some would be elicited by participants. This was to ensure that areas covered by pre-existing theory were explored and comparisons could be made across the sample but also allowed exploration of individual experience. Decisions on supplying or eliciting constructs has been subject to much debate. Traditionally, constructs were solely elicited by participants and evidence suggests they produce more cognitive complexity (Giancoli & Neimeyer, 1983). However, others have found people can easily make inferences using supplied constructs as long as the researcher has skilfully developed meaningful constructs (Adams-Webber, 1998). Therefore, time was taken discussing supplied constructs with participants to ensure they understood them.

Elements determine the context of meaning for constructs, defining the specific part of the individual's world which is being explored (Banyard & Grayson, 2000). They need to be personally relevant to the person and representative of the topic (Tindall, 1994). Therefore, elements were selected by the researcher in relation to the research questions addressed by the repertory grid (Fransella *et al.,* 2004). These were selected to enable participants to think about themselves historically ('self before training'), presently ('self-now') and in different trauma work situations ('self-struggling with trauma work' and 'self-coping well with trauma work'), as well as how they think about different people affected by trauma ('client deeply affected by trauma', 'client with posttraumatic growth' and 'non-traumatised, psychologically healthy individual').

Rating scales allow each construct to be rated numerically against each element within the grid, allowing comparisons between elements (Bell, 2005). A 5-point Likert scale was used for participants to rate each element. It provides a middle-point which indicates the element is outside the range of convenience for the construct or that the element fits equally between each pole of the construct (Jankowicz, 2004). Range of convenience is an assumption made within personal construct psychology, that each construct only applies to a finite set of events, therefore there will be some elements to which is does not apply.

Qualitative content analysis exploring the nature of constructs elicited by participants can provide insight into how participants construe their experiences of working with trauma. Rating scales open up an opportunity to analyse data obtained from the grids quantitatively and compare with data from psychometrics. Qualitative data from the grids can be analysed within statistically reliable parameters and quantitative data accurately reflects participants' intended meaning (Jankowicz, 2004). This allowed an aim of the current research to be met: exploring whether an existing psychometric measure of VT, TABS, reflects responses given on a more implicit measure of participants' beliefs about trauma work.

However, repertory grids are not without limitations. They can be an effective means for eliciting data on a person's beliefs within a specified area, but can only represent part of that person's thought repertoire. They are not considered exhaustive (Tindall, 1994). There is tension over reliance on a more positivist analysis of numeric ratings from grids and the constructivist origins of repertory grids (Robson, 2002). However, the balance offered between allowing exploration of participants' constructions of trauma work experiences and linking this to existing quantitative measures of VT beliefs was sufficient for grids to be selected as an appropriate methodology. The inclusion of semi-structured interviews also allowed for further exploration of participants' thought repertoires around working with trauma, with inductive analysis adding to the exploratory nature of this approach.

2.5 Justification for Psychometric Measures

Trauma & Attachment Beliefs Scale (TABS) (Pearlman, 2003)

This is the revised version of the Traumatic Stress Institute (TSI) Beliefs Scale (Pearlman, 1996). It was developed to incorporate CSDT theory and elements from the literature linking exposure to trauma, cognitions and psychological needs (Pearlman, 1996). It aims to assess the five belief areas, identified within CSDT, suggested to be negatively altered through accommodation of clients' trauma into professionals' schemas. There are 10 subscales measuring these

five belief areas as each is reflected as perceptions towards the self and to others. Higher scores reflect greater belief disruption, and therefore more VT. Those exposed to more client trauma should score higher, as CSDT suggests a cumulative effect of exposure and belief disruption. Some studies support this (Schauben & Frazier, 1995; Pearlman, 1996). However, conflicting results using this scale exist; some found no link between trauma work and scores (Baird & Jenkins, 2003; Kadambi & Truscott, 2003).

Initial structural assessment on the TSI-Beliefs Scale used multi-group factor analysis which identified two stable factors; autonomy and connection (Pearlman *et al.,* 1992; Stamm, Bieber & Pearlman, 1991; Stamm & Pearlman, 1996). This was conceptualised as representing the expression of beliefs towards 'self' and 'others'. Psychometric studies on the TSI-Beliefs Scale yielded Cronbach's alpha for total scale score of .98 and subscale alphas ranged from .77 to .91 (Pearlman, 1996). A later factor analysis of the TABS yielded three stable factors: self, other and safety (Varra, Pearlman, Brock & Hodgson, 2008). This was consistent with CSDT; self and other are distinct constructs measured by the scale. The fact that safety beliefs emerged as a distinct factor along with the broader concepts of self and other, suggested this belief area is given more weight than the other four. One may argue that an event cannot be traumatic without a threat to safety to self or others (Varra *et al.*, 2008).

As this is the only VT measure that measures all five belief areas theorised within CSDT and previous research has yielded conflicting results, this study aimed to triangulate data collected from alternative methodologies: repertory grids and semi-structured interviews, with TABS scores, to determine whether there was consistency in participant responses. It also sought to identify any other important areas which may not be covered by the TABS, as well as allowing the possibility for positive beliefs to be expressed by participants in relation to their experiences of trauma work. The TABS measures only belief disruptions, focussing only on negative beliefs, whereas qualitative research has identified positives associated with trauma work including appreciation of

others' resilience, satisfaction of observing client progress and increased compassion and emotional expressiveness (Arnold, Calhoun, Tedeschi & Cann, 2005; Eidelson, D'Alessio & Eidelson, 2003; Pearlman & Saakvitne, 1995; Schauben & Frazier, 1995; Steed & Downing, 1998).

Secondary Traumatic Stress Scale (STSS) (Bride, Robinson, Yegidis & Figley, 2004)

This is a measure of the symptoms associated with VT. McCann & Pearlman (1990) suggested that when therapists empathically engage with client trauma a process of inner change occurs, which includes therapists developing symptoms similar to those characterising PTSD, as well as belief change. A review of the literature on VT in therapists concluded that there was more support for these symptomatic responses, especially intrusion, but very limited support for belief changes as measured using tools like the TABS (Sabin-Farrell & Turpin, 2003).

Although this study was interested in exploring evidence of belief change in therapists working with trauma, it was important to also measure STS symptoms as CSDT suggests they form part of VT. It also offered an opportunity to either support previous research which demonstrated STS symptoms in the absence of belief change (Brady *et al.,* 1999; McLean, Wade & Encel, 2003; Bober & Regehr, 2006; Devilly *et al*., 2009).

Other measures which have been used in the literature to assess STS symptoms include the Impact of Events Scale (Horowitz, Wilner & Alvarez, 1979) and the Trauma Symptom Checklist-40 (Elliott & Briere, 1992). However, these were developed to measure symptoms resulting from direct exposure to trauma, rather than STS. They have not been validated for use with those indirectly exposed to trauma, questioning whether they are sensitive enough to be used with therapists indirectly exposed to client trauma. Participants would also need to be directed to complete the measure in relation to their experience of trauma work, otherwise the measures risk measuring symptoms related to personal exposure to trauma rather than indirect exposure.

Professional Quality of Life (ProQOL) Scale (Stamm, 2010)

This is one of the most widely used measures of positive and negative effects of working with clients who have experienced traumatic stress (Stamm, 2010). It contains three subscales: burnout, STS and compassion satisfaction. Burnout is not a specific consequence of trauma work (Jenkins & Baird, 2002) but describes a general process of apathy, emotional exhaustion and decline in personal accomplishment due to experiencing work as over-demanding and stressful (Figley, 1995). On the ProQOL burnout and STS are conceptualised as negative effects of working with trauma, which the author labels 'compassion fatigue'. This is defined as the negative impact of working as a 'helper' with those who are suffering, such as trauma work. Compassion satisfaction is the opposite of this, measuring positive aspects of trauma work. Within the field, there is lack of conceptual clarity between the terms burnout, compassion fatigue, STS and VT, often being used interchangeably (Sabin-Farrell & Turpin, 2003). STS is argued to be synonymous with compassion fatigue (Figley, 1995).

Stamm (2010) suggested a multimethod approach to convergent and discriminant validity supports the ProQOL's discriminant validity but factor analysis studies have not been completed (Bride, Radey, & Figley, 2007).

Although a measure of STS was already used (STSS) the ProQOL was also used as it separated STS, a measure specifically related to exposure to VT, and burnout, which is a more general measure of work stress. It also contained a measure of positive aspects of trauma work, which the TABS and STSS cannot provide. Inclusion of the positive items also reduce negative response sets, improving psychometric properties of the scale (Stamm, 2010). This may provide useful information to help contextualise the data in terms of whether participants are experiencing more positive or negative effects as a result of their work as trauma therapists.

Life Events Checklist (LEC) (Blake *et al*., 1995)

This was used to measure the occurrence of any personal trauma experienced by participants, aside to the trauma they are indirectly exposed to through client narratives. Previous studies found a link between personal trauma and VT; with those experiencing personal trauma also experiencing more VT (Cunningham, 2003; Jenkins & Baird, 2002; Pearlman & MacIan, 1995, VanDeusen & Way, 2006).

As the interview asked about participants' trauma work experiences it appeared more appropriate to include a quantitative measure of personal trauma exposure as some participants may have spontaneously reported personal trauma within interviews if it appeared salient to their reflections on their work experiences whereas others may not have done so. Therefore, providing a standardised measure for all participants allowed this to be assessed for all participants to contextualise the data.

Other measures of personal trauma exposure include the Traumatic Life Events Questionnaire (TLEQ) (Kubany *et al.,* 2000) and the Stressful Life Events Screening Questionnaire (SLESQ) (Goodman *et al.,* 1998). Both have strong psychometric properties but the LEC also compares favourably with these measures (Gray, Litz, Hsu & Lombardo, 2004). The TLEQ asks very specific questions, the level of detail of which was not required for the present study, which only aimed to use the measure to contextualise data. The SLESQ is similar but it asks participants to follow up their responses with a description of the event. Although this may have provided further information to help contextualise data collected within this study, exploring the impact of personal trauma on VT was not an aim of this study and going into this much detail with participants may cause excessive distress.

2.6 Study Design

The journal paper outlines the study design but further description and rationale for the decisions made for each component of the design is discussed here. Ethical considerations are then discussed.

Inclusion Criteria Rationale

Participants were included if they met the following criteria:

- Aged 21 or over – this was due to participants needing to be healthcare professionals or trainee clinical psychologists, therefore it was unlikely that those below the age of 21 would have acquired enough training or experience to be at this stage in their career.
- Experience of working with trauma in a therapeutic context – a self-defined sampling strategy was used rather than applying stringent criteria on the amount of experience participants needed to have of trauma work. This was due to the difficulties highlighted in the literature surrounding measurement of therapists' exposure to indirect client trauma (Elwood *et al*., 2010). Some have used hours per week working with trauma, percentage of clients who have experienced trauma on therapists' caseloads or years working with trauma clients (Brockhouse *et al.,* 2011). The difficulties operationalising amount of experience are partially due to differences in therapeutic focus. For example, two different clinicians may have the same number of trauma-exposed clients on their caseload, yet some clients may choose to engage in trauma-focussed therapy where vivid description is required of their trauma, whereas others may focus on non-trauma related difficulties within therapy. Therefore, a similar approach to Arnold *et al.* (2005) was taken. Participants were asked whether they perceive themselves to have worked with clients in a therapeutic capacity involving listening to their traumatic accounts and whether they perceive this to be recent experience. This was asked on study information sheets to filter out participants who are not eligible. This fits with the epistemology of the study as it is interested in the meaning to the participant, rather than applying stringent criteria.
- Ability to give informed consent – this was an ethical decision as participants needed to be able to understand what participation would involve.

- Be a qualified mental healthcare professional or trainee clinical psychologist – an aim of the study was to compare data from qualified staff such as clinical psychologists, nurses, social workers and psychiatrists with that of trainee clinical psychologists. Trainee clinical psychologists are a population which are yet to be studied within this field, whereas most previous research has focussed on qualified professionals so it was important to recruit both so comparisons could be made and related to previous research. Mental healthcare professionals were chosen due to the likelihood that their role would involve exposure to client trauma as well as empathic engagement with this, as CSDT suggests this as a potential mechanism by which VT occurs (McCann & Pearlman, 1990).

Individuals were excluded if they met the following criteria:

- Did not speak English – this was a practical decision as psychometric measures and interviews required English comprehension.
- Were retired psychological therapists – this decision was made to facilitate participant recollection of their experiences. The repertory grid asked participants to reflect on their experiences before training, so for retired professionals this may have been more difficult due to potentially being over 40 years since training by the time they retired. Participants were also encouraged to think about recent trauma work when completing repertory grids, again to aid recollection and richness of their accounts. Retired therapists were less likely to have recent trauma work experience to reflect on. It also made the sample more similar in that they were all currently working therapeutically with people exposed to trauma.

Sample size

Tuckett (2004) argues there are no definite guidelines on sample sizes for qualitative research. It usually relies on small numbers, aiming to achieve richness of data within a specific phenomenon so the sample is selected purposefully (Ezzy, 2002). Purposive sampling is mainly used in qualitative

research, aiming to select participants based on specific purposes to answer the research questions rather than random selection (Teddlie & Yu, 2007). It aims to find participants which are typical of a particular case on a factor of interest to allow comparability across cases on that factor. Probability sampling is used more in quantitative research, randomly selecting a large number of participants from a given population to achieve representativeness of data (Teddlie & Yu, 2007). Both types of sampling aim to select a sample that will answer the research questions and generalise to an external context. However, a methodological trade-off occurs between techniques in the sample size justification; purposive sampling leads to more in-depth information from a smaller carefully selected sample, whereas probability sampling gains more breadth of information from a larger sample selected to represent the wider population (Patton, 2002). Mixed methods sampling uses a combination of purposive and probability sampling, to varying degrees depending on the research questions, but in some cases using just one is sufficient if it stems from the research questions (Teddlie & Yu, 2007). When purposive sampling is used the characteristics of the sample and context to which the data is transferable to should be made explicit (Teddlie & Yu, 2007).

Although this study used mixed methods, the aim was not to generalise data but to gain a more in-depth understanding of the belief areas affected by indirect exposure to trauma in therapists. Therefore, the aims were more consistent with qualitative research sampling justifications, rather than attempting to recruit a large number of participants to generalise psychometric results. Psychometrics were used to contextualise and triangulate data, establishing whether existing theory was supported between the three methodologies. Therefore, a purposive sampling strategy was used. This study aimed to recruit 10 trainees and 10 qualified therapists, based on previous qualitative research samples in this area (Benatar, 2000; Killian, 2008, Goldblatt *et al.,* 2009) and repertory grid research (Walker, Trenoweth, Martin & Ramm, 2013; Blagden, Winder, Gregson & Thorne, 2014; Golynkina & Ryle, 1999). Having ten participants per group provides some breadth of experience but maintains manageability of data collection, and is arguably sufficient for an exploratory study.

Recruitment

This study aimed to recruit equal numbers of Qualified Psychological Therapists and Trainee Clinical Psychologists. As stated in the journal paper, advertisement of the study was supported by local collaborators within Nottinghamshire Healthcare NHS Foundation Trust and Lincolnshire Partnership NHS Foundation Trust. These were the Heads of Psychological Services for each trust, who agreed to circulate the recruitment email (Appendix E) and participant information sheet (Appendix D) to all Qualified Psychological Therapists working within their services. Equal numbers of staff were recruited from each trust. Trainee Clinical Psychologists were recruited through contact with course directors on the Leicester and Sheffield Clinical Psychology Doctorate Programmes. Both agreed to circulate the recruitment email and participant information sheet to their current trainees. However, a further two participants were required so the email was also sent out to the Trent programme, although for ethical reasons the study was only advertised to third year trainees on the programme due to proximity of the primary researcher to other cohorts. The researcher held email conversations with the local collaborators and course directors to address any questions they had about the study prior to them agreeing to circulate study information.

If those receiving the email wished to participate after reading the participant information sheet, they were asked to email the primary researcher and a time and location most convenient to them was arranged for the study to take place. Any questions the participants had about the study were addressed at this point by the primary researcher. On the information sheet, participants were asked whether they considered themselves to have experience of working therapeutically with clients exposed to trauma. Most questions participants had, particularly trainees, centred around whether they 'had enough' experience. It was explained to them that there were no stringent criteria on amount of experience as it was a self-selecting sample and interested in their perceptions of trauma experience. All of those who asked this question considered themselves to have trauma work experience and agreed to participate. All of those who contacted the researcher gave consent for participation and were

included in the study. After the required number of participants had been recruited, emails were sent to the local collaborators and course directors to thank them for their help with recruitment and inform them that recruitment was now closed.

Data Collection

Demographic Information

Demographic information was collected to contextualise the data and aid interpretation within the analysis. It was collected using a questionnaire (Appendix H) after the interviews when the other psychometric measures were completed. Rationale is provided for each item collected.

Age – (collected using the TABS) to provide information about the composition of the sample.

Gender – (collected using the TABS) to provide information about the composition of the sample.

Ethnicity – (collected using the TABS) to provide information about the composition of the sample.

Role – participants were asked to indicated whether they were a Qualified Psychological Therapist or Trainee Clinical Psychologist to allow for comparisons to be made between the two groups.

Year of training or years practicing – Trainee Clinical Psychologists were asked to indicate what stage of their training they were currently in and qualified therapists were asked how many years they had been practising since qualifying to contextualise the data. It also gave some indication of experience as CSDT suggests VT is cumulative; those with more experience are more likely to experience belief changes consistent with the theory (McCann & Pearlman, 1990).

Trauma-specific training – participants were asked to indicate whether they had undertaken any trauma-specific training as some researchers suggest training

can reduce the impact of VT (Pearlman & MacIan, 1995, Pearlman & Saakvitne, 1995, Harrison & Westwood, 2009).

Hours per week currently working with trauma – despite difficulties in the literature identified with measuring therapists' exposure to client trauma (Elwood *et al*., 2010) this was an attempt to measure participants' current exposure. This was to contextualise the data and identify any differences between groups.

Types of trauma worked with – participants were asked what the main types of client trauma were that they were exposed to in order to contextualise the data as some studies have identified differences in trauma type such as working with perpetrators of abuse versus victims of abuse (Way *et al.,* 2004).

Repertory Grids

Grid elements were pre-determined by the researcher to focus the interview on different self-states according to stages of the participants' careers and different other-states. These were presented in a blank grid and discussed with participants to ensure they were aware of what each one referred to and encouraged to think of an example for each to improve their recall. Seven elements were provided:

- *'self-now'* - referring to the participant's current self-state related to their present career stage
- *'self before training'* – referring to the participant's self-state prior to the Clinical Psychology Doctoral training programme or other mental health professional training such as social work, nursing or psychiatry
- *'self struggling with trauma work'* – participants were encouraged to think of an example of work with client trauma they had found difficult and to reflect on their self-state during this experience
- *'self coping well with trauma work'* – participants were encouraged to think of an example of trauma work which they felt was going well and to reflect on their self-state during this experience
- *'client struggling with their trauma'* – participants were asked to bring to mind and example of a client they had worked with who was struggling

with the effects of their exposure to trauma. They were asked to reflect on the 'other-state', so how they believed that client would feel at that time

- *'client experiencing posttraumatic growth'* – participants were asked to bring to mind an example of a client who was beginning to overcome their trauma and starting to experience a sense of personal growth through this process. They were asked to reflect on the 'other-state', so how they believed that client would feel at that time
- *'non-trauma exposed, psychologically healthy individual'* – participants were asked to think of somebody they knew, such as a family member or friend, who had not been exposed to any significant traumatic event or required input from mental health services. This was an attempt to provide a 'control' rating of somebody with no exposure to trauma either directly or vicariously. They were asked to reflect on the 'other-state', so how they believed that client would feel at that time

The researcher then went through the supplied constructs with the participant and asked them to think of an opposite word of that supplied to elicit the bipolar construct. These were recorded on the repertory grid matrix. Twelve constructs were supplied to ensure those relating to existing theory and research in the area were covered by the grids. These included: 'safe', 'trusting', 'powerful', 'dependent', 'kind', 'alienated', 'emotionally numb', 'confident', 'optimistic', 'fearful', 'energised' and 'spiritual'. The triadic method was then used to elicit any further constructs the participants believed were important (Kelly, 1955). To facilitate this, participants were presented with combinations of three different elements and asked 'in what way are two of these alike and therefore different to the third?'. This answer provided an emergent construct pole which was recorded on the grid. To elicit the implicit pole participants were then asked what the opposite word was to the one just elicited by asking them how the third element differed from the other two. This was repeated with all combinations of the elements until participants could no longer elicit any further constructs. If participants elicited a word that had already been supplied they were directed to this and asked whether they could think of any other ways the elements were

similar. Participants varied in the number of constructs they elicited using this technique; a total of between 13 and 17 constructs were included in each individual repertory grid. Guidance suggests stability of correlation coefficiants should be questioned when the ratio of elements to constructs is less than 3:1 (Winter, 1992). However, careful attention to the representativeness of the elements selected can address this problem. These were selected based on previous literature and were discussed with participants prior to grid completion to ensure understanding. Participants were encouraged to think of a specific example for each element to facilitate recollection. The final stage of the grids involved asking participants to rate elements against each construct on a scale of 1-5.

Semi-Structured Interview

Semi-structured interviews were used to build on the information collected from the repertory grids about participants' experiences of working with trauma. They are an appropriate method for collecting data for directed content analysis and thematic analysis (Mayring, 2000; Braun & Clarke, 2006). Interviews were considered more appropriate than focus groups, which would have been an efficient use of time and may have stimulated conversations about trauma work experiences between participants but can be uncomfortable for participants (Frith & Gleeson, 2012). Interviews allowed more in-depth exploration of each individual experience and were more appropriate for practical reasons Due to the geographical span of the study participants were interviewed in different locations, focus groups would have placed travel demands on participants. Interviews were conducted between March and June 2016. Interviews lasted between 45-60 minutes. The schedule was used flexibly within interviews and was not followed sequentially. Interviews were audio-recorded and transcribed by the primary research who also conducted the interviews, helping maintain confidentiality.

Development of Semi-Structured Interview Schedule

The interview schedule (Appendix G) was developed through extensive review of the literature. It was also discussed with another researcher who has studied

VT to further refine questions. A semi-structured approach was considered more appropriate than a structured interview as it allowed flexibility in questioning as questions could be modified and guided by participant answers. An unstructured interview was not appropriate as the interview aimed to cover specific areas related to existing theory, in order to answer the research questions.

Questions covered areas linked to symptomatology of VT such as thoughts about clients outside of work and built on this by asking how participants cope with experiences like this. They were asked to think about clients struggling with trauma and those who were developing a sense of posttraumatic growth and how this impacted their work with them. Questions were designed to cover both positive and negative experiences of trauma work as well as asking participants to reflect on any differences they had observed in their worldview as a result of working with trauma. This question was kept broad rather than leading participants by asking them about each individual belief area within CSDT.

2.7 Ethical Considerations

This study was reviewed and approved by the University of Nottingham's Research Ethics Committee (Appendix A). It was subsequently approved by the Nottinghamshire Healthcare NHS Foundation Trust Research and Development Department (Appendix B). A letter of access was granted by the Lincolnshire Partnership NHS Foundation Trust (Appendix C), allowing recruitment of Qualified Psychological Therapists from this trust and the researcher access to NHS premises to conduct the research. Ethical guidance of the British Psychological Society (BPS, 2010) was adhered to throughout the research process, details of which are provided in the following section.

Informed Consent

The participant information sheet had already been read by participants prior to them registering interest in participation. This informed them of the nature of the study and the researcher's motivations for conducting it. Participants therefore had over 24 hours between reading the information sheet and seeking their

consent. Any questions relating to the study were answered by the primary researcher to ensure participants understood what participation in the study would involve. Written informed consent was then obtained from all participants using the informed consent form (Appendix F). This was given to participants during the face-to-face meetings with the researcher, before the start of data collection. Any questions relating to the study were answered by the primary researcher to ensure participants understood what participation in the study would involve. If participants were still happy to take part in the study they were asked to sign and date the informed consent form, which was also signed by the researcher. A copy was retained by the researcher for the audit trail, and a copy was given to the participant for their records.

Right to Withdraw

Within the process of gaining informed consent it was explained to participants that they were free to withdraw at any point of the study, without penalty or loss of the High Street voucher given to thank them for their participation. It was also explained to participants that in the event of their withdrawal from the study, their data would also be withdrawn but only up to the point of analysis, where it would have been anonymised. In the event of this occurring, attempts to gain their consent for their data to be used in the final analysis would have been sought.

Risks to Participants

There were no serious risks posed to participants as a result of their participation in this study. Attempts to reduce the time demands placed on participants were managed by giving them a choice about where the study was conducted. Most participants chose their place of work or university due to ease of access. Although risk was minimal, the researcher discussed the possibility of some questions being emotionally charged and potential distress this may cause with participants prior to them giving consent. They were reminded that they did not have to answer any questions they felt uncomfortable with and were free to withdraw from the study at any time without penalty. Following the end of the study, the researcher asked participants how they felt and whether

they experienced any distress as a result of taking part. None of the participants studied reported any distress. They were then provided with a debrief sheet (Appendix I) which the researcher went through with them, directing their attention to the section suggesting contact details they could use if they required any support as a result of any distress caused.

Payment of Participants

Participants were provided with a £10 High Street Voucher to thank them for their time and contribution to the research. They were informed of this prior to agreeing to participate, within the Participant Information Sheet. They were made aware that if they chose to withdraw at any point, even before completion of all study elements, they would still receive this voucher. The amount was not considered sufficient to persuade participation.

Risk to Researcher

The researcher travelled alone away from the University of Nottingham base to locations agreed by the participants in order to conduct the study. Locations included university and NHS premises, as well as participant homes. The University Lone Worker and Fieldwork guidelines were followed at all times. Researcher privacy was maintained using a ‘pay as you go’ mobile phone, property of the University of Nottingham, for contact by participants if required. This was also used to ensure constant contact was available with the researcher during off-site visits.

Confidentiality & Data Anonymity

Participants were informed prior to giving informed consent that the interviews would be audio-recorded. These audio recordings were transcribed by the researcher conducting the interview to maintain confidentiality and were assigned a participant number to maintain anonymity. Any identifiable information mentioned within interviews, such as names or locations, was omitted during transcription to ensure anonymity of transcripts. Once transcribed, audio recordings were erased from the digital recorder. Electronic copies of recordings were kept on a secure IT server at the University of

Nottingham for audit purposes. Participants were made aware that quotes from their interview may be included in the analysis section of the journal paper and these would be anonymised. Questionnaires and repertory grid matrices were assigned a participant number to ensure anonymity and no personal identifiable information was kept. A single password-protected electronic document was retained by the primary researcher, linking participant names with their participant number and contact details, in case of later withdrawal of data by participants. Contact details were also kept as participants were asked after completing the study whether they would like a copy of the journal paper. Most participants registered interest in this so were informed they would be contacted by email when this was available.

All data was securely stored in a locked filing cabinet at the University of Nottingham, which only the researcher and research supervisors could access. This information will remain securely stored at the University of Nottingham for seven years in accordance with University protocol, after which time it will be securely destroyed.

Audit Trail

The critical realist paradigm informing study design and analysis required transparency about the collection and analysis of data to maximise data replication (Barker *et al.,* 2002). A research journal was therefore kept by the primary researcher to meet this requirement. It provided a record of thought processes during data collection and analysis. All versions of the study documents and correspondence with the Research Ethics Committee and NHS Research and Development centres were kept so study development could be tracked.

2.8 Analysis

There were different phases of analysis due to the varying data collection methods used. Initial phases involved qualitative analysis of interview data and analysis of repertory grids. This data was then triangulated with questionnaire data to integrate the study and answer the research questions.

Phase 1: Repertory Grids

Data from repertory grids was input into the computer program Idiogrid (Grice, 2002). This was used to calculate the distance between elements using standardised Euclidean Distances. Distances closer to 1 indicate more similarity between elements, those closer to zero represent dissimilarity between elements. This was used to test the hypothesis that if VT is present in therapists then 'self now' would be expected to be more similar to 'client struggling with trauma'. If VPTG effects are present, then 'self now' would be expected to be more similar to 'client experiencing posttraumatic growth'. And if there were no effects on working with trauma in the participants sampled 'self now' would be more similar to 'non-trauma exposed healthy individual' or 'self before training'. An overall effect for trainees and qualified samples was explored by calculating the average Euclidean Distances for each sample.

Phase 2: Interviews

Interviews were transcribed verbatim at the semantic level by the primary researcher. This included words spoken and pauses in speech. An initial directive content analysis was conducted, following the five stages suggested by Mayring (2000). The meaning unit of analysis was at the idea-level, comprising sets of statements within transcripts that indicated the same idea. The reliability of this was tested through the independent coding of one transcript by the primary researcher and a research supervisor. There was a 96.6% agreement; discrepancies were discussed to come to an agreement.

Category formation and development of the coding agenda were the first steps of the analysis. The main categories were formed using the five belief areas from CSDT (McCann & Pearlman, 1990). The sub-categories within each of these split them into 'self' and 'other', reflecting whether the ideas related to self-views of the participant or their perceptions of others. Definitions based on this theory and previous literature were developed for each category. Specific coding rules were developed for each category along with examples to help determine what may be coded under each category (see Appendix J for the coding schedule).

The next step, revision of coding categories and agenda, involved discussing these with the research supervisor. The reliability of the coding agenda was checked by the researcher and supervisor independently coding a transcript and then checking agreement. An inter-coder agreement of 58.3% for belief areas was found, but 100% agreement over positive/negative codes. There were no units coded differently, but lack of agreement occurred whereby the primary researcher had coded a unit which the secondary researcher had highlighted but was unsure how to code. This was likely due to the primary researcher being more familiar with the literature and coding agenda. Each discrepancy was discussed and a consensus was reached. Due to low initial agreement, a further transcript was coded separately by each researcher. Agreement increased to 75.9% for belief areas and 100% for the valence of codes. Disagreements were discussed and consensus was reached. The code most frequently missed by one researcher was 'esteem'. Therefore, all esteem codes were reviewed by both researchers. The agreement for 'other-esteem' was 100% and for 'self-esteem' was 93.33%. Those disagreed on all focussed on therapists believing they had become less judgemental as a result of trauma work. One researcher believed this could also be coded as 'other-esteem' as it related to seeing others more positively. Therefore, it was decided that due to this overlap the units would be coded for both 'other-esteem' and 'self-esteem'. Frequencies of each were calculated for trainees and qualified therapists.

Working through the transcripts then followed. The coding agenda was used to code all ideas contained within the transcripts that met coding criteria. As the theory suggests each belief area is mutually exclusive, each meaning unit could only be assigned one code. An Excel spreadsheet was used to record the coding of qualitative data. Each category was assigned a separate row and every time it was coded, the passage of text from the transcript was copied into the row. It was labelled whether this was from a trainee or qualified staff transcript so that differences between groups could be explored.

The final stage involved interpretation of the data. Extracts that demonstrated each category were selected and frequency of categories occurring across the dataset were calculated.

The remaining uncoded data was then subject to an inductive thematic analysis, following the stages suggested by Braun and Clarke (2006). It is noted that the analysis can never be 'purely inductive' as the researcher has knowledge of existing theory and research in the area as well as their own preconceptions. Braun and Clarke (2006) suggest coding can be done at either the semantic or latent level. However, even if analysis is done at the semantic level it aims to understand the meaning communicated by participants across the data set, implying a level of interpretation (Joffe, 2012). Therefore, although analysis will be done at the semantic level, identifying the explicit surface-meaning of data, consistent with the critical realist stance the researcher acknowledges that their experiences and beliefs will have an impact on how this data is interpreted and coded. Efforts to reduce bias and improve transparency of data analysis were achieved by keeping a reflexive diary throughout this process.

Stage 1 & 2 – familiarisation with the data had already started during the transcription process, completed by the primary researcher and the qualitative content analysis. All uncoded data was then re-read to increase familiarity. During this process, initial ideas relating to the research questions were noted on transcripts and subsequently coded (see Appendix K for coded transcript example).

Stage 3 – searching for themes began by developing mind-maps of all the initial codes and searching for patterns between these. These were explored and potential themes highlighted (Appendix L). A theme is defined as an important, patterned feature of the data which relates to the research question (Braun & Clarke, 2006). Frequency and prevalence alone did not quantify saliency of themes, the researchers' judgement regarding the meaning or patterned responses defined the saliency of themes (Braun & Clarke, 2006). Saliency refers to features of the data that relate to the research questions, codes are considered important and recurrent (Buetow, 2010).

Stage 4 – a provisional thematic map was developed (Appendix M). This was then checked against transcripts using Excel spreadsheets. Separate spreadsheets were developed for trainees and qualified staff. Extracts from all

transcripts corresponding to each theme were copied into the row representing that theme on the spreadsheet. Each column represented a different participant, allowing consistency to be checked for each theme. This allowed the spreadsheet to be re-organised and themes were clustered into broader categories describing the data and sub-themes within these. This was discussed with research supervisors and checked against transcripts to ensure the identified themes were grounded in the data and to reduce the impact of the primary researcher's preconceptions.

Stage 5 – definition and labelling of themes involved identifying what was interesting about each theme in relation to the research question and existing theory and the relationships between themes and sub-themes. Themes were not reduced to the frequency they appeared in the data but to contribution they made to the understanding of the effects of trauma work on therapists. Distinctions were made between themes common across both trainee and qualified therapist experiences and those that were specific to either sample.

Stage 6 – the report was produced, selecting extracts from transcripts that best represented each theme. Reference to the researcher's reflexive diary was also made within the commentary of each theme.

Phase 3 – Psychometrics

Descriptive statistics were calculated for each measure; TABS, STSS, LEC and ProQOL, using SPSS. The mean, range and standard deviations were reported for both groups: qualified therapists and trainees. This provided contextual information about the sample.

Phase 4 – Synthesis

A synthesis of qualitative and quantitative data was then undertaken, integrating methods in order to answer the research questions. This was done using SPSS to calculate correlations between the measures. Non-parametric tests were used because the data does not meet the assumptions for parametric test, namely that the data needs to be normally distributed. Distribution tends to be more normal with larger sample sizes (Langdridge, 2004). As this study used a

small sample, the use of statistical analysis of distribution can be unreliable, leading to non-normally distributed data being interpreted as normal. Therefore, Spearmans Rank Order correlations were calculated. This calculates a correlation coefficient which describes the relationship between two variables (Siegel & Castellan, 1988). It is computed from ranks so assumes that the data is at least ordinal; meaning the data can be ordered.

Spearmans correlations were calculated for the average total TABS score and the average Euclidean distances for 'self-now' and 'client with posttraumatic growth', 'self-now' and 'self-struggling with trauma work', 'self-now' and 'client struggling with trauma', 'self now' and 'non-trauma exposed individual' and 'self-now and self before training'. These were calculated separately for trainees and qualified therapists. Higher scores on the TABS indicate more negative disruption in beliefs associated with VT theory. Stronger positive correlations with the TABS score and the average Euclidean Distance for 'self-now' and 'client struggling with trauma' would support the negative effects of VT. A stronger negative correlation between TABS score and the average Euclidean Distance for 'self now' and 'client experiencing posttraumatic growth' would suggest VPTG is occurring, as lower scores on the TABS suggest less negative disruption in beliefs and a greater Euclidean Distance suggests more similarity between the therapists' self-perception and that of a client with posttraumatic growth.

The frequency of each negative and positive belief area from the directed content analysis was then correlated with the corresponding belief subscale on the TABS. For example, frequency of negative 'other-safety' beliefs across trainee interviews was correlated with the average score on the 'other-safety' subscale across the trainee sample. If VT occurred within this sample, stronger positive correlations were expected to be observed between negative beliefs identified from the content analysis and scores on the corresponding TABS subscale. If VPTG occurred within the sample, a stronger negative correlation would be observed between the belief frequency and corresponding TABS subscale score.

This provided data to answer the primary research question, exploring whether there is evidence of VT beliefs in trainee and qualified therapists which corresponded to the five belief areas identified within CSDT. Differences between trainees and qualified therapists were also explored. The overall frequencies of positive and negative codes were compared for each belief area, to determine whether there were significant differences. Where data was normally distributed a paired samples t-test was used to determine whether there were significant differences in the mean positive and negative codes identified from interview data. A Shapiro-Wilk test was used to assess the distribution of data, as this is more appropriate for small samples (less than 50 participants). A significance value above 0.05 indicated data was normally distributed so the paired samples t-test assumption was met. As data was from the same subjects in each group (positive and negative codes) and it was continuous ratio data, where a score of 0 was meaningful, all assumptions of a paired t-test were met. When data was not normally distributed, it was examined for symmetry by exploring the distribution of data on histograms. When data was symmetrical this met the assumption of the non-parametric version of the paired samples t-test, the Wilcoxon Signed-Rank Test. This was then used to compare differences between positive and negative codes for each belief area where data was not normally distributed. With data that was not normally distributed or symmetrical, a paired- samples sign test was used to determine whether there was a median distance between the two sets of codes. This has the same assumptions as the paired samples t-test and Wilcoxon Signed-Rank test but does not assume normal distribution so was appropriate for data violating these assumptions.

The secondary research question, whether there are any areas identified in participants' experiences of trauma work which are not covered by CSDT, was answered by the inductive thematic analysis. This explored remaining data to identify any important themes not previously identified in existing research.

Reflexivity

As Braun and Clarke (2006) acknowledge, the beliefs and preconceptions of researchers may influence study findings. To ensure quality and transparency in data analysis, researchers should make clear their prior experiences and epistemological position (Spencer & Ritchie, 2012). Critical-realism acknowledges that the findings reflect a co-construction of reality by the researcher and participants, therefore acknowledging the researchers' role in the current study is important for interpreting study results. The primary researcher was a female trainee clinical psychologist with some clinical experience of working therapeutically with trauma. The two other researchers were qualified clinical psychologists with extensive experience working therapeutically with trauma, one of which has conducted prior research in VT. The primary research held some preconceptions about there being a mixture of both positive and negative beliefs related to trauma work experiences in therapists.

3. Extended Results

3.1 Repertory Grids

The greatest (most similar) and smallest (least similar) Euclidean distances were discussed in the journal paper. This section will interpret other Euclidean distances calculated from the sample.

The mean Euclidean Distance between the elements ‘self now’ and ‘self before training’ was 0.66 for trainees and 0.61 for qualified therapists. This suggests participants are construing themselves differently with experience. This may be related to exposure to client trauma, but could also be general professional development. For trainees the Euclidean distance between ‘self now’ and ‘client struggling with trauma’ was 0.45, and for ‘self before training’ and ‘client struggling with trauma’ this was 0.45. These values are equal, suggesting no difference in how similar trainees construe themselves to clients with trauma resulting from trauma work. Euclidean distances between ‘self now’ and ‘client with posttraumatic growth’ was 0.71 and for ‘self before training’ and ‘client with posttraumatic growth’ was 0.68 suggesting trainees now construe themselves in a slightly more similar way to clients with posttraumatic growth than they did prior to working with trauma. For qualified therapists the Euclidean distance between ‘self now’ and ‘client struggling with trauma’ was 0.34, and for ‘self before training’ and ‘client struggling with trauma’ this was 0.5. This suggests qualified therapists construe themselves as less similar to clients with trauma as a result of trauma work, the opposite of what would be expected if they were experiencing VT. Euclidean distances between ‘self now’ and ‘client with posttraumatic growth’ was 0.75 and for ‘self before training’ and ‘client with posttraumatic growth’ was 0.66 suggesting therapists now construe themselves as slightly more similar to clients with posttraumatic growth than they did prior to working with trauma.

Tests of Normality

As the most and least similar Euclidean distances were compared in the journal paper it was important to determine whether this data was normally distributed,

in order to ensure the assumptions of parametric statistical tests were met. The Shapiro-Wilk test of normality was used as this is recommended as the best choice for sample sizes below (Elliott & Woodward, 2007). P-values above .05 suggest the data is normally distributed, meeting the assumption of parametric tests. P-values below .05 suggest the data is not normally distributed and non-parametric tests are required. SPSS was used to run the Shapiro-Wilk test on the data, results are presented in the table below.

Table 5. *Tests of Normality for Euclidean Distances Data*

Data	**Shapiro-Wilk P-Value**	**Normally Distributed?**
Euclidean distance - Self now & self before trauma	.880	Yes
Euclidean distance - Self now & self coping well with trauma work	.116	Yes
Euclidean distance - Self now & self struggling with trauma work	.017	No
Euclidean distance - Self now & client struggling with trauma	.085	Yes
Euclidean distance - Self now & client with PTG	.048	No
Euclidean distance - Self now & person with no trauma exposure	.184	Yes
Euclidean distance - Self coping well with trauma work & client with PTG	.018	No
Self struggling with trauma work & client struggling with trauma	.892	Yes

3.2 Psychometrics

Table 3 shows the descriptive statistics for the psychometric measures completed by trainees and qualified therapists.

Cut-offs

Where available, cut-off scores for each psychometric measure are provided and it is indicated whether the mean score for each group met this cut-off.

STSS – Scores below 28 indicate 'little or no STS', 28-37 is 'mild STS', 38-43 is 'moderate STS', 44-48 is 'high STS' and 49 and above is 'severe STS' (Bride, 2007). These cut-offs are derived from a sample of social workers.

Trainees in this sample had a mean score within the cut-off for mild STS. Qualified therapists' mean score fell below this cut-off, suggesting they experienced less STS symptoms than trainees.

ProQOL – Cut-offs are based on the 75th percentile (Stamm, 2010). Scores of 33 or below on compassion satisfaction subscale suggest job dissatisfaction. Both trainees and qualified participants in this sample scored above this cut-off, suggesting they experience their role positively. Scores below 18 on the burnout subscale suggest positivity about personal effectiveness at work and scores above 27 suggest burnout. Both groups fell below the cut-off for burnout, suggesting they were not experiencing this. Scores above 17 on the STS scale suggest STS is problematic. Qualified therapists fell below this cut-off but trainees had a mean score of 17 which is just at the cut-off, which supports their scores on the STSS which found STS was at the mild level for trainees.

TABS – T-scores of 60 or above indicate disruption in a given need area (Pearlman, 2003). The mean scores for trainees and qualified participants on the TABS total and each subscale fell below this cut-off, suggesting no disruption in any of the five CSDT belief-areas.

3.3 Directive Content Analysis

A summary of the directive content analysis results is given in the journal paper. The coding agenda (Appendix J) and its development are discussed in the

extended methods. This section builds on the results presented in the journal paper, offering more examples from each belief area and highlighting beliefs which were coded at greater and lesser frequency.

Self-Control

Positive self-control was coded in 8/10 trainee and 8/10 qualified therapist transcripts. Negative self-control was coded in 8/10 trainee and 9/10 qualified therapist transcripts. Some trainees discussed feeling able to be open with their emotions in supervision or with close others: '*I'm fairly open about talking about feelings in that sense, I don't kind of feel like you can't do that. So that's quite helpful'.* Some noticed a change in this ability with experience: *'able to talk in supervision about how I felt a bit more…and I don't think I would have felt as confident to do that as an assistant psychologist umm just because…there wasn't as much umm…permission*'. This was coded as positive self-control as it represents them feeling comfortable being themselves in front of others.

One trainee felt unable to do this, through fear of traumatising her supervisor: '*I do tend to withhold some of the little things that have formed up, formed my picture umm because…I don't want to kind of spread it* ', coded as negative self-control. One noticed she was like this initially but has been more open with experience. Some were able to be open with clients, coded as positive self-control, but only when clients had started to process their trauma and were less avoidant: '*there's much more of an opportunity to…umm (2) kind of ask more direct questions and be sort of…umm (2) be open yourself. You don't get kind of met with the same sort of brick wall or resistance*'. Some qualified therapists noted this being useful within therapy, allowing clients to see the emotional impact their stories had on them, rather than believing they should hide emotions from clients. This seemed to come with experience: *'if somebody had said that to me a couple of years ago I'd have said 'that sounds…you know, that doesn't sound appropriate' but…it's just if you notice a tear come to' your eye, let it, but bring it in the room. So umm…and enable to client to make sense of that'*. However, several qualified therapists felt they could not be open with clients about their emotions as they needed to contain clients: '*it's containing*

that, cos obviously you've got to contain your patient, you're not…you're not there for them to look after you'. Some qualified therapists also picked up on organisational factors which influenced their sense of control: '*I'm one of the management team so I'm not questioned in quite the same way*'.

Negative self-control related to feeling unable to control the world, specifically trauma exposure: '*powerlessness to change what has been done'* and *'helpless and hopeless umm…about the state of the world…which is something you…that you can't really ever solve'*. They also related to feeling unable to facilitate therapeutic change, relating this to lacking control over organisational pressures: '*limits in therapy…we've identified that is core underlying sense of worthlessness and weakness but we've only got so many sessions left so… we have to sort of…pick the battles which is not the most ideal way of doing things*'.

Other-Control

Positive other-control was coded in 9/10 trainee and 5/10 qualified therapist transcripts. Negative other-control was coded in 8/10 trainee and 8/10 qualified therapist transcripts. As well as positive beliefs related to feeling able to influence control over client progress in therapy, some trainees also recognised that although the changes they could facilitate were small, they were reassured by experience that this was part of the process: '*realise how many problems people have got it's realistic…you become quickly aware of how unrealistic it would be to think things can massively change*' and '*even if it's only a tiny bit…I don't think it's always necessarily that…from what I've seen, kind of sometimes people with…who've experienced trauma, just having a kind of…positive relationship that's had a positive ending is kind of a useful step for them*'. Some noticed they were also able to influence changes in the wider system around clients: *'by helping that one person you've had a knock-on effect on their partner or their family*'. Qualified therapists noted the tendency to feel overly responsible for facilitating change but had developed strategies for controlling this, therefore it was coded as positive other-control as negative other-control involves needing to be available for others irrespective of personal needs: '*you have to be very careful that you don't get stuck feeling that it's your*

responsibility and only your responsibility to make them better…using supervision so if I notice I'm doing it'.

Negative other-control beliefs mainly related to feeling unable to facilitate change in clients but also related to feeling unable to control clients within sessions for both trainees and qualified therapists: '*she would flip from…one subject to another umm the avoidance at times was quite overt, so trying to keep bringing her back…to the sort of subject or topic in hand kind of felt like I was herding cats*'. Sometimes this was linked to a sense of responsibility for the client: '*often with trauma it runs over the hour and you notice that. You're very, you know, it's hard to kind of contain it within an hour sometimes so there was an element of not wanting to let her go*'. Both groups communicated a sense of responsibility for clients and going out of their way to meet their needs, suggesting lack of control: '*you end up feeling personally as if you've failed if that doesn't happen, umm so I guess it's the kind of, the responsibility…the sense of responsibility'* and *'I don't believe that people should have to live through awful things happening to them and poverty and abuse and everything else. Those things should not have happened. And so then I feel responsible for that somehow'.* This can result in intrusions on their personal life due to activating a 'rescuer-role'*: 'when I take things home with me it's because …I really wanna do something about it and I really want to be able to help. And I think it's when I get that urge to rescue'.* Negative other-control sometimes related to client avoidance: *'when someone doesn't go to those places you come out with frustration, more at yourself than them'.* This qualified therapist interpreted client avoidance as being something they should have control over, resulting in self-blame when they could not influence it.

Qualified therapists also mentioned lacking control over external factors related to client trauma, resulting in feelings of helplessness: '*household is never going to change. The dysfunction will be there, when she's 30, when she's 40 umm and I'm aware that I can make very little impact on that*'.

Self-Esteem

Positive self-esteem was coded in 9/10 trainee and all qualified therapist transcripts. Negative self-esteem was only coded in 4/10 trainee and 2/10 qualified therapist transcripts. Most positive beliefs centred around observing positive shifts and posttraumatic growth in clients, creating a sense of satisfaction and view of their role as worthwhile: '*had a really good session, they feel better because of it and you think, that's why I do it. That's why I do my job. Yeah, it's a good moment'* and *'heart-warming, satisfying umm (4) yeah I guess a sense of fulfilment and umm…you know self-esteem'* and '*you can't not feel a sense of reward and…pleasure if you want to call it that, when somebody has made some changes'*. Some also mentioned observing their own growth in terms of increased competence and confidence in their skills, increased empathy and resilience: '*it's helped me recognise that I…I can be quite kind of strong*'; *'I learnt a lot from her and lots of skills as well of how to deal with her particular trauma and how to deal with the presentation that she brought. So I felt I came out of it a better therapist…So I feel like I've had some growth in the same way*' and '*I'm a survivor with them'*. Many mentioned feeling honoured that clients trust them to listen to their experiences: *'I'll look at them and I'll think 'wow they're sharing this with me' so I'll feel quite privileged. Umm (2) that they're...you know, trusting enough to do that with me*' and '*when you see the relief in someone who's never told anybody about a particular trauma I think I find that really umm (2) oh what's the word…like fulfilling*'. A strong theme of becoming less judgemental and more empathic was discussed in the journal paper. Further quotes demonstrating this include: '*I find it much easier to (2) I guess umm (3) not to not judge people but I guess I find it easier to have kind of curious thoughts about what people might have been through…I think it makes it easier to be compassionate towards people*'. Some directly commented on this being a change they had noticed in themselves, becoming more understanding of why people may engage in socially unacceptable ways: '*negative judgement I suppose from those people and I…and I honestly think that a few years ago I probably would have reacted in the same way umm but*

now…and I think it's through trauma work and other work, just generally understanding people better'.

Other-Esteem

Positive other-esteem was coded in 7/10 trainee and 9/10 qualified therapist transcripts. Negative other-esteem was coded in 5/10 trainee and 6/10 qualified therapist transcripts. Further examples of participants' beliefs in the resilience of the human spirit, coded as positive other-control, include: '*They might not see it like that I think you can…you can see how strong people can be in the face of…umm horrible experiences*' and '*human resilience to overcome the most horrendous experiences umm I think is amazing*'. Many discussed the difficulties of working with people who feel responsible for the trauma they experienced, and the positive impact and motivation felt by the therapist when the person progresses and realises they were not at fault: '*it's really rewarding, I really like seeing the look on their face umm when they suddenly realise something wasn't their fault. It's wonderful*'. As well as acknowledging the positive qualities of others, some also acknowledged the emotional impact on themselves of working with people who see themselves negatively and are blind to their positive attributes: *'I don't think he had one positive word to say about himself really he just thought he was…wasn't as good as anyone else umm (4) yeah it just makes me sad cos it wasn't true'*; '*I feel sad that that person…is holding…I guess the responsibility, the perpetrator's responsibility'* and *'they were a lovely person and someone had done something to them and they had convinced this person that it was their fault it made me feel quite…quite angry*'. Some felt this provided motivation to help clients overcome their trauma and allow them to see their positives: '*that just spurs me on a little bit because…I think 'no you do. You do deserve to be here' umm it makes me want to help them more*'.

Further examples of participants becoming more pessimistic about the world and people in general provide evidence of negative other-esteem; *'I'm a bit more pessimistic about the world now. To be honest, actually going back to the last question I'm probably a little bit more pessimistic about people as well'* and

'see the ugly side of life… you see how cruel and inhumane human beings can be…to each other'. Some trainees also discussed their views of society letting people down and adding to their experience of trauma through discrimination, adding to their pessimistic view of the world: '*how can someone…be forced into a situation where that is what they're doing. It makes me think wider, it makes me think about society, it makes me think why we live in a world where things like this happen*' and '*wider society around them and being discriminated against and…and…all of those…all of that just made me think…what's wrong with the world? There's something wrong with the world that people are treated like this*'.

Self-Intimacy

Positive self-intimacy was coded in 9/10 trainee and 7/10 qualified therapist transcripts. Negative self-intimacy was only coded in 2/10 trainee and 4/10 qualified therapist transcripts, suggesting this domain was more influenced by VPTG. Most positive self-intimacy beliefs related to feeling comfortable being alone and using that time to experience emotions aroused by trauma work: '*I would kind of stay with it…and I…I guess by experiencing it, it sort of allowed it to subside'*. Several trainees and qualified therapists specifically mentioned using long commutes as time to do this and process their emotions, helping them cope; '*hour and half journey each way and, in some ways, as much as that was horrendous, it was quite nice just to have that hour and a half just to shut off, be by myself*' and '*when I'm driving home I've got, kind of 45 minutes to process everything in my own head. So by the time I park outside my house, I'm able to step outside of the car and step away from work'*.

Further examples of trauma work triggering beliefs about lacking self-awareness, coded as negative self-intimacy, include '*it's been more difficult not to get drawn into my own stuff…because I wasn't necessarily aware of it…umm I thought I had a pretty good umm idea about me and my issues umm the stuff that I've been through … I have lots of clients…umm with a history of kind of uhh neglect, that…umm kind of got hold of me umm that I didn't really expect…I was unaware that tapped into something for me'* and *'before training, umm I*

found it difficult to distinguish (2) that what I was feeling was related to the trauma I'd heard'. As well as reflecting on lacking self-awareness prior to starting trauma work, one qualified therapist also mentioned how trauma work can sometimes have a negative impact on self-intimacy, leading her to not want to do things for herself; *'I can think I don't want to do loads of things…I might not want to walk the dog that night or something when actually I know if I do do that I feel a lot better. But sometimes it makes you feel you don't want to'.*

Other-Intimacy

Positive other-intimacy was coded in 9/10 trainee and all qualified therapist transcripts. Negative other-intimacy was coded in all trainee and qualified therapist transcripts. Further examples of using peer-support due to shared understanding, coded as positive other-intimacy, include; '*they have similar challenges. Umm (2) they can often ground you or reassure you…and it's usually the latter. So you know that you're actually on the right track;'* and *'the assistant in the room that kind of calmed me down…I kind of told her what had happened in the session and was able to off-load on her'*. This therapist acknowledges that connecting and sharing her distress with peers may help prevent negative impacts of trauma work: *'we've all done the training…so we're all very much kind of trying to help each other through it. Umm...I think I just acknowledge that it's a really rough ride sometimes, in this job, so I don't mind using my peers around me umm…I'd have never of just kept it isolated umm just purely because of burnout'*. Several trainees and qualified therapists also talked about using supervision to off-load emotionally, providing reassurance that what they were feeling was normal; '*My supervisor…was helpful as well to…to have a dialogue about it, about me rather than just the client umm (4) and yeah (4) it was mainly making sense and (3) coming to terms with why'* and *'my clinical supervisor was brilliant. So I did take it to supervision and we worked through it. She helped me work through the whole guilt'.* Participants felt positively connected to loved ones, despite it being a different relationship where they were not able to discuss details of their work due to maintaining client confidentially: *'going home to my husband and not necessarily like not*

telling him anything umm about the client…I like to go home to kind of like my safe place, but I think we now naturally kind of kick in certain things if I've…kind of had a difficult day or something like I've found something difficult to listen to or whatever that, it is kind of like a button down the hatches and like we're here, we're safe' and *'I don't share with my partner things about my clients cos obviously we don't but I might just say 'I'm struggling a little bit, you know I heard this today and I'm struggling with that' and maybe he's doing something to distract'.* Although this therapist felt his partner did not understand trauma work, he found this useful as a way of maintaining a work-life balance and felt connected to her in other important ways: *'I won't be able to get dragged down into it because…she doesn't understand…I think a lot of it goes over her head but it gives me a chance to kind of (2) umm (2) I have to not talk about it I suppose, there's other bits to my life that are important…that we can do together'.*

Others' lack of understanding of trauma work was sometimes coded negatively, if it led them to avoid sharing that part of their lives with others: '*family members here 'oh I couldn't do your job love. I couldn't do that. I couldn't hear that'* and *'friends…sometimes find them saying 'how do you do what you're doing?' …I find myself not giving them any other information'*. As well as participants avoiding talking about work due to others lacking understanding, some trainees and one qualified therapist discussed avoiding people at times. Examples include '*if I feel like a bit overwhelmed and a bit emotional and been affected by work then I won't hang around with people that probably need me to be more available'* and *'it was taking over my life and…like I wasn't seeing friends'.* One trainee related this to needing space linked to hearing client experiences of domestic violence *'I wanted to stay a bit more…a bit more physical distance. And my partner just inquired is everything alright?'.* Some felt others had sensationalised views based on media depictions of mental health, so avoided talking about work: '*friends if I mention something, 'oh my god! Really?' and kind of this response that…it's not news, it's not…something you read in the paper and you're amazed. It should be (2) more empathic'* and ''*voyeurism as in like oh it's umm they want to hear about…extreme human experiences or…like*

in, I don't know, the reason that I think is for entertainment'. Further examples of negative other-intimacy beliefs related to anxiety over how sharing experiences may affect family include *'very aware that you don't want other people to be affected by…by, you know, by…by what….by what you're bringing back out from work'; 'I have a huge fear that if I talked about…like if something's bothered me and that I have got, kind of, structures like professional structures around me umm that if I said something to him then I would just be…that I would traumatise him'.* Many participants discussed being able to connect emotionally in supervision. However, two trainees and one qualified therapist discussed poor experiences of supervision where they felt unsupported, coded as negative other-intimacy: *'busy supervisor and didn't really think…really I don't think she really understood' and 'in some placements I felt really left on my own, and just told to get on with it'.*

Self-Safety

Only 2/10 trainee and 2/10 qualified therapists communicated positive self-safety. Negative self-safety was only coded in 3/10 trainee and 2/10 qualified therapist transcripts. One trainee discussed her experience of working with victims of domestic violence, thinking about the risk to herself in new relationships, which was coded as negative self-safety: '*all the domestic violence thing it's made me more…more like think about cos I'm single at the moment, I kind of think ok like…you don't know who…who could be, you know maybe a bit more hypervigilant about it*'. The general awareness of danger in the world often linked to a sense that trauma can happen to anyone: '*recognition that that could happen to any of us. That any of us could be that…person, that it's almost like if you thought about it too much you'd never do anything*'.

Other-Safety

Positive other-safety was not coded in any qualified transcripts and only 1/10 trainees. Negative other-safety was coded in 5/10 trainee and 8/10 qualified therapist transcripts. Both discussed worries about clients and their vulnerability, often linked to intrusive thoughts outside of work: *'I was really*

panicky. I couldn't get hold of him either and I couldn't get hold of his umm care co-ordinator in the community and I thought about him when I got home, because I thought, I hope, you know, I hope he's ok. What's happened? Why's he not turned up? So it tends to revolve around…a safety thing'; '*if someone's struggling and then you hear a news report that someone's jumped in front of a train…the first thing that flashed through your head is all the clients that you're struggling with, or all the clients that are struggling*' and '*hope that person's alright' umm but it will literally be…that thought might come Into my mind and then it'll be, I won't think about it until I'm at work next, but then I might check on the online system just to see if there were any entries*'. Further examples of qualified staff experiencing negative disruptions related to their children's safety include *'my little boy went to one of his friend's houses for tea …and I know the mum…but I dropped him off…and I couldn't help but think I don't know who's in that house. Like I know that she's gone in with her son and my son but who…I don't know who visits or… then your cogs start going'* and *'having my own kids, sometimes I catch myself looking at them…and thinking oooh how could anybody hurt children*'.

Self-Trust

Positive self-trust was coded in 5/10 trainee and 8/10 qualified therapist transcripts. Negative self-trust was coded in 6/10 trainee and 5/10 qualified therapist transcripts. Further examples of participants' positive self-trust related to confidence in their skills include '*trauma work it's not really you know, low-intensity CBT which can be read in the newspaper, it needs that…I think, that therapeutic relationship umm where there's trust and umm there's something quite unique about it…it can really change people's lives*'. Some spoke about how their trust in therapy being useful helped engage clients; *'I've got faith in what I'm doing, to help them develop faith even though they're still struggling, …that therapy can help them so yeah, I think that's really important. If you have faith in what you're doing cos if you get caught up in their hopelessness which is very common, with trauma, you're going to lose them*'. Related to their trust in therapy being useful was several qualified therapists discussing using therapeutic techniques themselves as a way of helping them cope with the

demands of trauma work: '*use some kind of mindful meditation or do something kind of relaxing or do something…I suppose I benefit most from being quite active and doing things like that. So…I trying to kind of practice what I preach in terms of kind of self-care*' and '*mindfulness training…when I was an assistant and, so I've always used it on and off, but the more I work with trauma the more I use it. The more I use my own safe place, uhh leaves on a stream from ACT and those sort of things just to help me*'.

Negative self-trust mainly related to therapists questioning themselves and the therapeutic process, further examples include '*It's sometimes frustrating because you think what else can I be doing to help them through it. You're thinking ok what else…should I be doing something different? Are they just stuck? Should they be doing something different? What…what do I need to change in order to enable them to move through it'*. One therapist felt this got worse over time, as he expected to feel more competent with experience but this was not the case: '*you think you should know more but actually you probably know less, you know, but that's why I found it was quite hard to…to go for yes I'm perfectly happy and confident and everything because there's always an element there, that actually you're not, you don't know it all'*. However, others talked about the confidence improving with experience, specifically worries about re-traumatising clients reducing as they realised people's resilience: '*more tolerant or able to withstand some of that. Whereas when I think yeah before I started working with people with trauma I expected them to be distressed...but I think I was also a little bit scared about, you know, kind of mucking up or making mistakes. Umm…yeah fearful of kind of making that worse'* and *'I was frightened of kind of traumatising people or kind of saw them as a little bit more fragile, or that umm…it would be more risky to make mistakes in therapy, with that client group'.* Often self-doubt was linked to clients they were struggling with: '*helplessness…being overwhelmed umm and…like to the point that (2) kind of even trying to contain that for them…was, like didn't feel like that was enough. Like even though…I think I felt like that was the only thing at that point I could do'.*

Other-Trust

Positive other-trust was not coded at all. Negative other-trust was coded in 5/10 trainee and 7/10 qualified therapist transcripts. Negative other-trust related to a general distrust of others; '*there's a cynicism cos you listen to experiences that people have had and you start to be less trusting of people and you start to have thoughts and…yeah I think cynicism is probably the negative. You start to think that everyone is umm bad*'. For some this impacted their lives with them being more cautious of letting new people into their lives: '*what I hear every day does affect my ability to open up and trust people (2) in the beginning…in the beginning in relationships I think I'm definitely a bit more wary than I used to be'* and *'I am less trusting so I give less. I'd be less likely to tell people about myself than maybe I was in the past…so yeah. I think there's just that element of…keeping yourself safe'*. Some spoke about not being able to trust people to be there for them, requiring them to be more independent: '*you're not always able to get people that will…be there, so you have to look for it yourself*'. One qualified therapist discussed the differences between working with victims and perpetrators of trauma in terms of other-trust and how this led her to want to leave the profession: '*when I came out from working with uhh sexual offending in the prison service I was quite cynical when I came out of that, hence why I left'.* Some also discussed not trusting client intentions: '*does make me…view people differently because I'm then…doubting their…sometimes doubting what they're saying or what they're presenting and thinking 'is there more to this'? umm so I guess it kind of might have made me less trusting…of clients'* and *'I think some of the level of detail…was…felt almost a bit gratuitous at times and I did wonder whether there was a bit of an element of…you know is he trying to shock'*.

Summary of Directive Content Analysis Results

Overall, the results demonstrate that positive and negative beliefs can co-occur, but some areas do appear more negatively affected, specifically other-trust and self-safety. There is evidence for beliefs consistent with VT, which mimic items found on the TABS; for example, 'You can't trust anyone' is an other-trust

subscale item on the TABS which corresponds to some of the quotes coded as other-trust where participants reflected on viewing themselves as less trusting as a result of trauma work. However, the TABS items are global whereas examples coded within interviews tended to refer to specific examples such as feeling less trustful of people in new relationships rather than distrustful of everyone in their lives. A further example is the TABS self-control item 'I must be in control of myself' which again is a global statement, whereas negative self-control codes from participant examples included therapists believing they must be in control of their emotions within therapy or supervision, to avoid distressing others. This may provide some explanation for why interview data provides evidence for negative beliefs consistent with VT, whereas scores on the TABS suggested no such disruptions. The TABS uses more global examples which may not reflect how participants felt about all aspects of their lives so they scored lower on these. Within interviews they were able to discuss specific examples and contexts where these beliefs may be more relevant, meaning they were coded within interviews but not scored on the TABS. Overall, quotes demonstrating examples of belief coding tended to refer to specific examples, rather than global statements made by participants. This demonstrates the utility of qualitative data in allowing a deeper exploration of participant experiences, which quantitative measures may miss.

3.4 Relationship between TABS scores and Euclidean Distances

Further correlations between the TABS and Euclidean distance are explored and presented in Table 5. It is worth noting that none of the correlations were significant and all correlation coefficients were weak, which may represent the lack of power in this exploratory study.[2]

A Spearman's rank-order correlation was run to explore the relationship between total TABS score and the Euclidean distance between 'self now' and 'self-coping well with trauma work'. There was a weak negative relationship.

[2] Running multiple tests on the same data increases the chance of a Type I error being made (Benjamini & Hochberg, 1995). However, an adjustment to the significance value of 0.05 was not made as this is an exploratory, secondary analysis. Adjusting for multiple tests may miss important areas that could be followed-up in better powered further research.

The correlation co-efficient was R = -.325. This was non-significant (p=.162). This was in the expected direction as higher Euclidean distances suggest participants view themselves as coping well with trauma work which should result in less VT, therefore lower scores on the TABS. There was also a non-significant weak negative relationship with total TABS score and the Euclidean Distance between 'self coping well with trauma work' and 'client with posttraumatic growth', although this was also non-significant. This was also in the expected direction as higher Euclidean Distances suggested more VPTG, which should link to lower scores on the TABS. There was a non-significant weak negative correlation between total TABS score and the Euclidean distance between 'self now' and 'non-trauma exposed individual'. This was in the expected direction as similarities with a non-trauma exposed individual should represent a lack of VT, so as similarity increases TABS score decreases. There was also a non-significant weak negative correlation between total TABS score and the Euclidean distance between 'self now' and 'self before training'. Again, this was in the expected direction as it is assumed participants' exposure to client trauma prior to training is low so they should not be experiencing VT at this point. The more similar they see themselves now to how they were before training suggests no VT. There was a non-significant weak positive correlation between total TABS score and the Euclidean distance between 'self struggling with trauma work' and 'client struggling with trauma'. This was in the expected direction as higher scores on both should represent VT. However, the correlation coefficient was .098, which is very low and would be expected to be higher if the TABS and repertory grids were both measuring the same thing.

Table 6. *Correlations Between TABS and Euclidean Distances*

Correlation	**Spearman's Correlation Coefficient**	**Significance level (p=0.05)**
Total TABS score with Euclidean distance 'self-now' & 'client with posttraumatic growth'	.068	.777

Total TABS score with Euclidean distance ‘self-now’ & ‘client struggling with trauma’	.002	.995
Total TABS score with Euclidean distance ‘self-now’ & ‘self-coping well with trauma work’	-.325	.162
Total TABS score with Euclidean distance ‘self-now’ & ‘self-struggling with trauma work’	-.130	.584
Total TABS score with Euclidean distance ‘self-now’ & ‘non-trauma exposed individual’	-.106	.656
Total TABS score with Euclidean distance ‘self-now’ & ‘self before training’	-.089	.708
Total TABS score with Euclidean distance ‘self-coping well with trauma work’ and ‘client with posttraumatic growth’	-.103	.666
Total TABS score with Euclidean distance ‘self-struggling with trauma work’ and ‘client struggling with trauma’	.093	.697

3.5 Inductive Thematic Analysis

It is beyond the scope of this paper to fully report the thematic map in detail (a further journal paper will be produced). Instead, a dominant description of the themes is provided based on saliency analysis, which will be related to the other data analyses conducted. The thematic map (figure 1) shows potential processes therapists experience, leading to either distress (guilt) or acceptance

of the impact of trauma work. These are exploratory ideas, requiring further research to test and refine these processes.

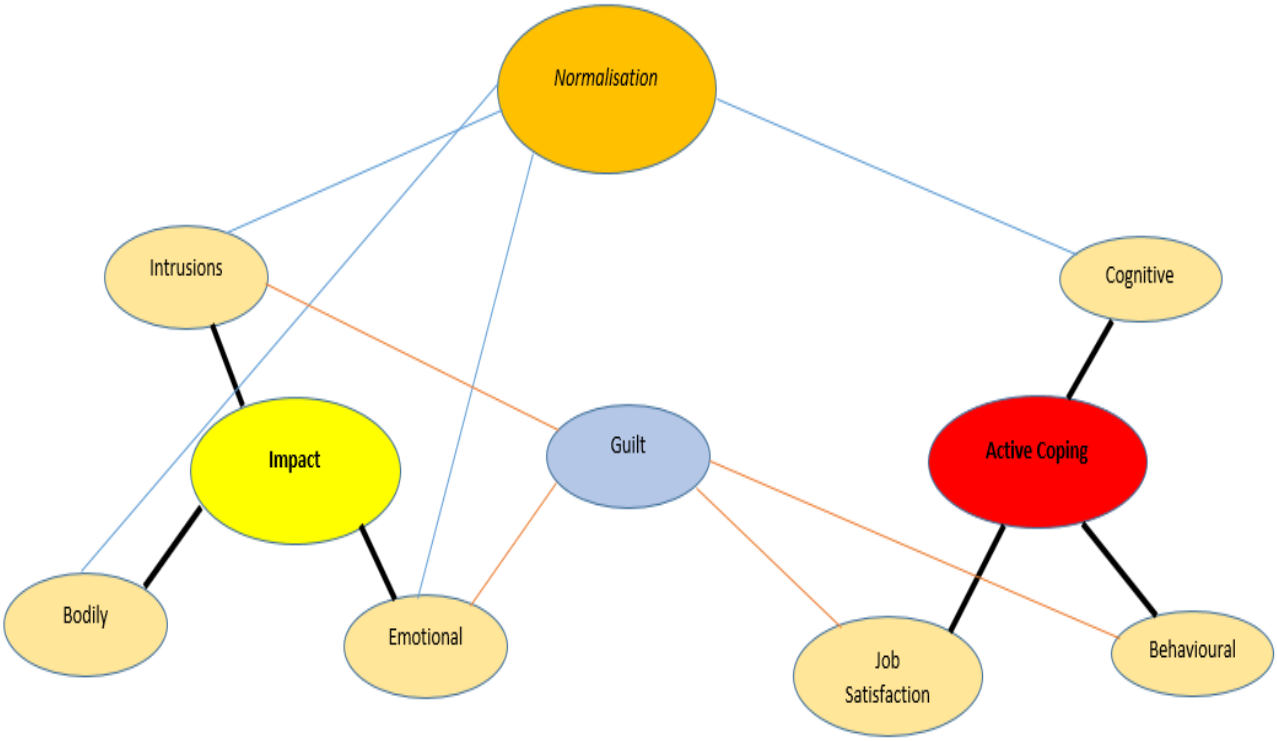


Figure 1. *Final Thematic Map*

Two main themes were found: impact and active coping. Both relate to the subthemes normalisation and guilt, which describe processes participants appear to go through when making sense of their exposure to client trauma. Impact contains the subthemes intrusions, emotional and bodily, which have all been identified in previous literature (Sabin-Farrell & Turpin, 2003). Coping contains the subthemes cognitive, behavioural and job satisfaction. Job satisfaction relates to compassion satisfaction, where participants take pleasure in helping others despite some cost to themselves (Stamm, 2005). The blue lines represent aspects where participants communicated a process of normalisation in making sense of these subthemes. The red lines represent subthemes where some participants reported experiencing a form of guilt. Guilt had three forms: guilt related to trauma work impacting on home life, guilt about the privilege of their own life compared to clients and guilt related to a feeling of

selfishness in taking pleasure from helping clients. A narrative explaining the links between these themes and subthemes is provided as they are linked.

Impact

Intrusions

The first subtheme, intrusions, is usually conceptualised as a negative, distressing effect of trauma work. However, participants in this study mainly made sense of them as a normal, expected part of their role, reducing their impact; '*I wouldn't say it stays with me as in it impacts my life…I think clients generally do stay with you anyway. They sort of shape who you are as a therapist and they can teach you stuff...the positive ones stick to mind more'.* This trainee discusses her positive attribution of intrusive thoughts about clients and how positive experiences have actually had more impact on her identity. This supports findings from the repertory grids where trainees constructed themselves as more similar to clients with posttraumatic growth. A similar process of normalising intrusions is discussed by this qualified therapist '*I kind of accept that it's part of…doing what we do. Umm that inevitably you will kind of take home (3) bits of people with you in a way. Umm…I don't view it as a particularly negative thing*'. Again intrusions are conceptualised as non-distressing and an inevitable part of the role.

There were some exceptions to this, with some participants struggling with the experience of intrusive thoughts of clients outside of work: '*I hate it. It's awful cos you feel guilty for feeling…for thinking about them for a start, because I really try and keep things separate*'. This therapist talks about the guilt she experiences as a result of involuntary thoughts about clients impacting on her home life and attempts to maintain boundaries. Another therapist spoke about not being able to normalise intrusions due to a belief that work and life can be kept separate and the discomfort linked to this: '*it's uncomfortable because…I suppose I kind of have this unrealistic fantasy that…well some people tell you they can switch off and… seem more gathered but I…I don't do that umm and sometimes it's kind of unwanted or intrusive, like on a Saturday morning when I want to have a lie-in'*. Interestingly, it was only qualified therapists who reported

these negative effects, despite them reporting an overall lower level of distress than trainees.

Bodily

There were several participants who experienced negative bodily responses to client trauma: '*hearing everything that has happened to somebody, and it does make you feel ill sometimes. It's…it's made me feel sick before. You can feel yourself retching at times, it's horrible'*. This qualified therapist describes the distressing physical reaction she had to listening to client trauma. Two qualified therapists linked these physical reactions to empathy, engaging in a process of intellectualising this and normalising it as part of therapy, which may have reduced their distress: '*mirror neurons and all of that kind of understanding the mechanisms by which umm your empathy was activated'.* This is seen as helpful to the therapeutic process by the therapists using the negative bodily sensations to help the client make sense of their own experiences: '*they haven't got a language for, that…and I can use this to help them become more connected to their experiences umm…is it umm…something about…a natural response to…hearing a story about threat. So when I think about mirror neurons that person's terrified while they're telling the story, there's going to be some…stuff going on in my brain that's going to have an impact on my body*'.

Emotional

The emotional impact on therapists of listening to client trauma was widely discussed. Many felt sad for what had happened to clients: '*it feels like a shadow over my heart. It's like a deep, deep kind of sadness...umm for people'*. This qualified therapist discusses the profound emotional impact of listening to client trauma. Some reflected on the process of listening to client trauma being more upsetting than they had expected: '*I thought it would be really upsetting but that I didn't think that I'd struggle with it as much as like I have done*'. The need to contain client trauma within sessions, and recognition of this being difficult, was mentioned by some: '*having to listen to some of the things that people have been through, you know, it's not nice…it can be quite traumatic just listening to that stuff and having to hold onto it*'. However, some described a

desensitisation effect: '*I think sometimes it…it's a bit scary actually how (3) used to hearing things you can become*'. This trainee appeared uncomfortable with this, possibly believing she should feel some distress when listening to client trauma.

Despite the negative impact, some engaged in a normalisation process, recognising that emotional engagement was a necessary part of their role: '*emotional umm but also I think positive particularly when you see the relief in someone who's never told anyone about a particular trauma. I think I find that really…like fulfilling*'. This trainee positively attributes the difficult emotions she feels when listening to client trauma as something that provides job satisfaction. This qualified therapist also sees the positives in listening to difficult stories, as they help therapy progress, whilst recognising the impact on herself: '*it's been a really hard session so you're delved deep into something and you've been through something with that person so although you get this kind of…nice feeling, this kind of elation that they're moving forward, you're also left with all the things you've just heard'*. This trainee mentions the necessity of the emotional impact as a therapist: '*someone's telling you the horrible things that have happened to them it does…connect and…you do feel something and if you didn't feel something I think you're in the wrong business'.*

Active Coping

Job Satisfaction

Consistent with the high scores on the compassion satisfaction subscale of the ProQOL, many spoke about the positive aspects of their role. Several discussed the hope provided by witnessing client growth, which can help them through the more difficult times when clients are still struggling: '*if you get caught up in their hopelessness which is very common, with trauma, you're going to lose them I think. So there's something about always keeping that positive experience somewhere in the back of your head*'. One therapist described this hope as the best part of his job: '*seeing them…move from a place of…umm fear and kind of a lack of hope and sadness…to…a place where there was some hope and there was a sense of, that things can be different*'. The rewards of witnessing

client trauma were often described as a motivator for the role, despite the recognition that the role is difficult: '*sometimes you are bogged down in the...awful stuff because that's the trauma work but then you get through it and I think it's that reward at the end. You see results quite quickly sometimes which is lovely. Very rewarding as a psychologist'.* There seemed to be a balancing of the negatives with this positive reward for some. All participants linked this positive to observing client progress, so it may be that those who do not observe as much progress are left only with the negative impacts, making it harder to cope. However, others experienced a sense of selfishness and guilt for taking this sense of reward from their work: '*selfishly, it feels really good to see that happening. Umm (4) yeah it keeps you going in the job'*. Although seeing clients progress felt good and motivating, this clinical psychologist appeared to struggle with some sense of guilt over thinking about the positives in the work for themselves. This may link to several talking about going into the role because they wanted to rescue others, putting others' needs before their own: '*get drawn into their…difficulties…being a rescuer, which I was worried about managing. I wanted to, kind of, save people'*. This was discussed in the other-control coding, where therapists struggled to maintain these boundaries and felt responsible for clients' progress.

Behavioural

Although other behavioural coping strategies were discussed, work-life balance is focussed on as it linked to guilt for one participant. Many talked about work-life balance as a way of helping them cope with the demands of the job: '*having a balance and not it all being about work…cos I think otherwise you can get a bit overwhelmed by it'.* Several related personal leisure time to a distraction from thoughts about work, something they needed to be actively engaged in: *'I have fun stuff to do as well. Umm which I always think helps and…yeah rather than kind of get stuck in other people's distress'*. One therapist talked about how when she is engaged in enjoyable activities outside work, she can think of clients and feel guilty, comparing her life to theirs: '*you feel…guilty sometimes, you could be having a wonderful time and then think 'oh they're having a terrible time' and you think 'oh that should never have happened to them*''.

Cognitive

Cognitive coping involved a process of making meaning from the negative impacts trauma work had. Several talked about only realising they needed to develop coping strategies after experiencing the negative impacts of work, seeing learning to cope as a process: '*process of being able to, or learning how to…sort of cope with all that rather than being static and not even knowing that you kind of have to learn to cope with it'*. Others engaged in a process of rationalising their distress and normalising it, to create distance with work and home-life: '*I use a lot of self-talk I suppose. I really rationalise things and think, do you know what, that's work. You help them by seeing them at work*'. Some also talked about the recognition of VT beliefs, but engaging in a process of rationalising these and reminding themselves that they have a skewed image of the world, to reduce the distress these beliefs may result in: '*I don't feel kind of jaded by it, I only get a particular snippet of the world but I think if you get caught up in it, you feel like oh God it's a bit of a grotty world we live in'*. This process was echoed by another therapist: '*you see more of your share of bad things but...all you're doing is seeing one section of it in any one particular time. And it's not all like that. So if people get shot on a beach in Tunisia…it doesn't mean that people are being shot on beaches all over the world. you know…it's just…you know; you do have a sense of balance about it'*. This demonstrates a process of normalising that exposure to client trauma may result in distressing worldviews, but reminding oneself that this is due to the nature of their work helps them achieve balance in their thoughts, reducing distress.

3.6 Extended Synthesis of Results

Interpreting these themes in relation to data from the initial analyses is important. Overall, the sample showed more evidence for VPTG on the repertory grids, although there were also some small similarities in the way both groups construed themselves and a client struggling with trauma as neither had an Euclidean distance of 0 (representing total dissimilarity). The content analysis demonstrated that VT and VPTG beliefs can occur in parallel, and some belief areas experienced a greater degree of each. Trainees had more

belief areas affected by VT, whereas qualified staff experienced VPTG in half of their belief areas. The inductive thematic analysis revealed that there is a recognition of the negative impact trauma work has emotionally, physically and cognitively in the form of intrusive thoughts. This prompted a need to establish coping strategies, which are behavioural or cognitive. Participants appear to search for the positives in the work, holding on to moments when therapy goes well and getting a sense of fulfilment from helping others. This allows them hope when struggling to cope with the demands of trauma work. Many spoke about a process of normalising the distressing impacts as part of the experience of a trauma work therapist. This may relate to other-intimacy and the significance of having peer support to offload and share their experiences with mutual understanding.

There were times when participants did struggle and were left feeling guilty: for work impacting on their personal life, for what had happened to clients and for feeling rewarded by their work despite the trauma clients had gone through. Overall, there was recognition within the sample that trauma work is hard for therapists but most were able to find some positives in this, accepting it as part of their role. This may explain why they saw themselves as more similar to clients with posttraumatic growth on the repertory grids, as although they have been through the distress of trauma these clients have also been able to take something positive from this.

4. Extended Discussion

Overview

This section focuses on how the findings of this study relate to previous qualitative and quantitative findings, with particular focus on the inductive thematic analysis as this was not presented in the main journal paper *(a further qualitative paper will be produced drawing on qualitative results in more detail).* A critique of the study and how this impacts the results is expanded, with further recommendations for future research and clinical implications. The critical reflection considers the author's use of a reflective diary throughout the research process.

4.1 Discussion of findings in relation to past literature

The findings within 'esteem' beliefs of participants perceiving themselves to be less judgemental and more accepting of others, due to an awareness that trauma can impact anyone, is concordant with previous qualitative research (Bell, 2003). Some therapists became more compassionate in their views on perpetrators of abuse, viewing them as 'wounded rather than evil' (Arnold *et al.,* 2005). Viewing this in terms of professional development, suggests trauma work offers a broader awareness of human behaviour and making sense of distressing behaviour may reduce the distress related to increased awareness of the horrible things some humans do to each other. This relates to findings from posttraumatic growth literature, suggesting trauma exposure may inspire paradoxical understanding which reflects gains in wisdom (Calhoun & Tedeschi, 1998). However, it could be argued that increased understanding of human behaviour is a central part of the clinical psychologist role, as formulation, which involves making sense of behaviour, is a key competency (Tarrier & Callam, 2002), rather than a specific development arising from trauma work.

Within other-safety, several qualified therapists discussed the impact of trauma work on their parenting. This was not discussed by trainees. However, this may be due to trainees being younger on average and possibly less likely to have children. Parental status was not measured in this study, although it may have

been useful to ask to provide context to data, as several participants discussed this. This finding replicates previous research which found therapists were more protective of their children (Chrestman, 1999), increasing their efforts to protect their families from danger. This relates to a hypervigilance to child abuse mentioned by some participants in the current study. Some recognised that they had a skewed view due to working mainly with victims of abuse, but also felt this impacted their perceptions of their current environment, meaning they were hyper-alert to their children's safety. Some studies found this led them to be over-protective of their children (Clemans, 2004; Lonergan *et al*., 2004; Jankoski, 2010) or doubt their parenting skills (Menashe *et al.,* 2014), whereas others felt this increased perception of danger made them better parents (Pistorius *et al.,* 2008). This was supported by one psychologist in the current sample, who mentioned educating others about the potential danger to their children: '*I'm more mindful I guess of the children that are in my life and how to protect them and how to umm educate, I guess, friends and family, and…not overly but…I would be uncomfortable with the children in my life staying at a strangers'*.

A central theme identified within the inductive thematic analysis was participants' recognition of the array of negative impacts trauma work could have. This included the subthemes emotional, bodily and intrusions. This supports previous studies which have found therapists experience a range of emotions resulting from trauma work (Iliffe & Steed, 2000; McCann & Pearlman, 1990; Schauben & Frazier, 1995), such as anger, anxiety and sadness, all of which were communicated by the current sample. A new finding was some participants discussed this emotional impact as being a necessary and normal part of the role. A couple mentioned desensitisation and that they should connect emotionally to client trauma, believing if they no longer felt emotionally impacted by their work then this would be a sign that they should leave the profession. Generally, intrusions were perceived as non-distressing and a 'normal' part of the participants' roles. Some even attributed them positively, viewing them as helpful to the therapeutic process. When they were viewed

negatively, this related to guilt about work impacting their home life or comparing their own privileges to their clients' misfortunes.

Intrusions are conceptualised as a negative part of the VT experience and included as a symptom on measures of STS (Bride *et al.,* 2004). However, no literature has been identified which explores what therapists perceive as intrusive. This is a strength of this study being grounded in critical realism as it explores the perceptions and meanings attributed to these experiences. Morris, Shakespeare-Finch, Rieck and Newbery (2005) argue intrusions are related to positive changes post-trauma. This cognitive interaction with trauma is necessary for development of new schemas that open the process for personal growth. This study supports this theory as participants generally showed evidence of VPTG and perceived intrusions to be a positive, non-distressing experience. They can be conceptualised as an attempt to understand client trauma and process it cognitively (Helgeson, Reynolds & Tomich, 2006) and Joseph and Linley (2005) argue a period of cognitive processing is necessary for PTG to occur. This ability to derive positive meaning facilitates positive changes in the view of the self and the world (Janoff-Bulman, 2006). Meaning-making post-trauma can therefore integrate knowledge of the past, beliefs about trauma and expectations for the future (Abel *et al.,* 2014).

The finding that some participants experienced intrusive thoughts related to trauma work, but viewed these positively and non-distressing, has implications for measures of STS symptoms. The STSS just asks about frequency of these symptoms, including intrusive thoughts. It does not ask whether the participant experiences these as distressing or explore their attributions of these experiences. It is assumed that they are a negative experience, resulting in distress. This may give an incorrect picture of participants' experiences if they are attributing these symptoms positively. The same could be true for items measuring hyper-arousal, as previous studies have found therapists experiencing hyper-arousal as a result of trauma work, attribute this positively, believing it keeps them and others safe (Chrestman, 1999; Pistorius *et al.,* 2008). Therefore, further research is required exploring the attributions therapists make of any STS symptoms they experience, which can then be

used to develop existing measures. Measuring frequency alone may give an inaccurate measure of therapist experience of these symptoms. This has theoretical implications for these measures, which assume symptoms are experienced negatively, and do not account for what therapists do to cope with these experiences. Including a second question, after assessing the frequency of which each item occurs, asking whether participants experience distress as a result of this symptom, may give a more comprehensive measure of these experiences.

This study highlights a limitation of previous literature which has focussed on VT, using CSDT to explain how negative changes to therapists' belief systems occur following exposure to client trauma, not fully explaining how positive changes may also emerge. Most research has investigated the processes of VT and VPTG separately, whereas this study highlights that they can co-occur and therapists can experience positive beliefs whilst simultaneously experiencing distress. CSDT can also be used to explain VPTG (Saakvitne *et al.,* 1998). They argue the uniqueness of an individual's response to trauma is determined by the meaning they ascribe to it, their life experiences and psychological resources. Response to trauma is conceptualised by the interaction of perception, cognition and emotional processing, including the need to make meaning (van der Kolk, 1986). CSDT describes the impact of a traumatic event on the development of the sense of self. It integrates psychoanalytic and social learning theories, conceptualising personality development as the interaction between core self-capacities and constructed beliefs, which include the attribution of meaning to life experiences, that then shape perception and later experiences (Saakvitne *et al*., 1998). CSDT conceptualises the reaction to trauma as an interaction between the individual's personality, life history, and the traumatic event, within the sociocultural context. Individuals construct their own realities (Epstein, 1985), so every individual is affected by trauma in a unique way. Symptoms which develop following exposure to trauma are seen as adaptive strategies aimed at managing feelings which threaten self-integrity (Saakvitne *et al.,* 1998). CSDT does not propose directional relationships. Change is not assumed to be unidimensional and negative belief changes may

have positive consequences, such as becoming more realistic (Saakvitne *et al.,* 1998). CSDT also assumes automatic, as well as effortful change. Automatic adaptation occurs through the cognitive processes of accommodation (Piaget, 1971). Conscious exploration of beliefs and development of skills and beliefs to aid meaning-making is more effortful, suggesting with conscious effort individuals can change some aspects of themselves relevant to self-capacities (Saakvitne *et al.,* 1998).

Trauma disrupts an individual's' frame of reference and healing from this involves struggling with beliefs about the self, the world and spirituality. The changes in frame of reference hypothesised by CSDT parallel the five areas of posttraumatic growth: new possibilities, relating to others, personal strength, spiritual change and appreciation of life (Tedeschi & Calhoun, 1996). In CSDT, growth and distress are not mutually exclusive, but indistinguishably linked in recovery from trauma. Growth is linked to understanding of the trauma and its personal meaning, occurring when the individual can understand their beliefs and distress, in the context of their past. This allows development of a sense of choice and power, creating opportunities for personal growth (Saakvitne *et al.*, 1998). Applying this to the inductive findings of this study explains how participants are making sense of the distress and negative impacts of trauma work. By attributing these as normal and necessary parts of their role as therapists, they achieve acceptance and positive beliefs that what they are doing is helpful and grounded in hope. Therapists have been found to feel positive about helping others, despite some costs to themselves (Barrington & Shakespeare-Finch, 2013a). This fits with this study's findings that both trainees and qualified therapists reported high compassion fatigue and job satisfaction was seen as way of coping with some of the negative impacts of trauma work within the inductive analysis.

Toosheh (2012) offers a further theory linking meaning-making with VPTG. He proposes that self-awareness may mediate the link between empathy for client trauma and therapist VT. Attending to the reality, within a higher level of consciousness may allow them to access more insights from the VT experience. Therefore, distress resulting from client distress may not have a

negative emotional impact but could provide a platform for therapist development. This is related to a process of existential processing, where therapists consciously search for meaning in the challenges they face through trauma work. This may lead to a deep self-understanding and transcend the experience of trauma impact to increased self-awareness. Self-awareness involves acknowledging what is happening, becoming aware and searching for meaning. It involves paying attention to their own processing, such as allowing time to sit with emotions and connecting with this. The search for meaning involves recognising their internal experiences and connecting their processing with their client's processing. Toosheh (2012) found therapists generally viewed trauma work as a constant learning process. He suggests gaining inner support through connecting with self-experience and a sense of purpose may protect the therapists' ego. Participants considered VT as a way of finding meaning and purpose in their lives, supporting previous points arguing distress and VPTG co-occur (Abel *et al.,* 2014). Being mindful of the impact of trauma work was also related to the belief that their work was rewarding and fulfilling (Tooseh, 2012). This theory is also supported by Barrington and Shakespeare-Finch (2013b) who found, despite negative impacts of trauma work, therapists also reported positives including increased self-understanding and comprehension of life.

This theory around self-awareness relates to this study's findings within the theme of self-intimacy. Both trainees and qualified therapists communicated significantly more positive self-intimacy beliefs. These centred around giving themselves time alone to sit with emotions and seeking self-awareness. Many highlighted the importance of giving themselves time to reflect on the emotional impact of trauma work and some felt this had improved with time, supporting Toosheh's point about self-awareness being a journey of personal development. Some also spoke about trauma work enlightening them about their own vulnerabilities, prompting them to discuss this in supervision, engage in self-reflection or access personal therapy. This relates to the argument that therapists can protect themselves from VT through awareness of their own vulnerabilities (Pearlman & Saakvitne, 1995). It also relates to themes extracted from the inductive analysis whereby participants discussed being aware of the

negative impact of trauma work but coping with this through normalisation and finding satisfaction in their work.

This processing can also be linked to other-intimacy, as Toosheh (2012) found therapists in his sample believed expressing the impact trauma work was having on them within supervision or with peers was part of this processing. Supervision can raise self-awareness and facilitate therapist growth. This relates to this study's coding of other-intimacy, where both trainees and qualified staff mentioned the positive support they received, particularly from peer supervision. Many noted that 'dumping' the emotions on somebody who had shared knowledge of trauma work, and taking time out after a difficult session to talk this through with a colleague, was useful in helping them cope. This is supported by previous research, finding peer support was related to decreased belief disruptions in trauma practitioners (Catherall, 1995). Lyon (1993) suggests sharing trauma reduces isolation and helplessness, which may relate to the 'dumping of trauma' participants in this study mentioned. Being able to talk with peers and vent emotions may reduce rumination and formation of negative memory structures (Oliveri & Waterman, 1993).

4.2 Critique

It has been noted that the study may have been limited by sampling bias. A further factor impacting this was the time requirements of the study. Although efforts were made to reduce the burden on participants by the researcher travelling to them, the study took each participant an average of 2.5 hours to complete. Therefore, as already noted, those who were more stressed by greater workplace demands may have perceived this to be too burdensome and chosen not to participate. Pearlman (1999) emphasises the importance of time between sessions to allow therapists to process the impact of empathically engaging with client trauma. Previous studies have found higher caseloads to be correlated with greater STS (Bride, Jones & MacMaster, 2007), compassion fatigue (Sprang *et al.,* 2007) and VT (Devilly *et al*., 2009), Therefore, those therapists who struggle with organisational pressures and high caseloads may have been less likely to participate and the sample may have been biased to

those experiencing less distress from their trauma work experiences. The sampling bias also meant this study was unable to capture the experiences of those who chose to leave their role, possibly due to struggling with the impacts of trauma work. It was noted that this would be an important population to study, although ethical and practical considerations may impact recruitment.

Although this study is strengthened by the use of repertory grids, which have low face validity and are therefore less susceptible to socially desirable answers, it is important to consider the possibility that participants may have minimised distress within interviews. Munroe (1999) argues that therapists may use denial as a way of coping with VT symptoms. This seems unlikely as most participants acknowledged some distress and negative impacts of trauma work, as evidenced by negative beliefs mentioned within interviews and the impact theme from the inductive analysis. Regardless of this, many mentioned not perceiving intrusive thoughts as distressing, despite these being conceptualised as negative within the literature (McCann & Pearlman, 1990). There may be wider societal or professional reasons for minimising VT experiences. Munroe (1999) argues for a risk of victim blaming, whereby therapists are perceived as poorly trained or unable to do their job if they experience VT. This relates to previous research conceptualising VT as a negative 'hazard' of trauma work, linked to therapists making poor professional judgements (Pearlman & Saakvitne, 1995) and reduced job performance (Figley, 1995; Stamm, Varra, Pearlman & Giller, 2002; Lonergan *et al.,* 2004) and the recent inclusion of indirect trauma exposure within the DSM-V PTSD criteria, pathologising the experience (APA, 2013). Fear of distress being seen as a sign of negatively impacting their practice may result in therapists denying or minimising signs of distress (Swearington, 1990). O'Connor (2001) suggests the demands related to psychological therapists' roles may promote this minimisation of their own distress; emotionally intense sessions without time to process this before the next session, heightened sensitivity to others' distress, willingness to meet others' needs before one's own and containing personal emotional responses whilst holding those of their clients. As highlighted previously, many therapists are motivated by the desire to help others, therefore they may deny their own

distress. The findings of this study relate to this, as other-control negative coding included therapists' awareness of slipping into the 'rescuer-role', sometimes blurring therapeutic boundaries due to their strong desire to help their clients recover. Berger (2001) argues this activation of 'rescue-roles' is a countertransference reaction. The desire to rescue is part of most therapists and this is activated by the desire to be rescued inherent in those who have experienced trauma.

There were also significantly more positive self-esteem codes for both trainees and qualified therapists, so they possibly may have been inflating these perceptions to protect them from any distress experienced. There was also mild to no indication of distress on psychometric measures. Previous research has found denial of burnout is common (Stadler, 1990), attributing this to the belief that professional training protects therapists from emotional problems. This potential limitation does seem unlikely to fully account for this study's results as participants did acknowledge some level of distress within interview data and spoke about the difficulties faced within trauma work, but it is important to acknowledge this potential minimisation when interpreting the results.

An alternative to this idea of minimisation is that therapists were acknowledging their distress but engaging in successful coping strategies to resolve this. Pearlman (1999) produced some coping strategies for trauma therapists. Balancing trauma caseload, using supervision, maintaining a work-life balance and making time for self-care were all suggestions. The inductive analysis within this study revealed participants were engaging in some of these active coping techniques. Therefore, it could be argued that that they are already engaging in protective processes, so are not experiencing trauma work as completely negative.

This study may be criticised for the high level of personal trauma reported by the sample. However, findings relating therapists' trauma histories to later psychological symptoms are inconsistent (Jenkins *et al.,* 2010). Gelso and Hayes (2007) argue personal trauma must be healed and understood to prevent interference with therapeutic skills. The concept of 'wounded healer' suggests

therapists' personal trauma can carry restorative powers for clients (Zerubavel & O'Dougherty Wright, 2012). Personal trauma may provide an internal reference for understanding client pain (Hayes, 2002), which could help facilitate the therapist's empathic engagement. Participants in the current study were generally reporting more VPTG and felt able to cope with the distress resulting from trauma work, with some reflecting that trauma work had brought personal issues to mind which they had then processed. Therefore, it could be that their personal experiences of trauma had positive impacts on their work.

It may be motivation for trauma work that links personal trauma with VT. A study of counsellors with personal trauma found those motivated to be therapists due to these experiences were more likely to have negative beliefs on the TSI-Beliefs Scale, but also more positive changes. They felt trauma work helped them successfully address their own trauma (Jenkins *et al.,* 2010). This study was quantitative and most participants scored below the cut-off on the TSI-Beliefs Scale. Issues related to the quantitative measurement of VT beliefs identified by the current study warrant further qualitative research exploring how motivation for trauma work impacts VT. Those who reported more negative effects were often motivated by a sense of higher order, so may have had overly optimistic expectations for client progress (Jenkins *et al.,* 2010), which, when not met, resulted in distress. This relates to a coping strategy identified within the inductive analysis of this study where participants described normalising small changes as part of trauma work and celebrating these in supervision. This cognitive processing and making sense of the difficulties of trauma work may help them cope with the frustration and distress when clients do not make expected progress. It would have been useful for this study to ask participants directly about their motivations for trauma work and explore any relation to personal trauma within interviews. However, this was not the aim of the study and should be addressed by future qualitative studies.

The thematic analysis may have been limited by the use of a semi-structured interview as this can restrict conversation and end up dictating the themes extracted. However, the themes do not map directly onto the interview schedule and it was necessary to have some structure in order to meet the aims of the

deductive aspect of the study. Although the aim of the inductive thematic analysis was to explore any additional themes not covered by the CSDT belief areas, it must be acknowledged that this was unlikely to be truly inductive. The primary researcher held pre-existing knowledge of the VT literature and personal experience of conducting trauma work, therefore was not approaching interview data blindly. Efforts were made to ensure quality of the analysis, by discussing coding and thematic maps with the research team and grounding the extracted themes in participant quotes. Gray (2013) argues that inductive analysis does take note of pre-existing theories as researching the topic implies judgements on the importance of the phenomenon under study related to pre-existing values. However, inductive approaches do not set out to falsify a theory, instead they aim to establish patterns and meaning from the data, which this study did. The researchers' pre-existing ideas were made clear prior to conducting the inductive analysis, which were 'bracketed' to allow the data to speak for itself as much as possible (Gray, 2013). This is reflected in some of the results being unexpected, based on the researchers' preconceptions. For example, intrusive thoughts being seen as normal and non-distressing, as the literature mainly conceptualises these as negative and upsetting for therapists.

A further limitation was the low interrater agreement for the directed coding analysis. Interrater agreement is required as it measures the extent different coders assign exactly the same code to each item (Tinsley & Weiss, 2000). Kolbe and Burnett (1991) argue interrater agreement is often seen as the standard measure of research quality; high levels of disagreement suggest potentially poor operational definitions and coder training. Also, percentage agreement is the most widely used measure of interrater agreement. However, some argue it is misleading and overestimates true interrater agreement (Lombard, Snyder-Duch & Bracken, 2002). This suggests that the coding was not completely objective. However, this fits within the critical realist paradigm which recognises the researcher's perceptions influence results. The aim of the study was not to be completely objective and there was complete agreement in the positive-negative direction of codes, which is what the study draws on in terms of its conclusions around VT and VPTG, suggesting these conclusions

are reliable. The lack of agreement fits with the conclusions of the study which argue measures like the TABS, which treat belief areas as mutually exclusive, may be theoretically flawed. For example, the belief areas 'control' and 'esteem' showed overlap, occasionally being coded differently by researchers. It could be argued that when therapists feel like they have more control over therapy, others and themselves, they feel more positive about themselves. This is supported by research showing personal control and self-esteem are positively correlated (Gecas, 1989). Self-esteem generally refers to seeing oneself as worthwhile, whereas self-control refers to perceiving oneself as effective. Self-esteem is more related to others' evaluations of them as worthwhile, whereas self-control results from successful achievements (Rosenberg, 1989). Although there is a distinction between the two, they are related, which may explain the inconsistency in interrater agreement for these belief-areas.

This study may be criticised for the repertory girds having a ratio of elements to constructs of less than 3:1 (Winter, 1992). However, this is more likely to be an issue if principal component analysis was conducted and is less likely to be an issue in the calculation of Euclidean distances. All participants had the same opportunity to elicit additional constructs, some elicited more than others. This is indicative of individual psychological flexibility. Those who were able to elicit more had a larger construct space. Idiogrid was used to analyse each participant's grid separately, so this would not affect the calculation of Euclidean distances as they are measured within each individual's construct space. Whilst it was important to provide some supplied constructs in order to answer the research question by including areas from the TABS, there may be a priming effect of supplied constructs. However, within a critical realist paradigm it is believed that each participant will interpret these based on their own individual experiences.

4.3 Future Research

The difficulties of differentiating beliefs relating to personal experiences from indirect exposure to client trauma were discussed. There is no way of knowing from the current study whether beliefs changed because of trauma work

exclusively. However, the repertory grids do provide some insight into this with the inclusion of the element 'self before training'. Although there was not enough information collected about personal trauma experiences to ascertain whether these happened before or after training, this element does control for exposure to client trauma as participants are unlikely to have only engaged in trauma work prior to training. However, it might have been useful to provide further context to the data if participants were asked about exposure to trauma prior to starting training. The Euclidean distances between 'self-now' and 'self before training' were 0.66 for trainees and 0.61 for qualified therapists. Euclidean distances of 1 indicate that participants are construing themselves completely the same, so a value below this suggests they perceived some changes resulting from exposure to trauma work. Their Euclidean distance for 'self-now' and 'client with posttraumatic growth' was more similar than this and for 'self-now' and 'client struggling with trauma' was less similar, suggesting overall there have been more positive effects following exposure to trauma work. However, there is still a need for longitudinal research to control for the potential confounds of personal trauma exposure so belief changes can be attributed to trauma work. The only longitudinal study published was conducted on Turkish psychiatrists and social workers (Colak *et al.*, 2012). They quantitatively measured beliefs specifically related to working with sexually abused children before and after starting work. Significant differences were found after working with abused children, including increased negative beliefs about the safety of their own children as well as STS symptoms. Replication of this study design is required in British trainee and qualified clinical psychologists, as well as qualitative investigations to examine any identified changes in beliefs due to problems noted with quantitative measures. However, there are practical difficulties conducting longitudinal research, especially with trainees who frequently change placements. Therefore, exposure to client trauma, opportunities for trauma work and organisational factors would be highly variable with potentially multiple confounding variables impacting on the interpretation of longitudinal results.

This research was exploratory, the first to use a mixed methods design with British trainees and qualified therapists. It has demonstrated the occurrence of beliefs consistent with VT and VPTG in both groups, suggesting these concepts may be relevant to this population. However, due to the small sample size it is important that these results are replicated in further British samples to further establish their relevance to British therapists, who may face different occupational demands than participants included in research conducted in America. Larger sample sizes are required with sufficient power to detect potential differences between trainees and qualified therapists. This study highlighted some potential differences such as within the belief areas of self-trust, other-esteem and other-intimacy. However, this was from the content analysis of qualitative data. Differences were not detected in these areas on the TABS, and recruiting large samples for qualitative investigation may face practical difficulties.

Although this study did find some evidence of distress and negative beliefs related to trauma work, overall the sample appeared to be coping well and also experiencing beliefs consistent with VPTG. The inductive analysis highlighted job satisfaction, work-life balance, meaning making and a process of normalisation as aspects potentially helping participants cope with the distress and form positive beliefs. Kadambi and Ennis (2004) argue the most consistent finding within the VT literature is that most professionals cope well with exposure to client trauma. Therefore, further research could shift to focusing on factors that influence this resilience to the demands of trauma work.

Within the evidence-based practice in psychology guidelines (APA, 2006) an aspect of clinical expertise is the continued self-reflection and skill development of therapists. A large body of literature exists on therapist professional development, which is beyond the scope of this paper. Two models which may be important include Hill, Charles and Reed (1981). Their four-phase model of counselling trainees' development consists of sympathy, counsellor stance, transition and integrated personal style. In the first stage, trainees are sympathetically involved with clients, offering them constant positive support. If clients improve, therapists feel successful. Counsellor stance follows whereby

the focus is on mechanical mastery of a therapy technique. Transition then occurs where input from clients, supervisors and theory results in the trainee moving away from relying solely on one method. Integration is the final stage where techniques and theory combine into their own personal style. In this stage, client feedback is considered in a more objective manner.

The second is the three stage developmental model (Loganbill, Hardy & Delworth*.,* 1982). The first stage is stagnation: the therapist has a constricted view of the world, low self-concept and depends on the supervisor. They may have a problem-solving view of therapy. Confusion is the second stage: involving an unfreezing of attitudes and emotions where they fluctuate between feeling competent and lacking expertise. Feelings towards the supervisor shift between disappointment and anger. This stage provides opportunities for new learning. Integration is the final stage; this involves integration, cognitive flexibility and personal security based on awareness of insecurity. It may be useful to use these models when researching trauma work impact as many participants referred to noticing shifts in themselves over time and described trauma work as a journey. For example, many talked about feeling more positive about themselves when clients made progress which was coded as self-esteem, other-control or self-trust depending on how they attributed this. However, it could be understood within either of these models of therapist development and may reflect a general process therapists go through during their career, rather than a unique aspect of trauma work. This study's finding of more negative self-trust for trainees may also be conceptualised as them being within the stagnation stage (Loganbill *et al.,* 1982) whereby they doubt themselves and rely more on supervisors, rather than being related to belief disruption. Therefore, research investigating these models of therapist development within trauma work and other types of therapy will be interesting, especially when comparing trainees and qualified therapists.

4.4 Clinical Implications

The limitations section noted the potential for therapists to deny distress related to trauma work and this study found a process of normalising distress was an important coping strategy for many participants. Although exploratory, it does relate to previous research which has found participants view the negative impact of trauma work as a normal and essential therapeutic response (Gill, 2015). This could have implications for making training and knowledge about the potential negative impacts of trauma work easily accessible to therapists, supervisors, trainees and organisations. Courtois and Gold (2009) suggest the impact of psychological trauma should be included in the professional curriculum, in order to prepare trainees, and lack of training may increase susceptibility to VT (Pearlman & Saakvitne, 1995). Training should emphasise the view that experiencing distress and VT symptoms does not reflect negatively on one's professional skills, but is a normal aspect. This may encourage therapists to openly express any distress they experience, and probe supervisors to ask about it within supervision, so that it is accepted as part of the role. This also has ethical implications, as if potential therapists are made aware of the effects they may experience through trauma work, they can then make an informed decision as to whether they wish to pursue a career in that area. It also has wider organisational implications in terms of keeping staff, as the average cost of training a clinical psychologist is £159,420 (Health Education England, 2016). If trainees are made aware of the potential hazards involved in trauma work and prepared to cope with these, they may be less likely to leave the field.

This study, as well as previous studies, have found identification with others appeared to offer protection from VT; even the briefest interactions with team members were perceived as helpful in supporting participants with the impact of trauma work (Trippany *et al.,* 2004). Peer supervision was identified as the preferred coping strategy by 85% of therapists (Pearlman & MacIan, 1993). The theory relating self-awareness with VPTG (Toosheh, 2013) and participants in this study commenting on the importance of space to be with their emotions and share these with peers who have shared experiences may have implications for

therapist development. The BPS professional practice guidelines specify that psychologists should play a role in reflective practice and peer supervision within their general practice (BPS, 2008). The potential link between self-awareness promoting VPTG suggests reflective practice could be an important aspect within trauma work. This could be facilitated within a group, opening opportunities for peer supervision and shared experiences to communicate a sense of normality around the impacts of trauma work. This study provides some initial ideas on topics for reflection, including the CSDT belief areas, memories client trauma evokes and work-life impacts.

5. Critical Reflection

As part of the research process, to ensure quality and transparency within the qualitative aspects, a reflexive diary was kept. This was used as a tool for making the researcher's assumptions explicit in an attempt to manage researcher bias. This process allows the researcher to be clear of their assumptions so they can then be put aside or combined within the analysis (Morrow, 2005). Critical realism advocates the use of a reflexive diary, as the researcher's construction of reality is key to data interpretations (Morrow, 2005). Extracts from the reflexive diary which consider the theoretical, scientific and ethical issues inherent with this study are discussed.

Theoretical

The underlying theory guiding my research was CSDT, which follows constructivist epistemology. This generally lends itself to qualitative research, exploring individual ideas and experiences. However, most research in the area aimed at testing CSDT had been quantitative, which follows a positivist stance, so approaching this study using mixed methods was important. This was mainly due to the discrepancies highlighted between quantitative and qualitative studies (Sabin-Farrell & Turpin, 2003). Combining methods within the same sample provided the opportunity to explore any differences related to methodology. As a clinician, I naturally sway more towards constructivist ways

of thinking about reality which focus on the individual ways people experience the world, rather than there being an objective reality. Generally, I am critical of quantitative measures as I believe they miss individual experiences and there is no way of determining differences in the way individuals may interpret individual items. However, I appreciate their usefulness in providing a structure to measuring experiences and allowing comparisons to be made. This was a difficulty when designing my research and trying to incorporate these two approaches. My reading around epistemology and research methods helped me understand how my position influenced my interpretations of the data. Critical realism best fitted with my way of thinking. It does not deny that there is an objective reality but accounts for the influence of the researcher and participants' constructions of this reality.

The following extract reflects some of the difficulties I experienced in my thinking around combining methods and how this fits with my epistemology:

16th March 2016

Second interview done with a trainee. She seemed a lot more stressed in some aspects but also spoke about positives and holding on to a sense of hope. Most of her experiences of working with trauma were prior to training and in another country. This involved work with perpetrators of violence and she spoke briefly about how this related to some of the local culture and the downward spirals of trauma within families, which could create a sense of hopelessness as a therapist. It got me thinking about other extraneous variables that will affect therapists' experience of vicarious trauma as she spoke about having to move to the UK to study and the stress and occasional feelings of isolation she had experienced as a result. Trauma is so complex and so are human beings that it is reductionist to think that there are key identifiable causal factors to vicarious trauma. Everyone's experience will be different and we all have different pasts and journeys onto and during training. This got me thinking about my research and the literature in general which has mainly relied on quantitative measures, resulting in conflicting findings. Is this a result of the measure itself? Or is everyone's experiences unique and individual? What implications does this have for a theory which specifies belief changes in 5 key areas? I've not done enough interviews yet to know if there are similarities in how my participants are affected by trauma but both participants so far have discussed other sources of stress that affect their reactions to trauma work. This made me wonder whether I have put enough controls in to measure these, but this conflicts with my epistemology as not everything can be controlled and predicted. There will undoubtedly be some areas missed by my interviews and psychometrics, but

allowing people to speak openly about their experiences will hopefully mean they are talking about those factors they perceive as important.

This highlights that there is not a single, correct way of analysing data; all approaches have their limitations. Whilst this study did not have the rigorous controls of a purely quantitative study, it did allow exploration of what was important to participants' constructions of trauma work experiences. This means that the data is less generalizable and interpretations made must be considered within the context of the sample, but it offers a deeper understanding of individual experiences not afforded by quantitative measures alone. This fits with critical realism's stance on reality being a joint construction between the researcher and participant and has taught me the value of being guided by epistemology through the process of data interpretation, making assumptions clear as they influence this process.

Scientific

As structured and semi-structured interviews provided the majority of the data analysed it is important to reflect on my role within the generation of data. A power dynamic is created between the researcher and participant as I controlled the topic of the research, direction of questioning and the resulting analyses. There was also an influence of my role as a trainee clinical psychologist, which all participants were aware of. This may have afforded me 'inside status' (Taylor, 2001) as I was part of the same system as participants which we were exploring together within interviews. We both had some experience of trauma work, although many of the qualified participants had more experience than me, as well as more power within the workplace, and could have potentially supervised me over the course of my training. Having this shared experience may have facilitated participant openness, which relates to the theme of 'other intimacy' as many talked about it being easier to talk to those with shared experiences of trauma work due to mutual understanding. However, this may have had different effects for trainee and qualified participants. Trainees may have related more to me, due to us having the same role, allowing them to potentially open up more about the more negative aspects of their experiences. Qualified participants may have held some

information back, particularly regarding negative experiences of trauma work, due to not wanting to 'put me off'. Research has found supervisors may hold back information if they anticipate a negative reaction from the supervisee (Hoffman, Hill, Holmes & Frietas, 2005). However, other research has found many supervisors self-disclose within supervision (Ladany & Lehrman-Waterman, 1999); which mirrors my experiences within a specialist trauma-service, as reflected by the following extract:

17th November 2016

I have been thinking about my own experiences of trauma work today during clinical supervision on placement. Me and my supervisor were talking about using Narrative Exposure Therapy with my refugee clients and how this relates to my research as their stories need to be told in great detail, which potentially could increase the risk of vicarious trauma. I felt like although their stories made me feel sad, I had not noticed any other negative effects on myself, and felt more in admiration of what they had been through and to still be amazing people so full of hope. We reflected on why this may be and I felt that it may be more difficult to put myself in their shoes due to their experiences being so far out of my worldview, their stories felt like they were almost on a film, a different world due to the completely different cultures and contexts. Maybe this was a protective factor from vicarious trauma. My supervisor opened up that she found it more difficult to work with clients where she could put herself in their shoes and imagine their trauma happening to her, such as sexual assault. She also spoke about avoiding work with grief due to the loss of her own parents and finding this too difficult due to it triggering her own traumas. This encouraged me to think about my own life and situations with clients that I might find more difficult to hear due to me being able to put myself in that client's shoes and relate to their pain.

This extract considers my clinical supervisor's use of self-disclosure which prompted me to think about what may be upsetting for me to hear within trauma work. This was useful in supervision, and prompted development of self-intimacy, in terms of being aware of my emotional reactions. It was helpful for my development as my supervisor was comfortable discussing her personal reactions with me. Although this may be different to the relationship I had with participants, as my supervisor and I have developed a closer relationship than the one-off interviews, it does suggest that this difference in dynamic may not have affected qualified participants' disclosure. There are likely to be individual

differences between participants, so it is important to reflect on this possibility as it may impact the data in terms of qualified participants generally reporting more positive beliefs. This was interpreted as being related to them having more experience observing client growth, but could be a result of the dynamic within interviews and them wanting to protect me as a trainee. My experiences also mirror some of the trainees' experiences of normalisation, where they spoke about supervisors sharing difficult experiences of trauma work with them to normalise the challenges they faced.

This has taught me the importance of considering the effects of the wider context on my position as a researcher and how this may impact interpretation of the data.

Ethical

From the outset of study design I was mindful of the time requirements made of participants. Data collection took an average of 2.5 hours to complete for each participant and as a trainee myself I am aware of the time pressures on trainee and qualified therapists working within the NHS. Although efforts were made to reduce the demands of participants by me travelling to them, I was mindful of this throughout and it is reflected in the following extract:

8th April 2016

After the interviews I had an informal chat with one of the participants. She felt the study was interesting but that it was too long. She was concerned with the amount of data I would have to process, as well as recruiting further participants due to the time demands. This opened up an ethical dilemma, as although the time was fitting within the estimated time on participant information sheets and was cleared through ethics, participants may perceive it as too long. I was thinking about the demands placed on qualified therapists I had worked with on placement, as well as the personal demands I faced as a trainee. Taking out 2-3 hours to participate in research was quite an ask. This made me think about sampling and possible bias – what were people's motives for taking part? There was obviously the voucher payment and I guess the empathy on my part in that they had all been through, or would be going through, the struggle of recruiting participants for thesis research, so wanted to help out with that. This was reflected in some meetings with people wishing me luck with my research and reflecting on their own struggles with that process. There must also be an interest in trauma as the participants were self-defined based on their

perception of their work. It made me think about those who may be more stressed out and struggling to cope with the demands of their work, would they take the time out to participate? Probably not, as it was a lot of time to take out of their working day. On the other hand, they may take the time to speak about their experiences as the NHS was allowing them time out of their working hours to participate. This may allow them to voice their stress and be heard. It is impossible to tell I guess whether my sample would be biased by people's motives for participating.

This extract reflects my thinking about how this issue may have impacted the sample, and introduction of potential sampling bias. It is important to be aware of this when interpreting the data, but also highlights the uncertainty as it can never really be known how those who chose not to participate were affected by trauma work. This highlights the importance of further research exploring the experiences of those who chose to leave the trauma work field, and reasons related to this decision.

A related ethical consideration was the large amount of data I ended up with because of the lengthy data collection processes. As the content analysis yielded a large amount of qualitative data, I felt it was important to ground these findings in participant experience so wanted to include quotes in the journal paper. This meant there was not enough space to include the inductive thematic analysis, so it is presented in the extended paper, with the aim of writing a separate paper focussing on this at a later date. This taught me the importance of having clear research aims. The main aim of my research was to explore evidence for the CSDT belief areas which was achieved by the content analysis. Therefore, it was important this was done in sufficient detail in the journal paper. The inductive thematic analysis allowed exploration of other areas not included in CSDT, but was not a main research aim so it was appropriate to include it as an additional analysis in the extended paper which can be followed up later. This represents the dilemma of collecting information from participants that was not used. However, not all information from interviews will be used in qualitative analysis as information that relates to research aims is what is focussed on, with other information discarded.

A further ethical consideration relates to the measurement of VT and STS. Although most participants fell below the cut-offs on these psychometrics, some did meet the threshold for ‘mild’ STS symptoms. These measures pathologise therapists’ experiences of trauma work and there may have been negative consequences of communicating to participants that they were meeting the threshold for these ‘symptoms’. However, there is the ethical dilemma in completing these measures and not communicating the results to participants if they did appear distressed. My personal stance is that these constructs pathologise some of the normal reactions to trauma work so labelling these as ‘mild STS’ could be damaging. It also relates to the shortcomings of the measures as although they assess the frequency of each experience, they do not ask whether this is linked to any distress. This is reflected by the qualitative results, where participants discussed intrusive thoughts. This would score as a ‘symptom’ on the STS, but they perceived these as a normal, non-distressing part of their role. This has implications for measures of symptoms, which will also impact my clinical work and the importance of exploring the meaning of symptoms with clients, as it should not be assumed these are necessarily distressing.

References

Abel, L., Walker, C., Samios, C., & Morozow, L. (2014). Vicarious posttraumatic growth: predictors of growth and relationships with adjustment. *Traumatology: An International Journal, 20(1),* 9-18.

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

Adams-Webber, J. R. (1998). Differentiation and sociality in terms of elicited and provided constructs. *Psychological Science, 9(6)*, 488-501.

Agerfalk, P. J. (2013). Embracing diversity through mixed methods research. *European Journal of Information Systems, 22(3)*, 251-256.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th Edition.). Washington, DC: APA.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th Edition.). Washington, DC: APA.

Antaki, C., Billig, M., Edwards, D., & Potter, J. (2002). Discourse analysis means doing analysis: a critique of six analytic shortcomings. *Discourse Analysis Online, 1(1)*, 1-24. Retrieved from: extra.shu.ac.uk/daol/articles/open/2002/002/antaki2002002-paper.html

Arnold, D., Calhoun, L. G., Tedeschi, R., & Cann, A. (2005). Vicarious posttraumatic growth in psychotherapy. *Journal of Humanistic Psychology, 45(2)*, 239-263.

Baird, S. A., & Jenkins, S. R. (2003). Vicarious traumatization, secondary traumatic stress, and burnout in sexual assault and domestic violence agency staff. *Violence and Victims, 18(1),* 71-86.

Bannister, D., & Fransella, F. (1986). *Inquiring man: the psychology of personal constructs.* Kent, UK: Croom Helm Ltd.

Banyard, P., & Grayson, A. (2000). *Introducing Psychological Research: Revised and Expanded* (2nd Edition.)*.* Basingstoke, UK: Palgrave.

Barker, C., Pistrang, N., & Elliott, R. (2002). *Research Methods in Clinical Psychology* (2nd Edition.). Chichester, UK: John Wiley & Sons.

Barrington, A. G., & Shakespeare-Finch, J. (2013a). Working with refugee survivors of torture and trauma: An opportunity for vicarious post-traumatic growth. *Counselling Psychology Quarterly, 26(1),* 89-105.

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

Bazeley, P. (2009). *Mixed methods data analysis*. In S. Andrew & E. Halcomb (Eds.), *Mixed methods research for nursing and the health sciences* (pp. 84-118). Chichester, UK: Wiley-Blackwell.

Bechtel, W. (2009*). Philosophy of science: An overview for cognitive science.* Hove, East Sussex: Psychology Press.

Bell, H. (2003). Strengths and secondary trauma in family violence work. *Social Work, 48(4),* 513-522.

Bell, R. (2005). The repertory grid technique. In F. Fransella (Ed.), T*he essential practitioner's handbook of personal construct psychology.* Chichester, UK: John Wiley & Sons.

Benatar, M. (2000). A qualitative study of the effect of a history of childhood sexual abuse on therapists who treat survivors of sexual abuse. *Journal of Trauma & Dissociation, 1*, 9-28.

Benjamini, Y., & Hochberg, Y. (1995). Controlling the false discovery rate: a practical and powerful approach to multiple testing. *Journal of the Royal Statistical Society Series B (Methodological), 57(1),* 289-300.

Ben-Porat, A., & Itzhaky, H. (2009). Implications of treating family violence for the therapist: secondary traumatization, vicarious traumatization and growth. *Journal of Family Violence, 24(7)*, 507-515.

Benton, T., & Craib, I. (2001). *Philosophy of social science: The philosophical foundations of social thought.* London, UK: Palgrave.

Berger, H. (2001). Trauma and the therapist. In T. Spiers (Ed.), *Trauma: A practitioner's guide to counselling* (pp. 189-212). East Sussex, UK: Brunner-Routledge.

Berger, K. S. (2008). *The Developing Person Through the Lifespan* (7th Edition.). New York, NY: Worth.

Betts-Adams, K., Matto, H. C., & Harrington, D. (2001). The Traumatic Stress Institute Belief Scale as a measure of vicarious trauma in a national sample of clinical social workers. Families in Society: The Journal of Contemporary Human Sciences, 82(4), 363−371.

Bhaskar, R. (1975). *A Realist Theory of Science*. Leeds, UK: Leeds Books.

Björklund, L. (2008). The Repertory Grid Technique: Making Tacit Knowledge Explicit: Assessing Creative Work and Problem Solving Skills. In H. Middleton (Ed.). *Researching Technology Education: Methods and Techniques* (pp. 46-69). Linköpring, Sweden: Sense Publishers.

Blagden, N., Winder, B., Gregson, M., & Thorne, K. (2014). Making sense of denial in sexual offenders: a qualitative phenomenological and repertory grid analysis. *Journal of Interpersonal Violence, 29(9),* 1698-1731.

Blair, D. T., & Ramones, V. A. (1996). Understanding VT. *Journal of Psychosocial Nursing and Mental Health Services, 34(11)*, 24–30.

Blake, D. D., Weathers, F. W., Nagy, L. M., Kaloupek, D. G., Gusman, F. D., Charney, D. S., & Keane, T. M. (1995). The development of a clinician-administered PTSD scale. *Journal of Traumatic Stress, 8(1),* 75-90.

Bober, T., & Regehr, C. (2006). Strategies for reducing secondary or vicarious trauma: do they work? *Brief Treatment & Crisis Intervention, 6,* 1-9.

Borja, S. E., Callahan, J. L., & Long, P. J. (2006). Positive and negative adjustment and social support of sexual assault survivors. *Journal of Traumatic Stress, 19(6),* 905–914.

Boscarino, J. A., Figley, C. R., & Adams, R. E. (2004). Compassion fatigue following the September 11 terrorist attacks: A study of secondary trauma among New York City social workers. *International Journal of Emergency Mental Health, 6(2),* 57−66.

Boyatzis, R. E. (1998). *Transforming qualitative information: Thematic analysis and code development*. London: UK: Sage.

Brady, J. L., Guy, J. D., Poelstra, P. L., & Brokaw, B. F. (1999). Vicarious traumatization, spirituality, and the treatment of sexual abuse survivors: a national survey of women. *Professional Psychology: Research & Practice, 30(4),* 386-393.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3(2),* 77-101.

Bride, B. E. (2007). Secondary traumatic stress among social workers. *Social Work, 52(1),* 63–70.

Bride, B.E., Jones, J.L., & MacMaster, S.A. (2007). Correlates of secondary traumatic stress in child protective service workers. *Journal of Evidenced-Based Social Work, 4(3-4),* 69-80.

Bride, B. E., Radey, M., & Figley, C. R. (2007). Measuring compassion fatigue. *Clinical Social Work Journal, 35(3),* 155-163.

Bride, B. E., Robinson, M. M., Yegidis, B., & Figley, C. R. (2004). Development and validation of the Secondary Traumatic Stress Scale. *Research on Social Work Practice, 14(1),* 27-35.

British Psychological Society (2008). Generic Professional Practice Guidelines (2nd Edition.). Leicester, UK: The British Psychological Society. Retrieved from http://www.bps.org.uk/sites/default/files/documents/generic_professional_practice_guidelines.pdf

British Psychological Society (2010). *Code of Human Research Ethics.* Leicester, UK: The British Psychological Society. Retrieved from

http://www.bps.org.uk/sites/default/files/documents/code_of_human_research_ethics.pdf

Brockhouse, R., Msetfi, R. M., Cohen, K., & Joseph, S. (2011). Vicarious exposure to trauma and growth in therapists: the moderating effects of sense of

coherence, organizational support, and empathy. *Journal of Traumatic Stress, 24(6),* 735-742.

Bryman, A. (2006). Integrating quantitative and qualitative research. *Qualitative Research, 6(1),* 97-103.

Buetow, S. (2010). Thematic analysis and its reconceptualization as ‘saliency analysis’. *Journal of Health Services Research & Policy, 15*(2), 123-125.

Butt, T. (2004). *Understanding People*. Hampshire, UK: Palgrave MacMillan.

Calhoun, L. G., & Tedeschi, R. G. (1998). Posttraumatic growth: Future directions. In R. G. Tedeschi, C. L. Park, & L. G. Calhoun (Eds.), *Posttraumatic growth: Positive changes in the aftermath of crisis* (pp. 215-238). Mahwah, NJ: Lawrence Erlbaum.

Capri, C., Kruger, L. M., & Tomlinson, M. (2003). Sexual abuse workers’ emotional experiences of working therapeutically in the Western Cape, South Africa. *Child & Adolescent Social Work Journal, 30(5),* 365-382.

Carter, S. M., & Little, M. (2007). Justifying knowledge, justifying method, taking action: Epistemologies, methodologies, and methods in qualitative research. *Qualitative Health Research*, *17*(10), 1316-1328.

Catherall, D. R. (1995). Coping with secondary traumatic stress: The importance of the therapist’s professional peer group. In B. H. Stamm (Ed.),

Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators. 80–94. Lutherville, MD: Sidran.

Cho, J. Y., & Lee, E. H. (2014). Reducing confusion about grounded theory and qualitative content analysis: similarities and differences. *The Qualitative Report, 19(64),* 1-20.

Chouliara, Z., Hutchinson, C., & Karatzias, T. (2009). Vicarious traumatisation in practitioners who work with adult survivors of sexual violence and child sexual abuse: Literature review and directions for future research. *Counselling and Psychotherapy Research, 9(1)*, 47-56.

Chrestman, K. R. (1999). Secondary exposure to trauma and self-reported distress among therapists. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (2nd Edition.), (pp. 37-47). Lutherville, MD: Sidran Press.

Clark, M. L., & Gioro, S. (1998). Nurses, indirect trauma and prevention. *Image: Journal of Nursing Scholarship, 30(1),* 85-87.

Clemans, S. E. (2004). Life changing: the experience of rape-crisis work. *Affilia, 19(2),* 146-159.

Cohen, K., & Collens, P. (2013). The impact of trauma work on trauma workers: a metasynthesis on vicarious trauma and vicarious posttraumatic growth. *Psychological Trauma: Theory, Research, Practice, and Policy, 5(6),* 570-580.

Colak, B., Sismanlar, S. G., Karakaya, I., Etiler, N., & Bicer, U. (2012). Vicarious traumatization in professionals working with sexually abused children. *Anadolu Psikiyatri Dergisi, 13(1), 51-58.*

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

Creamer, T. L., & Liddle, B. J. (2005). Secondary traumatic stress among disaster mental health workers responding to the September 11 attacks. *Journal of Traumatic Stress, 18(1),* 89−96.

Creswell, J. W. (2009). *Research design: Qualitative and mixed methods approaches.* London, UK: SAGE.

Creswell, J. W. (2011). Controversies in Mixed Methods Research. In N. K. Denzin, & Lincoln, Y. S. (Ed.), *The Sage Handbook of Qualitative Research* (4th Edition.), (pp. 269-283). London, UK: Sage.

Cunningham, M. (1997). Vicarious traumatization: Impact of trauma work on the clinician. *Dissertation Abstracts International, 57(9-A),* pp. 4130. (UMI No. 9705502).

Cunningham, M. (2003). Impact of trauma work on social work clinicians: Empirical findings. *Social Work, 48*(4), 451-459.

Cresswell, J. W., & Plano-Clark, V. L. (2007). *Designing and Conducting Mixed Methods Research.* Thousand Oaks, CA: Sage Publications.

Danieli, Y. (1994). Countertransference and trauma: Self-healing and training issues. In M. B. Williams & J. F. Sommer (Eds.), Handbook of post–traumatic therapy (pp. 540-550). Westport, CT: Greenwood Press.

DeForge, R., & Shaw, J. (2012). Back- and fore-grounding ontology: exploring the linkages between critical realism, pragmatism, and methodologies in health & rehabilitation sciences. *Nursing Inquiry,* 19(1), 83-95.

Denzin, N. K., & Lincoln, Y. S. (2011). The Discipline and Practice of Qualitative Research. In N. K. Denzin, & Lincoln, Y. S. (Ed.), *The Sage Handbook of Qualitative Research* (4th ed., pp. 1-21). London, England: Sage.

Devilly, G.J., Wright, R., & Varker, T. (2009). Vicarious trauma, secondary traumatic stress or simply burnout? Effect of trauma therapy on mental health professionals. *Australian and New Zealand Journal of Psychiatry, 43(4),* 373-385.

Dunkley, J., & Whelan, T.A. (2006). Vicarious traumatisation in telephone counsellors: internal and external influences. *British Journal of Guidance & Counselling, 34(4), 451*-469.

Dutton, M. R., & Rubinstein, F. L. (1995). Working with people with PTSD: Research implications. In C. R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (pp. 82-100). New York, NY: Brunnar/Mazel.

Dyregrov, A., & Mitchell, J. T. (1992). Work with traumatised children: psychological effects and coping strategies. *Journal of Traumatic Stress, 5(1),* 5-17.

Eidelson, R. J., D'Alessio, G. R., & Eidelson, J. I. (2003). The impact of September 11 on psychologists. *Professional Psychology: Research and Practice*, 34(2), 144–150.

Elliott, D. M., & Briere, J. (1992). Sexual abuse trauma among professional women: validating the Trauma Symptom Checklist-40 (TSC-40). *Child Abuse and Neglect, 16(3)*, 391–398.

Elliott, A. C., & Woodward, W.A. (2007). *Statistical analysis quick reference guidebook with SPSS examples*. London UK: Sage Publications.

Elo, S., & Kyngäs, H. (2008). The qualitative content analysis process. *Journal of Advanced Nursing, 62(1),* 107-115.

Elwood,L. S., Moht, J., Lohr, J. M., & Galovski, T. E. (2010). Secondary trauma symptoms in clinicians: a critical review of the construct, specificity and implications for trauma-focussed treatment. *Clinical Psychology Review, 31(1)*, 25-36.

Engstrom, D., Hernandez, P., & Gansei, D. (2008). Vicarious resilience: a qualitative investigation into its description. *Traumatology, 14(3),* 13-21.

Epstein, S. (1985). The implications of cognitive-experimental self-theory for research in social psychology and personality. *Journal for the Theory of Social Behaviour, 15(3),* 283-310.

Ezzy, D. (2002). *Qualitative Analysis: Practice and Innovation*. New South Wales, Australia: Allen & Unwin.

Feilzer, M. Y. (2010). Doing mixed methods research pragmatically: Implications for the rediscovery of pragmatism as a research paradigm. *Journal of Mixed Methods Research, 4(1)*, 6–16.

Fereday, J., & Muir-Cochrane, E. (2006). Demonstrating rigor using thematic analysis: A hybrid approach of inductive and deductive coding and theme development. *International Journal of Qualitative Methods, 5(1),* 80-92.

Figley, C. R. (1995). Compassion fatigue as secondary traumatic stress disorder: An overview. In C.R. Figley (Eds.). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatised* (pp. 1-20). New York, NY: Brunner/Mazel Publishers.

Figley, C. R. (1999). Compassion fatigue: Toward a new understanding of the costs of caring. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (2nd ed., pp. 3-28). Lutherville, MD: Sidran Press.

Figley, C. R. (2002). Compassion fatigue: Psychotherapists' chronic lack of self-care. *Psychotherapy in Practice, 58(11),* 1433-1441.

Fransella, F., Bell, R., & Bannister, D. (2004). *A Manual for Repertory Grid Technique*. Chichester, UK: John Wiley and Sons Ltd.

Frith, H., & Gleeson, K. (2012). Qualitative data collection: asking the right questions. In D. Harper & A. R. Thompson (Eds.), *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners* (pp. 55-68). Chichester, UK: Wiley-Blackwell.

Gecas, V. (1989). The social psychology of self-efficacy. *Annual Review of Sociology, 15,* 291-316.

Gelso, C. J., & Hayes , J. A. (2007). *Countertransference and the therapist's inner experience: Perils and possibilities*. Mahwah, NJ: Erlbaum.

Giancoli, D. L., & Neimeyer, G. J. (1983). Liking preferences towards handicapped persons. *Perceptual and Motor Skills, 3(1),* 1005-1006.

Giddings, L. S., & Grant, B. M. (2007). A Trojan horse for positivism? A critique of mixed methods research. *Advances in Nursing Science, 30*(1), 52-60.

Gill, S. (2015). Is secondary traumatization a negative therapeutic response? *Journal of Loss & Trauma, 20(5)*, 410-416.

Glaser, B. G., & Strauss, A. L. (1967). *The Discovery of Grounded Theory: Strategies for Qualitative Research.* Chicago, IL: Aldine Publishing Company.

Goldblatt, H., Buchbinder, E., Eisikovits, Z., & Arizon-Mesinger, I. (2009). Between the professional and the private: the meaning of working with intimate partner violence in social workers' private lives. *Violence Against Women, 15(3),* 362-384.

Golynkina, K., & Ryle, A. (1999). The identification and characteristics of the partially dissociated states of patients with borderline personality disorder. *British Journal of Medical Psychology, 72(4),* 429-445.

Goodman, L., Corcoran, C., Turner, K., Yuan, N., & Green, B. (1998). Assessing traumatic event exposure: General issues and preliminary findings for the Stressful Life Events Screening Questionnaire. Journal of *Traumatic Stress, 11(3),* 521-542.

Gray, D. E. (2013). *Doing research in the real world* (3rd Edition.). London, UK: Sage Publications, Ltd.

Gray, M., J., Litz, B. T., Hsu, J. L., & Lombardo, T. W. (2004). Psychometric properties of the Life Events Checklist. *Assessment, 11(4),* 330-341.

Grice, J. W. (2002). Idiogrid: Software for the management and analysis of repertory grids. *Behavior Research Methods, Instruments, & Computers, 34(3)*, 338-341.

Guhan, R., & Leibling-Kalifani, H. (2011). The experiences of staff working with refugees and asylum seekers in the United Kingdom: A grounded theory exploration. *Journal of Immigrant & Refugee Studies, 9(3),* 205-228.

Guy, J. D., Poelstra, P. L., & Stark, M. J. (1989). Personal distress and therapeutic effectiveness: National survey of psychologists practicing psychotherapy. *Professional Psychology, Research, and Practice, 20(1),* 48–50.

Hall, R. (2013). Mixed methods: in search of a paradigm. In T. Le & O. Le (Eds.). *Conducting Research in a Changing and Challenging World* (pp. 71-78). Hauppauge, NY: Nova Science Publishers.

Hanson, W. E., Creswell, J. W., Clark, V. L. P., Petska, K. S., & Creswell, J. D. (2005). Mixed methods research designs in counselling psychology. *Journal of Counselling Psychology, 52*(2), 224-235.

Hargrave, P. A., Scott, K. M., & McDowall, J. (2006). To resolve or not to resolve: Past trauma and secondary traumatic stress in volunteer crisis workers. *Journal of Trauma Practice, 5(2)*, 37−55.

Harper, D., & Thompson, A. R. (2012). *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners*. West Sussex, UK: Wiley-Blackwell.

Harrison, R. L., & Westwood, M. J. (2009). Preventing vicarious traumatization of mental health therapists: identifying protective factors. *Psychotherapy Theory, Research, Practice, & Training, 46(2),* 203-219.

Hayes, J. A. (2002). Playing with fire: Countertransference and clinical epistemology. *Journal of Contemporary Psychotherapy, 32(1)*, 93-100.

Health Education England (2016). Review of clinical and educational psychology training arrangements. Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/510725/Review_of_clinical_and_educational_psychology_training_arrangements_report.pdf

Helgeson, V. S., Reynolds, K. A., & Tomich, P. L. (2006). A meta-analytic review of benefit finding and growth. *Journal of Consulting and Clinical Psychology, 74(5),* 797–816.

Herman, J. (1992). *Trauma and recovery.* New York, NY: Basic Books.

Hesse, A. R. (2002). Secondary Trauma: How Affecting with Trauma Survivors Affects Therapists. *Clinical Social Work Journal, 30*(3), 293-308.

Hill, C. E., Charles, D., & Reed, K. G. (1981). A longitudinal analysis of changes in counselling skills during doctoral training in counselling psychology. *Journal of Counselling Psychology, 28(5),* 428-436.

Hoffman, M. A., Hill, C. E., Holmes, S. E., & Frietas, G. F. (2005). Supervisor perspective on the process and outcome of giving easy, difficult, or no feedback to supervisees. *Journal of Counseling Psychology*, 52*(1),* 3-13.

Hollway, W., & Jefferson, T. (2013). *Doing qualitative research differently* (2nd Edition.). London: UK: Sage.

Horowitz, M., Wilner, N., & Alvarez, W. (1979). Impact of Event Scale: A measure of subjective stress*. Psychosomatic Medicine, 41(3)*, 209-218.

Howitt, D. (2010). *Introduction to qualitative methods in psychology* (2nd Edition.). Harlow, UK: Pearson.

Hsieh, H. F., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research, 15(9),* 1277-1288.

Iliffe, G., & Steed, L. G. (2000). Exploring the counselor's experience of working with perpetrators and survivors of domestic violence. *Journal of Interpersonal Violence, 15(4)*, 393–412.

Jankoski, J. A. (2010). Is vicarious trauma the culprit? A study of child welfare professionals. *Child Welfare, 89(6),* 105-120.

Jankowicz, D. (2004). *The easy guide to repertory grids*. Chichester, UK: John Wiley & Sons.

Janoff-Bulman, R. (2004). Posttraumatic growth: Three explanatory models. *Psychological Inquiry, 15(1),* 30-34.

Janoff-Bulman, R. (2006). Schema-change perspectives on posttraumatic growth. In L. G. Calhoun & R. G. Tedeschi (Eds.), *Handbook of posttraumatic growth: Research and practice*. Mahwah, NJ: Erlbaum.

Jenkins, S.R., & Baird, S. (2002). Secondary traumatic stress and vicarious trauma: A validational study. *Journal of Traumatic Stress, 15(5),* 423-432.

Jenkins, S.R., Mitchell, J.L., Baird, S., Whitfield, S. R., & Meyer, H.L. (2010). The counselor's trauma as counselling motivation: vulnerability or stress inoculation? *Journal of Interpersonal Violence, 26(12),* 2392-2412.

Joffe, H. (2012). Thematic Analysis. In D. Harper & A. R. Thompson (Eds.), *Qualitative research methods in mental health and psychotherapy* (pp. 209-225). Chichester, UK: Wiley Blackwell.

Johnson, C. N. E., & Hunter, M. (1997). Vicarious traumatization in counsellors working in the New South Wales Sexual Assault Service: an exploratory study. *Work and Stress, 11(4)*, 319–328.

Joseph, S., & Linley, P. A. (2005). Positive adjustment to threatening events: An organismic valuing theory of growth through adversity. *Review of General Psychology, 9(3),* 262–280.

Joseph, S., & Linley, A. P. (2008). *Trauma, recovery and growth: Positive psychology perspectives on posttraumatic stress*. Hoboken, NJ: Wiley.

Kadambi, M. A., & Truscott, D. (2003). Vicarious traumatisation and burnout among therapists working with sex offenders. *Traumatology, 9(4),* 216-230.

Kadambi, M. A., & Ennis, L. (2004). Reconsidering vicarious trauma. *Journal of Trauma Practice, 3(2),* 1-21.

Kassam-Adams, N. (1995). The Risks of Treating Sexual Trauma: Stress and Secondary Trauma in Psychotherapists. In B. H. Stamm (Ed.) *Secondary Traumatic Stress: Self Care Issues for Clinicians, Researchers and Educators,* (pp.37-47). Lutherville, MD: Sidran Press.

Kelly, G. A. (1955). *The Psychology of Personal Constructs - Volume 1: A Theory of Personality & Volume 2: Clinical Diagnosis and Psychotherapy*. New York, NY: Norton.

Killian, K. D. (2008). Helping till it hurts? A multimethod study of compassion fatigue, burnout, and self-care in clinicians working with trauma survivors. *Traumatology, 14(2),* 32-44.

King, N. (2004). Using templates in the thematic analysis of text. In C. Cassell & G. Symon (Eds.), *Essential Guide to Qualitative Methods in Organizational Research.* London, UK: Sage.

Kita, E. (2015). Public safety, psychological security: a practice-informed research study exploring how California parole agents experience their work. *Smith College Studies in Social Work, 85(1),* 5-29.

Knight, C. (1997). Therapists' affective reactions to working with adult survivors of child sexual abuse: an exploratory study. *Journal of Child Sexual Abuse, 6(2)*, 17–41.

Knight, C. (2010). Indirect trauma in the field practicum: secondary traumatic stress, vicarious trauma, and compassion fatigue among social work students and their field instructors. *The Journal of Baccalaureate Social Work, 15(1),* 31-52.

Kolbe, R. H. & Burnett, M. S. (1991). Content-analysis research: An examination of applications with directives for improving research reliability and objectivity. *Journal of Consumer Research, 18*(2), 243-250.

Kondracki, N. L., & Wellman, N.S. (2002). Content analysis: review of methods and their applications in nutrition education. *Journal of Nutrition Education & Behavior, 34(4),* 224-230.

Kubany, E., Haynes, S., Leisen, M., Owens, J., Kaplan, A., Watson, S., & Burns, K. (2000). Development and preliminary validation of a brief broad-spectrum measure of trauma exposure: The Traumatic Life Events Questionnaire. *Psychological Assessment, 12(2),* 210-224.

Ladany, N., & Lehrman-Waterman, D. E. (1999). The content and frequency of supervisor self-disclosures and their relationship to supervisor style and the supervisory working alliance. *Counselor Education and Supervision*, *38(3),* 143–160.

Langdridge, D. (2004*). Introduction to Research Methods and Data Analysis in Psychology.* Harlow, UK: Pearson Education Ltd.

Leiter, M. P., & Schaufeli, W. B. (1996). Consistency of the burnout construct across occupations. *Anxiety, Stress & Coping, 9(3)*, 229-243.

Lerias, D., & Byrne, M.K. (2003). Vicarious traumatisation: Symptoms and predictors. *Stress and Health, 19(3),* 129-138.

Linley, P. A., & Joseph, S. (2004). Positive change following trauma and adversity: A review. *Journal of Traumatic Stress, 17*(1), 11-21.

Linley, P. A., Joseph, S., & Loumidis, K. (2005). Trauma work, sense of coherence, and positive and negative changes in therapists. *Psychotherapy and Psychosomatics, 74(3),* 185−188.

Linley, P. A., & Joseph, S. (2007). Therapy work and clinician's positive and negative well-being. *Journal of Social and Clinical Psychology, 26(3),* 385–403.

Lipscomb, M. (2011). Critical realism and realist pragmatism in mixed methods: problematics of event identity and abductive inference (evolving paradigms in mixed methods research). *Proceedings of the American Educational Research Association Annual Meeting. R*retrieved from: http://eprints.uwe.ac.uk/14188/

Loganbill, C., Hardy, E., & Delworth, U. (1982). *Supervision: a conceptual model. The Counselling Psychologist, 10,* 3-42.

Lombard, M., Snyder-Duch, J., & Bracken, C. C. (2002). Content analysis in mass communication: Assessment and reporting of intercoder reliability. *Human Communication Research, 28(4),* 587-604.

Lonergan, B. A., O'Halloran, M., & Crane, S. M. (2004). The development of the trauma therapist: A qualitative study of the child therapist's perspectives and experiences. *Brief Treatment & Crisis Intervention, 4(4),* 353-366.

Lyon, E. (1993). Hospital staff reactions to accounts by survivors of childhood abuse. *American Journal of Orthopsychiatry, 63(3),* 410–416.

Makadia, R., Sabin-Farrell, R., & Turpin, G. (In press). Indirect exposure to client trauma and the impact on trainee clinical psychologists: secondary traumatic stress or vicarious traumatization? *Clinical Psychology & Psychotherapy*.

Manning-Jones, S., de Terte, I., & Stephens, C. (2015). Vicarious posttraumatic growth: A systematic literature review. *International Journal of Wellbeing, 5(2),* 125-139.

Maslach, C. (1982). *Burnout, the cost of caring.* Englewood Cliffs, NJ: Prentice-Hall.

Mayring, P. (2000). Qualitative content analysis. *Forum: Qualitative Social Research, 1(2),* Art. 20, retrieved from http://www.qualitative-research.net/fqs-texte/2-00/02-00mayring-e.htm

Mayring, P. (2014). *Qualitative content analysis: theoretical foundations, basic procedures and software solutions.* Klagenfurt. Retrieved from: http://nbn-resolving.de/urn:nbn:de:0168-ssoar-395173

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

McCullough, M. E., Root, L. M., & Cohen, A. D. (2006). Writing about the personal benefits of a transgression facilitates forgiveness. *Journal of Consulting and Clinical Psychology, 74(5),* 887-897.

McLean, S., Wade, T.D., & Encel, J.S. (2003). The contribution of therapist beliefs to psychological distress in therapists: An investigation of vicarious traumatization, burnout and symptoms of avoidance and intrusion. *Behavioural and Cognitive Psychotherapy, 31(4),* 417-428.

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

Menashe, A., Possick, C., & Buchbinder, E. (2014). Between the maternal and the professional: the impact of being a child welfare officer on motherhood. *Child & Family Social Work, 19(4),* 391-400.

Mertens, D. M. (2010). *Research and Evaluation in Education and Psychology: Integrating Diversity with Quantitative, Qualitative and Mixed Methods* (3rd Edition.). London, UK: Sage Publications.

Morris, B., Shakespeare-Finch, J., Rieck, M., & Newbery, J. (2005). Multidimensional nature of posttraumatic growth in an Australian population. *Journal of Traumatic Stress, 18(5),* 575–585.

Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology, 52*(2), 250-260.

Morse, J. (2003). Principles of mixed methods and multimethod research design. In A Tashakkori & C. Teddlie (Eds.), *Handbook of Mixed Methods in Social and Behavioral Research*. Thousand Oaks, CA: Sage Publications.

Motta, R., Joseph, J., Rose, R., Suozzi, J., & Leiderman, L. (1997). Secondary trauma: Assessing intergenerational transmission of war experiences with a modified stroop procedure. *Journal of Clinical Psychology, 53(8),* 895-903.

Munroe, J.F. (1999). Ethical issues associated with secondary trauma in therapists. In B.H. Stamm (Ed.). *Secondary Traumatic Stress: Self-Care Issues for Clinicians, Researchers, and Educators* (2nd Edition.). Lutherville, MD: Sidran.

Najjar, N., Davis, L. W., Beck-Coon, K., & Doebbeling, C. C. (2009). Compassion fatigue: A review of research to date and relevance to cancer providers. *Journal of Health Psychology, 14(2)*, 267−277.

Namey, E., Guest, G., Thairu, L., & Johnson, L. (2008). Data reduction techniques for large qualitative data sets. In G. Guest & K. M. McQueen (Eds.), *Handbook for Team Based Qualitative Research* (pp. 137-163). Plymouth: UK: Altamira Press.

Neimeyer, R. A., & Raskin, J. D. (2000). *Constructions of disorder: Meaning-making frameworks for psychotherapy*. Washington, DC: American Psychological Association.

Neumann, D. A., & Gamble, S. J. (1995). Issues in the professional development of psychotherapists: countertransference and vicarious traumatization in the new trauma therapist. *Psychotherapy, 32(2),* 341–347.

O'Connor, M. F. (2001). On the etiology and effective management of professional distress and impairment among psychologists. *Professional Psychology: Research and Practice, 32(4),* 345-350.

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

Ortlepp, K., & Friedman, M. (2002). Prevalence and correlates of secondary traumatic stress in workplace lay trauma counselors. *Journal of Traumatic Stress, 15*(3), 213-222.

Osborn, M., & Smith, J. A. (1998). The personal experience of chronic benign lower back pain: an interpretative phenomenological analysis. *British Journal of Health Psychology, 3(1),* 65-83.

Pack, M. (2010). Transformation in progress: the effects of trauma on the significant others of sexual abuse therapists. *Qualitative Social Work: Research and Practice, 9(2),* 249-265.

Patton, M. Q. (1990). *Qualitative Evaluation and Research Methods* (2nd Edition.). Newbury Park, CA: Sage Publications.

Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3rd Edition.). Thousand Oaks, CA: Sage.

Pearlman, L. A. (1996). Psychometric review of the TSI Belief Scale, Revision-L. In B. H. Stamm (Ed.), *Measurement of Stress, Trauma, and Adaptation* (pp. 415-418). Lutherville, MD: Sidran Press.

Pearlman, L.A. (1999). Self-care for trauma therapists: Ameliorating vicarious traumatisation. In B. Hudnall Stamm (Ed.) *Secondary Traumatic Stress: Self Care Issues for Clinicians, Researchers and Educators* (2nd Edition), (pp.51-65). Lutherville, Maryland: Sidran Press.

Pearlman, L. A. (2003). *The Trauma Attachment Belief Scale manual*. Los Angeles, CA: Western Psychological Services Inc.

Pearlman, L. A., MacIan, P. S., Mas, K., Stamm, B. H., & Bieber, S. L. (1992). *Understanding disrupted schemas: The relation among theory, psychotherapy, and research.* Paper presented at the eighth annual meeting of the International Society for Traumatic Stress Studies, Los Angeles.

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

Pearlman, L. A., & MacIan, P. S. (1995). Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. *Professional Psychology: Research and Practice, 26(6*), 558-565.

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

Perron, B. E., & Hiltz, B. S. (2006). Burnout and secondary trauma among forensic interviewers of abused children. *Child and Adolescent Social Work Journal, 23(2),* 216−234.

Piaget, J. (1971). *Psychology and epistemology: Towards a theory of knowledge.* New York, NY: Viking Press.

Pines, A.M., & Aronson, E. (1988). *Career burnout: Causes and cures*. New York, NY: Free Press.

Pistorius, K. D., Feinauer, L. L., Harper, J. M., Stahmann, R. F., & Miller, R. B. (2008). Working with sexually abused children. *The American Journal of Family Therapy, 36(3),* 181-195.

Ponterotto, J. G. (2005). Qualitative research in counselling psychology: A primer on research paradigms and philosophy of science. *Journal of Counselling Psychology*, *52*(2), 126- 136*.*

Potter, W.J., & Levine-Donnerstein, D. (1999). Rethinking validity and reliability in content analysis. *Journal of Applied Communication Research, 27(3),* 258-284.

Pring, R. (2000). *Philosophy of educational research*. London, UK: Continuum.

Racanelli, C. (2005). Attachment and compassion fatigue among American and Israeli mental health clinicians working with traumatized victims of terrorism. *International Journal of Emergency Mental Health, 7(2),* 115-124.

Rich, K. D. (1997). Vicarious traumatization: A preliminary study. In S. B. Edmunds (Ed.), *Impact: Working with sexual abusers* (pp. 75-88). Brandon, VT: Safer Society Press.

Robinson, J.R., Clements, K., & Land, C. (2003). Workplace stress among psychiatric nurses: Prevalence, distribution, correlates & predictors. *Journal of Psychosocial Nursing and Mental Health Services, 41(4),* 32-41.

Robson, C. (2002). *Real world research* (2nd Edition.). Oxford, UK: Blackwell.

Rosenberg, M. (1989). *Society and the adolescent self-image*. Middletown, CT: Wesleyan University Press.

Saakvitne, K.W., Tennen, H., & Affleck, G. (1998). Exploring thriving in the context of clinical trauma theory: Constructivist self-development theory. *Journal of Social Issues, 54(2),* 279–299.

Sabin-Farrell, R., & Turpin, G. (2003). Vicarious traumatization: implications for the mental health of health workers? *Clinical Psychology Review, 23(3),* 449-480.

Sale, J. E. M., Lohfeld, L. H., & Brazil, K. (2002). Revisiting the quantitative-qualitative debate: Implications for mixed methods research. *Quality and Quantity, 36(1)*, 43-53.

Satkunanayagam, K., Tunariu, A., & Tribe, R. (2010). A qualitative exploration of mental health professionals' experience of working with survivors of trauma in Sri Lanka. *International Journal of Culture and Mental Health, 3(1),* 43-51.

Sayer, A. (2000). *Realism and Social Science*. London, UK: Sage Publications.

Schauben, L. J., & Frazier, P. A. (1995). Vicarious trauma: The effects on female counsellors of working with sexual violence survivors. *Psychology of Women Quarterly*, *19(1)*, 49-64.

Scotland, J. (2012). Exploring the philosophical underpinnings of research: relating ontology and epistemology to the methodology and methods of the scientific, interpretative and critical research paradigms. *English Language Teaching, 5(9),* 9-16.

Shamai, M., & Ron, P. (2009). Helping direct and indirect victims of national terror: Experiences of Israeli social workers. *Qualitative Health Research, 19(1),* 42-54.

Shew, A. M. (2010). *The effects of resilience training on secondary traumatic stress reactions: An empirical study*. Unpublished Doctoral Dissertation, University of the Rockies. Retrieved from: http://eric.ed.gov/?id=ED522611

Silverman, D. (2011). *Interpreting qualitative data (4th ed.).* London: UK: Sage.

Smith, J. A. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology, 1*, 39-54.

Smith, J. A., Harré, R., & Van Langenhove, L. (1995). Idiography and the case study. In J. A. Smith, R. Harré & L. Langenhove (Eds.), *Rethinking Psychology*. London, UK: Sage.

Spencer, L., & Ritchie, J. (2012). In pursuit of quality. In D. Harper & A. R. Thompson (Eds.), *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners* (pp. 16). Chichester, UK: Wiley-Blackwell.

Splevins, K. A., Cohen, K., Joseph, S., Murray, C., & Bowley, J. (2010). Vicarious posttraumatic growth among interpreters. *Qualitative Health Research, 20(12),* 1705-1716.

Sprang, G., Clark, J. J., & Whitt-Woosley, A. (2007). Compassion fatigue, compassion satisfaction, and burnout: Factors impacting a professional's quality of life. *Journal of Loss and Trauma, 12(3),* 259-280.

Stadler, H. A. (1990). Counselor impairment. In B. Herlihy & L. Golden, (Eds.), *AACD ethical standards casebook* (4th Edition.). Alexandria, VA: American Association for Counselling and Development.

Stamm, B. H. (2010). *The Concise ProQOL Manual* (2nd Edition.). Pocatello, ID: ProQOL.org.

Stamm, B. H. (2005). *The professional quality of life scale: Compassion satisfaction, burnout & compassion fatigue/secondary trauma scales.* Baltimore, MD: Sidran Press.

Stamm, B. H., Bieber, S. L., & Pearlman, L. A. (1991). *A preliminary report on scale construction and generalizability of the TSI Belief Scale.* Paper presented at the seventh annual meeting of the International Society for Traumatic Stress Studies. Washington, DC.

Stamm, B. H., & Pearlman, L. A. (1996). Psychometric review of TSI Autonomy &Connection Scales. In B. H. Stamm (Ed.), *Measurement of stress, trauma, and adaptation* (pp. 412-414). Lutherville, MD: Sidran Press.

Stamm, B. H., Varra, E. M., Pearlman, L. A., & Giller, E. (2002) *The Helper's Power to Heal and To Be Hurt - Or Helped - By Trying*. Washington, DC: Register Report: A Publication of the National Register of Health Service Providers in Psychology. Retrieved from: http://riskingconnection.com/rc_pdfs/RC_ResearchPage/Helper's%20Power%20to%20Heal.pdf

Steed, L. G., & Downing, R. (1998) A phenomenological study of vicarious traumatization amongst psychologists and professional counsellors working in the field of sexual abuse/assault. *The Australasian Journal of Disaster and Trauma Studies, 2*. Retrieved from http://www.massey.ac.nz/~trauma/issues/1998-2/steed.htm.

Swearington, C. (1990). The impaired psychiatrist. *Psychiatric Clinics of North America, 13*, 1-11.

Sweetman, D., Badiee, M., & Creswell, J. W. (2010). Use of the Transformative Framework in Mixed Methods Studies. *Qualitative Inquiry, 16(6),* 441-454.

Tarrier N., & Calam, R. (2002). New developments in cognitive-behavioural case formulation. Epistemological, systemic and social context: an integrative approach. *Behavioural and Cognitive Psychotherapy, 30(3),* 311-328.

Tashakkori, A. (2009). Are we there yet? The state of the mixed methods community. *Journal of Mixed Methods Research, 3*(4), 287-291.

Taylor, S. (2001). Locating and conducting discourse analytic research. In M. Wetherell, S. Taylor, & S. Yates. (Eds.), *Discourse as data: a guide for analysis* (pp. 5-48). London, UK: Sage.

Teddlie, C., & A. Tashakkori. (2003). Major issues and controversies in the use of mixed methods in the social and behavioral sciences. In Tashakkori, A., & C. Teddlie (Eds.), *Handbook of Mixed Methods in Social and Behavioral Research. Thousand Oaks* (pp. 3-50). CA: Sage Publications.

Teddlie, C., & Tashakkori, A. (2011). Mixed Methods Research: Contemporary Issues in an Emerging Field. In N. K. Denzin, & Lincoln, Y. S. (Eds.), *The Sage Handbook of Qualitative Research* (4th Edition.), (pp. 285-299). London, UK: Sage.

Teddlie, C., & Yu, F. (2007). Mixed methods sampling: a typology with examples. *Journal of Mixed Methods Research, 1(1),* 77-100.

Tedeschi, R. G., & Calhoun, L. G. (1996). The posttraumatic growth inventory: Measuring the positive legacy of trauma. *Journal of Traumatic Stress, 9(3),* 455-471.

Tehrani, N. (2010). Compassion fatigue: Experiences in occupational health, human resources, counselling and police. *Occupational Medicine, 60(2)*, 133–138.

Tesch, R. (1990). *Qualitative research: Analysis types and software tools*. Bristol, PA: Falmer.

Tindall, C. (1994). Personal construct approaches. In Banister, P.; Burman, E.; Parker, I.; Taylor, M. & Tindall, C. (1994). *Qualitative methods in psychology: A research guide.* Buckingham, UK: Open University Press.

Tinsley, H. E. A. & Weiss, D. J. (2000). Interrater reliability and agreement. In H. E. A. Tinsley & S. D. Brown (Eds.), *Handbook of Applied Multivariate Statistics and Mathematical Modeling* (pp. 95-124). San Diego, CA: Academic Press.

Toosheh, A. (2012). *Therapist, trauma and meaning: a psycho-spiritual developmental journey of the trauma therapist through meaning-oriented trauma practice.* Saarbrücken, Germany: Lap Lambert Academic Publishing.

Trippany, R. L., White Kress, V. E., & Wilcoxin, S. A. (2004). Preventing vicarious trauma: What counselors should know when working with trauma survivors. *Journal of Counseling and Development, 82(1),* 31– 37.

Tuckett, A. (2004). Qualitative research sampling-the very real complexities. *Nurse Researcher. 12(1),* 47-61.

Tweed, A., & Charmaz, K. (2012). Grounded theory methods for mental health practitioners. In A.R. Harper & D. Thompson (Eds.), *Grounded Theory Methods for Mental Health Practitioners* (pp. 131-146). West Sussex, UK: John Wiley & Sons, Ltd.

van der Kolk, B. (1986). Psychological trauma. Washington DC: American Psychiatric Press.

VanDeusen, K.M., & Way, I. (2006). Vicarious trauma: An exploratory study of the impact of providing sexual abuse treatment on clinicians' trust and intimacy. *Journal of Child Sexual Abuse, 15(1),* 69-85.

Van Minnen, A., & Keijsers, G. P. J. (2001). A controlled study into the (cognitive) effects of exposure treatment on trauma therapists. *Journal of Behaviour Therapy and Experiential Psychiatry, 31*, 189-200.

Varra, E. M., Pearlman, L. A., Brock, K. J., & Hodgson, S. T. (2008). Factor analysis of the Trauma and Attachment Belief Scale: a measure of cognitive schema disruption related to traumatic stress. *Journal of Psychological Trauma, 7(3),* 185-196.

von Glaserfeld, E. (1995). *Radical constructivism: A way of knowing and learning.* London, UK: The Falmer Press.

Walker, H., Trenoweth, S., Martin, C., & Ramm, M. (2013). Using repertory grid to establish patients' views of psycho-education. *Psychology & Psychotherapy, 3(1),* 108. doi:10.4172/2161-0487.1000108

Waring, R., & Wainwright, D. (2008). Issues and challenges in the use of template analysis: two comparative case studies from the field. *The Electronic Journal of Business Research Methods, 6(1),* 85-94.

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

Weaks, K. (2000). Effects of treating trauma survivors: Vicarious traumatization and style of coping (Doctoral dissertation, TX Woman's University, 2000). *Dissertation Abstracts International, 60,* 4915.

Weber, R. P. (1990). *Basic content analysis.* Beverly Hills, CA: Sage.

Willig, C. (2008). *Introducing qualitative research in psychology* (2nd ed.). Berkshire, UK: Open University Press.

Winter, D. A. (1992). *Personal Construct Psychology in Clinical Practice: Theory, Research and Applications*. Hove, UK: Routedge.

Yin, R. K. (2006). Mixed methods research: are the methods genuinely mixed or merely parallel? *Research in the Schools, 13(1),* 41-47.

Young, C. M. (2000). Vicarious traumatization in psychotherapists who work with physically or sexually abused children. *Dissertation Abstracts International, 60 (9),* 4918B.

Zerubavel, N., & O'Dougherty Wright, M. (2012). The dilemma of wounded healer. *Psychotherapy, 49*(4), 482-491.

Appendices

Appendix A: Initial Letter of Ethical Approval (University)

The University of Nottingham

Faculty of Medicine and Health Sciences

Research Ethics Committee
School of Medicine Education Centre
B Floor, Medical School
Queen's Medical Centre Campus
Nottingham University Hospitals
Nottingham
NG7 2UH

Direct line/e-mail
+44 (0) 115 8232561
Louise.Sabir@nottingham.ac.uk

22nd January 2016

Emma Millard
Trainee Clinical Psychologist/student
Trent Doctorate in Clinical Psychology Programme
Division of Psychiatry and Applied Psychology
School of Medicine
B Floor, Yang Fujia Building
Jubilee Campus
University of Nottingham
Wollaton Road
NG8 1BB

Dear Emma

Ethics Reference No: J18012016 SoM RGS 15100– **please always quote**
Study Title: A mixed-Methods Approach Investigating Cognitive Changes in Vicarious Trauma within Trainees and Experienced Therapists.
Short Title: Cognitive Effects of Trauma-work in Qualified and Trainee Therapists.
Chief Academic/Supervisor: Thomas Schröder, Associate Professor in Clinical Psychology/Co Director Trent Doctorate in Clinical Psychology Programme, Psychiatry and Applied Psychology, School of Medicine
Other key Researchers/supervisor: Rachel Sabin-Farrell, Clinical Psychologist/Senior Academic Tutor Trent Doctorate in Clinical Psychology Programme, Division of Psychiatry and Applied Psychology, School of Medicine.
Student name and Course: Emma Louise Millard, Trainee Clinical Psychologist on Trent Doctorate in Clinical Psychology.
Duration of Study: January 2016- January 2017 12 mths
No of Subjects: 20

Thank you for submitting the above application which was considered by the Committee at its meeting on 18th January 2016 and the following documents including revised documents with minor changes requested were received:

Cognitive Effects of Trauma-work in Qualified and Trainee Therapists:

- FMHS Research Ethics Committee Application Form version draft 1, Date:17/12/2015
- UoN Sponsorship Statement dated 10 November 2015
- Evidence of Insurance Henderson Insurance Brokers 21 July 2015
- Protocol Final Version 1.0 Date 27/10/15
- Recruitment E-mail Final Version 1.0 Date 10/11/15
- Recruitment E-mail Final Version 1.1 Date 18/01/16
- Participant Information Sheet Version 1.0 Date10/11/2015
- Participant Information Sheet Version 1.1 Date 18/01/2016
- Consent Form Draft Version 2.0: 06/11/2015
- Interview Schedules fv1.0 10/11/15
- Participant Debrief Sheet fv1.0 10.11.15
- Participant Debrief Sheet fv 1.1 18.01.2016
- Questionnaire Measures fv1.0 10.11.15

The University of Nottingham

A favourable opinion is given on the understanding that the Conditions set out below are followed.

1. You must follow the protocol agreed and inform the Committee of any changes using a notification of amendment form (please request a form).
2. You must notify the Chair of any serious or unexpected event.
3. This study is approved for the period of active recruitment requested. The Committee also provides a further 5 year approval for any necessary work to be performed on the study which may arise in the process of publication and peer review.
4. An End of Project Progress Report is completed and returned when the study has finished (Please request a form).

Yours sincerely

pp Lamagatni

Professor Ravi Mahajan
Chair, Faculty of Medicine & Health Sciences Research Ethics Committee

Appendix B – Nottinghamshire Healthcare HNS Foundation Trust Research & Development Approval Letter

Nottinghamshire Healthcare NHS
NHS Foundation Trust

Research and Development
Nottinghamshire Healthcare NHS Foundation Trust
Duncan Macmillan House
Porchester Road
Mapperley
Nottingham
NG3 6AA

E-mail: shirley.mitchell@nottshc.nhs.uk

Date of NHS Permission: 22 February 2016

Dr Thomas Schröder
Associate Professor in Clinical Psychology
Division of Psychiatry & Applied Psychology
University of Nottingham
Yang Fujia Building – B Floor
Jubilee Campus
Triumph Road
Nottingham, NG8 1BB

Dear Dr Schröder

Study title: A mixed-methods approach investigating cognitive effects in vicarious trauma within trainees and qualified therapists
Sponsor: University of Nottingham

Thank you for submitting your project to the Nottinghamshire Healthcare NHS Foundation Trust's R&D Department. The project has now been given NHS permission by:

Dr Julie Hankin: R & D Director, on behalf of Nottinghamshire Healthcare NHS Foundation Trust

NHS permission for the above research has been granted on the basis described in the application form, study protocol and supporting documentation. The following documents were reviewed:

Document	Version
Recruitment Email	1.1, 180116
Participant Information Sheet	1.1, 180116
Questionnaire Measures	1.0, 101115
Debrief	1.1, 180116
Protocol	1.0, 101115
Interview Schedule	1.0, 101115
Consent Form	1.0, 101115

Permission is granted on the understanding that the study is conducted in accordance with the Research Governance Framework, ICH GCP [ONLY if applicable], and NHS Trust policies and procedures available http://www.nottinghamshirehealthcare.nhs.uk/contact-us/freedom-of-information/policies-and-procedures/

The research sponsor or the Chief Investigator, or the local Principal Investigator at a research site, may take appropriate urgent safety measures in order to protect research participants against any immediate hazard to their health or safety. The R&D office should be notified that such measures have been taken. The notification should also include the reasons why the measures were taken and the plan for further action. The R&D Office should be notified within the same time frame of notifying the REC and any other regulatory bodies. All amendments (including changes to the local research team) need to be submitted in accordance with guidance in IRAS.

Please note that the NHS organisation is required to monitor research to ensure compliance with the Research Governance Framework and other legal and regulatory requirements. This is achieved by random audit of research.

Yours Sincerely

Shirley Mitchell
Head of Research and Innovation

cc.

Student: Emma Millard

Sponsor: University of Nottingham

Appendix C – Lincolnshire Partnership NHS Foundation Trust Research & Development Letter of Access

Making a difference

Lincolnshire Partnership NHS
NHS Foundation Trust

Our ref: DT/TMc
Your ref:

Research, Innovation and Clinical Effectiveness
Learning and Development Centre
Unit 3, The Reservation
East Road
SLEAFORD
NG34 7BY

Tel: 01529 416255
Fax: 01529 222226
Email: research@lpft.nhs.uk

Date: 10 February 2016

Dear Emma Millard

Study title: Cognitive effects of trauma work in qualified and trainee therapists
Chief Investigator: Dr Thomas Schroder
REC No: University of Nottingham - J18012016 SoM RGS 15100
Date of permission: 10 February 2016

List of all site(s) for which NHS permission for research is given:

Lincolnshire Partnership NHS Foundation Trust

NHS permission for the above research has been granted by Lincolnshire Partnership NHS Foundation Trust on the basis described in the application form, protocol and supporting documentation.

Permission is granted on the understanding that the study is conducted in accordance with the Research Governance Framework, ICH GCP and NHS Trust policies and procedures (available at http://www.lpt.nhs.uk/).

Permission is only granted for the activities for which a favourable opinion has been given by the REC [and which have been authorised by the MHRA]

List of any conditions of approval: letter of access required – to be issued under separate cover

The research sponsor or the Chief Investigator, or the local Principal Investigator at a research site, may take appropriate urgent safety measures in order to protect research participants against any immediate hazard to their health or safety.

The Research and Effectiveness office should be notified, at the address above, that such measures have been taken. The notification should also include the reasons why the measures were taken and the plan for further action. The Research and Effectiveness Office should be notified within the same time frame of notifying the REC and any other regulatory bodies.

Any research carried out by a Trust employee with the knowledge and permission of the employing organisation will be subject to NHS indemnity. NHS indemnity provides indemnity against clinical risk arising from negligence through the Clinical Negligence Scheme for Trusts (CNST). Further details can be found at Research in the NHS: Indemnity arrangements (Department of Health 2005).

All amendments (including changes to the local research team) need to be submitted in accordance with guidance in IRAS.

Please inform the Research and Effectiveness department of any changes to study status.

Please note that the NHS organisation is required to monitor research to ensure compliance with the Research Governance Framework and other legal and regulatory requirements. This is achieved by random audit of research.

We are pleased to inform you that you may now commence your research. Please retain this letter to verify that you have Trust permission to proceed. We wish you every success with your work.

Yours sincerely

Dianne Tetley

Dianne Tetley
Assistant Director Research, Innovation and Clinical Effectiveness
Lincolnshire Partnership NHS Foundation Trust

Cc Sponsor – University of Nottingham
Local Collaborator – Dr Graham Evans, LPFT

Appendix D – Participant Information Sheet

Participant Information Sheet

Study Title: A Mixed Methods Approach Investigating Cognitive Changes in Vicarious Trauma within Trainees and Experienced Therapists

Name of Researcher: Emma Millard

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. If you have any questions whilst reading this please email the researcher who will go through the information sheet with you and answer any questions you have. Talk to others about the study if you wish. Ask us if there is anything that is not clear.
If, after reading the following information, you wish to participate, please email the researcher using the details provided at the end of this document.

What is the purpose of the study?

Most research looking at the effects of listening to client's traumatic material on therapists has been conducted on qualified therapists working in settings outside the United Kingdom (UK). There has been one unpublished survey-based study on trainee clinical psychologists in the UK, therefore it is important to explore the effects in trainees and qualified mental health therapists working in the UK. The study will be included in a Clinical Psychology Doctorate dissertation as part of the Trent Doctorate in Clinical Psychology.

Why have I been invited?

You are being invited to take part because you are either a qualified mental health worker or a trainee clinical psychologist, working in UK mental health settings. You should consider yourself to have experience of working therapeutically with client trauma. We are inviting 20 participants like you to take part.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. This would not affect your legal rights.

What will happen to me if I take part?

The investigator will travel to you at a time and place which is most convenient to you. You will be asked to complete a structured interview (repertory grid – this is a set of questions about how similar or different various people are to the self on a number of concepts), a semi-structured interview about your experiences of working with trauma and four short pen & paper questionnaires. These will take a maximum of 2 hours to complete. If you require any breaks during this time, you are free to take them. You will not be required to give any personal details other than brief details about your experience of trauma work. Your data will be anonymised.
There will be no follow-up, it is a one-off participation, but if you wish to be informed of the study results or have any questions after participation you will be provided with the researchers' contact details to use if required.
To thank you for your participation you will be provided with a £10 High Street voucher.

Expenses and payments

Participants will not be paid to participate in the study, but will be offered a £10 High Street Voucher as recognition of the inconvenience of taking part. Travel expenses will not be offered for any visits incurred as a result of participation, as the researcher will travel to you.

What are the possible disadvantages and risks of taking part?

Taking part will involve you giving up some of your time to complete the three parts of the study. Whilst this will be completed all in the same session and the investigator will travel to you to reduce time constraints, it is appreciated that you are likely to have a busy schedule. It may be that talking about exposure to client's trauma evokes strong emotions in you, whereas some people may not be distressed at all. It is important that you feel you have coping resources in place to manage the possibility of these emotions. You do not have to discuss anything you do not want to and the study has been designed to be sensitive to your feelings.
If you do experience distress as a result of this study, we will be able to offer you advice and signpost you to support services.
Also, the study is interested in your experience working with clients. It is important not to break confidentiality of your clients, we ask you to focus on your experience of working in the role of supporting others who have suffered trauma.

What are the possible benefits of taking part?

By taking part in the study the information you and the other participants provide may help to inform theory around the effects on therapists of working with people who have experienced trauma. This may have improve understanding of what support needs to be offered to therapists as part of their role.

What happens when the research study stops?
After your participation in the interviews and completion of questionnaires you will not be required for any further study interventions. You will have chance immediately after participation to discuss any concerns or questions you have about the study. You will also be

provided with the researchers' details which you can use to contact the research team if you have any questions after participation or of you wish to be sent the study results.

When the research is completed it will be submitted in partial fulfilment of the Trent Doctoral Research Programme at the University of Nottingham. It will also be sent to journals for publication.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. The researchers contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting the University of Nottingham Faculty of Medicine & Health Sciences (FMHS) Research Ethics Administrator, c/o the School of Medicine Education Centre, B Floor Medical School, QMC Campus, Nottingham University Hospitals, NG7 2UH e-mail: louise.sabir@nottingham.ac.uk.

Will my taking part in the study be kept confidential?

We will follow ethical and legal practice and all information about you will be handled in confidence.

If you join the study, some parts of the data collected for the study will be looked at by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

All information which is collected about you during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database. Any information about you will have your name and address removed (anonymised) and a unique code will be used so that you cannot be recognised from it.

All research data will be kept securely for 7 years. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team will have access to your personal data.

Although what you say in the interview is confidential, should you disclose anything to us which we feel puts you or anyone else at any risk, we may feel it necessary to report this to the appropriate persons.

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

Your participation is voluntary and you are free to withdraw at any time, without giving any reason, and without your legal rights being affected. If you withdraw then the information collected so far cannot be erased and this information may still be used in the project analysis.

What will happen to the results of the research study?

The results of the study will be presented to the Institute of Psychiatry and Applied Psychology at the School of Medicine, University of Nottingham. This will be in partial fulfilment of the Trent Doctorate in Clinical Psychology. The research will be submitted for publication to a peer-reviewed journal. You will not be identified in any presentation of the data. A copy of the study findings can be provided by Emma Millard upon your request (see contact details below).

Who is organising and funding the research?

This research is being organised by the University of Nottingham and is being funded by the University of Nottingham.

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 interests. This study has been reviewed and given favourable opinion by the University of Nottingham Research Ethics Committee (UREC ref: FMHS J18012016 RGS15100).

Further information and contact details

Researcher: Emma Millard (Doctorate in Clinical Psychology Trainee) – email: msxelmi@nottingham.ac.uk, Tel: 07934101718

Chief Investigator: Thomas Schröder (Associate Professor in Clinical Psychology) – email: Thomas.schroder@nottingham.ac.uk, Tel: 0115 846 8181

Research Supervisor: Rachel Sabin-Farrell (Senior Academic Tutor) – email: Rachel.sabin-farrell@nottingham.ac.uk , Tel: 0115 8466734

Correspondence to all 3 of the above research team can be sent to:
Doctorate in Clinical Psychology
B Floor Yang Fujia Building
Jubilee Campus
Wollaton Road
Nottingham
NG8 1BB

Support Services:

- University of Nottingham Counselling Service: Tel: 01159 513695. Email: counselling.service@nottingham.ac.uk
- Samaritans (24 hour helpline for people in distress): 08457 909090: www.samaritans.org

Can also advice on any local support services if required, based on geographical location of participant – speak to researcher for further information

Alternatively, you may want to speak to a member of a health care team.

Please contact the researcher using the email address provided above if you wish to participate in this research. We will then arrange a convenient time and location for you to take part.

Appendix E – Recruitment Email (received by participants)

Dear *(Insert name of DClinPsy Course Director or NHS Head of Psychology Service),*

I obtained your email address from your DClinPsy programme website / my research supervisor, Rachel Sabin-Farrell / the NHS trust psychological services website *(delete depending on recipient).*

I am a second year Trainee Clinical Psychologist on the Trent programme (based at the University of Nottingham). As part of the requirements for this doctorate I am planning to undertake research which will form my thesis. This research is supervised by Dr Rachel Sabin-Farrell, Clinical Psychologist and Senior Academic Tutor, and Dr Thomas Schröder, Director of the Trent course. My research is a mixed methods investigation into the effects of vicarious trauma on both qualified mental health therapists and trainee clinical psychologists.

The study has received approval from both the NHS Research and Development Office and the University of Nottingham Research Ethics Committee (UREC ref: FMHS J18012015/RGS15100).

I am writing to ask whether you would be willing to pass on the study information to your trainees/qualified mental health workers *(delete depending on recipient).* (Qualified mental health workers can include clinical psychologists, counselling psychologists, CBT therapists, psychotherapists and any other therapist who is exposed to indirect client trauma through their role).

Please find attached the Participant Information Sheet which has more details of what participation will involve. If you are willing to circulate please send this sheet round by email to potential participants and ask them to email me using the details provided if they have any questions or wish to participate.

If you require any further information before agreeing to circulate, please do not hesitate to contact me.

Many thanks,

Emma Millard

Appendix F – Participant Informed Consent Form

The University of Nottingham
UNITED KINGDOM · CHINA · MALAYSIA

(Form to be printed on local headed paper)

CONSENT FORM
(Final Version: 06/11/2015)

Title of Study: A Mixed-Methods Approach Investigating Cognitive Changes in Vicarious Trauma within Trainees and Experienced Therapists

REC ref: *(to be added after approval given)*

Name of Researcher: Emma Millard

Name of Participant: **Please initial box**

1. I confirm that I have read and understand the information sheet version number XXX dated XXX for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my medical care or legal rights being affected. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis. ☐
3. I understand that data collected in the study may be looked at by authorised individuals from the University of Nottingham, the research group and regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential. ☐
4. I understand that the interview will be recorded and that anonymous direct quotes from the interview may be used in the study reports. ☐
5. I agree to take part in the above study. ☐

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Person taking consent	Date	Signature

2 copies: 1 for participant and 1 for the project notes

Appendix G – Semi-structured Interview Schedule

From what we have just done, I am now going to build on this information by asking you some questions about your experiences working as a therapist with clients who have suffered trauma. Firstly, did completing the grid bring anything to mind that you would like to discuss?

Before you started working with trauma clients, what did you imagine this work would be like? **Prompt:** *Were your expectations met?*

I'd like you to bring to mind a session with a client who is struggling with their traumatic experiences – can you describe your experience immediately after a session like this?

Prompts: *how did you feel? What thoughts were you having? Did you notice any bodily sensations?*

What has influenced how you cope?

Thinking about a client who is deeply affected by their trauma – how do they tend to think about themselves?

How has this impacted your experience of working with them?

Now bring to mind a client you have worked with who has processed their trauma and developed a sense of positive growth in the way they see themselves and the world – can you describe this experience?

And have you noticed any differences in yourself after working with clients who are still suffering with their trauma, compared to those who have developed a sense of personal growth?

Have you experienced thoughts about clients with trauma outside of work – if so, what was this like? **Prompt:** *How did you cope?*

What do you feel is the most positive thing about working with trauma clients?

And what is the most negative thing?

Describe your identity as a therapist working with trauma?

Have you noticed any differences in the way you think about other people/the world, since working as a therapist with trauma clients?

General prompts: 'Tell me more about it'

'Is there anything else you'd like to add?'

'So what you're saying is..'

'I don't quite understand what you mean when you say…could you explain that part again?'

Closing the interview: We've now come to the end of the interview, is there anything else you would like to add or anything I've left out that you think is important to discuss? *If not, thank them for their time and move on to questionnaire*

Appendix H – Questionnaire Measures (Including Demographics)

Pp Number:____ **Questionnaire Measures**

Now the interview is over please take some time to complete the following questionnaires. If you do not wish to answer any questions please either leave these out or discuss with the researcher if you have any questions.

Demographic Data

The following data will be collected to aid interpretation of results from the study. You will not be identifiable from this data but if you do not wish to disclose some information please indicate this using the *'Information not shared'* option.

1. Are you a?

- Trainee Clinical Psychologist ☐
- Qualified Psychological Therapist ☐

2. **If you are a trainee, what year of training are you in?**

- First year ☐
- Second Year ☐
- Final Year ☐
- Information not shared ☐

3. **If you are a qualified therapist, how many years have you been practicing?**

_____years

Information not shared ☐

4. **Have you had any trauma-specific training?**

- Substantial (e.g. attended multiple courses, extensive formal training) ☐
- Minimal (e.g. one workshop or seminar) ☐
- None ☐
- Information not shared ☐

5. In your current caseload, approximately how many hours a week involve working with trauma-related content?

_____hours per week

Information not shared ☐

6. What are the main types of trauma you work with (e.g. childhood abuse (specify type – sexual/emotional/physical), military, accident, assault, natural disaster)?

_____

_____

Information not shared ☐

Trauma and Attachment Beliefs Scale (TABS)

Paper copies only due to copyright laws ordered by the University of Nottingham from:

http://www.wpspublish.com/store/p/3011/trauma-and-attachment-belief-scale-tabs#purchase-product

Reference: Pearlman, L. A. (2003). *Trauma and Attachment Belief Scale*. Los Angeles, CA: Western Psychological Services.

Secondary Traumatic Stress Scale (STSS)

The following is a list of statements made by persons who have been impacted by their work with traumatized clients. Read each statement then indicate how frequently the statement was true for you in the **past seven (7) days** by circling the corresponding number next to the statement.

NOTE: *"Client" is used to indicate persons with whom you have been engaged in a helping relationship. You may substitute another noun that better represents your work such as consumer, patient, recipient, etc.*

	Never	Rarely	Occasionally	Often	Very Often
1. I felt emotionally numb	1	2	3	4	5
2. My heart started pounding when I thought about my work with clients	1	2	3	4	5
3. It seemed as if I was reliving the trauma(s) experienced by my client(s)	1	2	3	4	5
4. I had trouble sleeping	1	2	3	4	5
5. I felt discouraged about the future	1	2	3	4	5
6. Reminders of my work with clients upset me	1	2	3	4	5
7. I had little interest in being around others	1	2	3	4	5
8. I felt jumpy	1	2	3	4	5
9. I was less active than usual	1	2	3	4	5
10. I thought about my work with clients when I didn't intend to	1	2	3	4	5
11. I had trouble concentrating	1	2	3	4	5
12. I avoided people, places, or things that reminded me of my work with clients	1	2	3	4	5
13. I had disturbing dreams about my work with clients	1	2	3	4	5
14. I wanted to avoid working with some clients	1	2	3	4	5
15. I was easily annoyed	1	2	3	4	5
16. I expected something bad to happen	1	2	3	4	5
17. I noticed gaps in my memory about client sessions	1	2	3	4	5

Life Events Checklist (LEC)

Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that:

(a) it happened to you personally,

(b) you witnessed it happen to someone else,

(c) you learned about it happening to someone close to you (not a client),

(d) you're not sure if it fits,

(e) it doesn't apply to you.

Be sure to consider your entire life (growing up as well as adulthood) as you go through the list of events.

Alternatively, if you do not wish to disclose specific personal events please indicate whether you consider yourself to have experienced a personal traumatic experience(s) during your life?

☐ Yes

☐ No

	A – happened to me	**B - witnessed it**	**C – learned about it**	**D – not sure**	**E – doesn't apply**
1. Natural disaster (for example, flood, hurricane, tornado, earthquake)					
2. Fire or explosion					
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)					
4. Serious accident at work, home, or during recreational activity					
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)					
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)					
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)					
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act					

through force or threat of harm)					
9. Other unwanted or uncomfortable sexual experience					
10. Combat or exposure to a war-zone (in the military or as a civilian)					
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)					
12. Life-threatening illness or injury					
13. Severe human suffering					
14. Sudden, violent death (for example, homicide, suicide)					
15. Sudden, unexpected death of someone close to you					
16. Serious injury, harm, or death you caused to someone else					
17. Any other very stressful event or experience					

Professional Quality of Life Scale (ProQOL)

When you help people you have direct contact with their lives. As you may have found, your compassion for those you help can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a helper *(please note 'helper' refers to your role as a therapist)*. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *last 30 days*.

1=never	2=rarely	3=sometimes	4=often	5=very often

_ _____ 1. I am happy.

_____ 2. I am preoccupied with more than one person I help.

_____ 3. I get satisfaction from being able to help people.

_____ 4. I feel connected to others.

_____ 5. I jump or am startled by unexpected sounds.

_____ 6. I feel invigorated after working with those I help.

_____ 7. I find it difficult to separate my personal life from my life as a helper.

_____ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I help.

_____ 9. I think that I might have been affected by the traumatic stress of those I help.

_____ 10. I feel trapped by my job as a helper.

_____ 11. Because of my helping, I have felt "on edge" about various things.

_____ 12. I like my work as a helper.

_____ 13. I feel depressed because of the traumatic experiences of the people I help.

_____ 14. I feel as though I am experiencing the trauma of someone I have helped.

_____ 15. I have beliefs that sustain me.

_____ 16. I am pleased with how I am able to keep up with helping techniques and protocols

_____ 17. I am the person I always wanted to be.

_____ 18. My work makes me feel satisfied.

_____ 19. I feel worn out because of my work as a helper.

_____ 20. I have happy thoughts and feelings about those I help and how I could help them.

_____ 21. I feel overwhelmed because my case work load seems endless.

_____ 22. I believe I can make a difference through my work.

_____ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I help.

_____ 24. I am proud of what I can do to help.

_____ 25. As a result of my helping, I have intrusive, frightening thoughts.

_____ 26. I feel "bogged down" by the system.

_____ 27. I have thoughts that I am a "success" as a helper.

_____ 28. I can't recall important parts of my work with trauma victims.

_____ 29. I am a very caring person.

_____ 30. I am happy that I chose to do this work.

Appendix I – Participant Debrief Sheet

The University of Nottingham

UNITED KINGDOM · CHINA · MALAYSIA

Nottinghamshire Healthcare NHS

NHS Foundation Trust

Participant Debrief Sheet

Thank you for your time in completing this research. It forms part of the researcher's Doctorate in Clinical Psychology and will be submitted to the University in partial fulfilment of the Doctorate. It will also be submitted to peer-reviewed journals for publication. Direct quotes from the research may be used but these will be anonymised and all your personal information will remain confidential.

Purpose

This study was an investigation of vicarious trauma, this is the phenomenon of experiencing indirect trauma as a result of empathically engaging with client trauma. It is not something you will necessarily experience as part of your work as a therapist, but it is something which requires more research as the changes hypothesised within vicarious trauma theory have varied between studies. There are two areas which the theory suggests are affected by indirect exposure to trauma. These include symptoms which resemble those of Posttraumatic Stress Disorder such as re-experiencing client trauma and hypervigilance. Previous research has demonstrated clearer evidence for the existence of these symptoms in therapists as a result of their work. Previous research has found conflicting evidence for the second hypothesised effect. These are changes in beliefs; specifically power, intimacy, esteem, control and trust. This was the purpose of the repertory grids to examine your beliefs in these areas at different stages in your career. The study also takes an inductive approach, to explore whether there are any effects reported by participants which have not been hypothesised by vicarious trauma theory.

Vicarious trauma theory focuses on the negative impacts of trauma work; however research has also identified positive effects, termed vicarious posttraumatic growth. There is growing recognition that therapists exposed to indirect trauma cope well and includes increased optimism, compassion and appreciation of life. This study aimed to examine evidence for both positive and negative effects of trauma work.

This study explored the effects of trauma work in both trainee and qualified therapists to look at whether there are differences in therapist experience as a result of experience, this is not something which has been previously looked at in qualitative research. It is also the first study in this research field to use Repertory Grids to explore therapist experience.

Contact after the Research

If you have any questions after taking part in the study or would like to be sent a copy of the study results when they become available please email the researcher (Emma Millard) using the contact details provided at the end of this page. Please be aware that the researcher (Emma Millard) finishes her doctorate in September 2017, so may no longer be available on the provided contact details after this time. Please contact the Chief Investigator or Research

Supervisor if you have any questions or comments to make after this time, details are also provided at the end of this document.

Complaints

In the event that you have any complaints to make regarding the research process, please either contact the Chief Investigator or Research Supervisor. If you remain unhappy and wish to complain formally, you can do this by contacting the University of Nottingham Faculty of Medicine & Health Sciences (FMHS) Research Ethics Administrator, c/o the School of Medicine Education Centre, B Floor Medical School, QMC Campus, Nottingham University Hospitals, NG7 2UH e-mail: louise.sabir@nottingham.ac.uk.

Further information and contact details

Researcher: Emma Millard (Doctorate in Clinical Psychology Trainee) – email: msxelmi@nottingham.ac.uk, Tel: *research mobile provided by university number yet to be allocated*

Chief Investigator: Thomas Schröder (Associate Professor in Clinical Psychology) – email: Thomas.schroder@nottingham.ac.uk, Tel: 0115 846 8181

Research Supervisor: Rachel Sabin-Farrell (Senior Academic Tutor) – email: Rachel.sabin-farrell@nottingham.ac.uk , Tel: 0115 8466734

Correspondence to all of the above research team can be sent to:
Doctorate in Clinical Psychology,
B Floor Yang Fujia Building,
Jubilee Campus,
Wollaton Road,
Nottingham,
NG8 1BB

Support Services:

- University of Nottingham Counselling Service: Tel: 01159 513695. Email: counselling.service@nottingham.ac.uk
- Samaritans (24 hour helpline for people in distress): 08457 909090: www.samaritans.org

The research team can also advice on any local support services if required, based on your geographical location – speak to researcher for further information

Alternatively you may want to speak to a member of a health care team.

Further Reading

If you are interested in understanding more about Vicarious Trauma or Vicarious Posttraumatic Growth please see below for a selection of references which influenced the research you participated in.

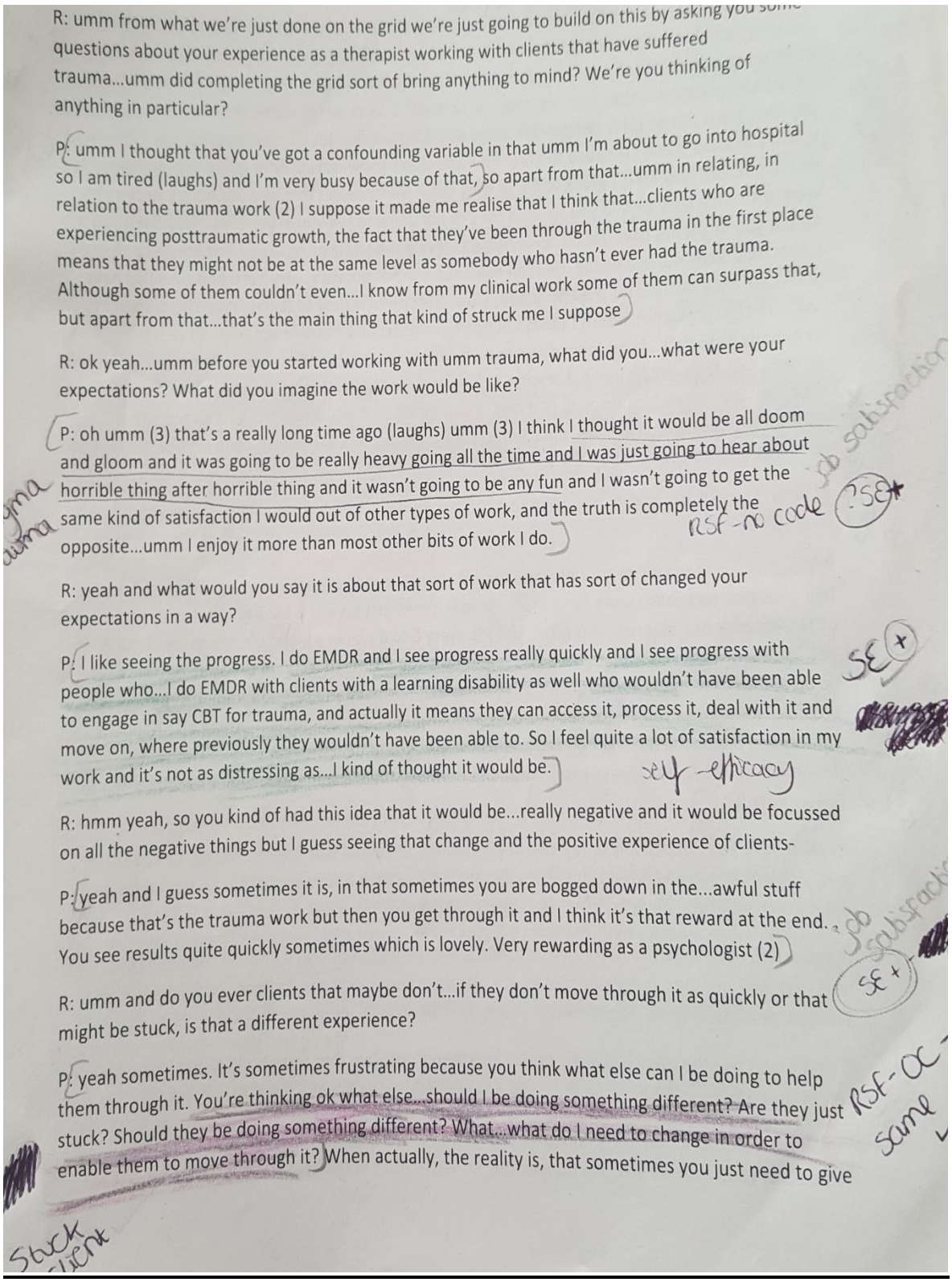
- Arnold, A. Calhoun, L. G., Tedeschi, R., & Cann, A. (2005). Vicarious posttraumatic growth in psychotherapy. *Journal of Humanistic Psychology, 45(2),* 239-263.
- Cohen, K., & Collins, P. (2013). The Impact of Trauma Work on Trauma Workers: A Metasynthesis on Vicarious Trauma and Vicarious Posttraumatic Growth. *Psychological Trauma: Theory, Research, Practice, and Policy, 5(6),* 570-580.
- Devilly, G. J., Wright, R., & Varker, T. (2009). Vicarious trauma, secondary traumatic stress or simply burnout? Effect of trauma therapy on mental health professionals. *Australian and New Zealand Journal of Psychiatry, 43(4)*, 373-385.
- McCann, I. I., & Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims*. Journal of Traumatic Stress, 3,* 131-149.
- Sabin-Farrell, R., & Turpin, G. (2003). Vicarious traumatization: implications for the mental health of health workers? *Clinical Psychology Review, 23,* 449-480.

Appendix J – Directive Coding Schedule

Category	Sub-category	Definitions	Coding Rules
Control	Self-control – positive	A sense of self-efficacy or power to influence the world/ events, feelings of independence, feel like they can be themselves around others	- Responses refer to the self (participant) - Positive responses only – participant feels they have control/can be themselves
	Self-control – negative	Feeling like they lack or have little control over events, helplessness, powerless, despair about the uncontrollable nature of others and the world, feelings of dependence, cannot be themselves around others	- Responses refer to the self (participant) - Negative responses only – participant feels they lack control or cannot be themselves around others. Different to other intimacy where they feel understood by others must communicate discomfort in being themselves
	Other-control – positive	Feeling able to manage or exert control over others in interpersonal situations, comfortable with others being in charge	- Responses refer to people other than the participant - Positive responses only –happy for others to have control or feel they have control over others
	Other-control - negative	Feeling unable to manage or exert control over others, needing to be available for others irrespective of own needs, uncomfortable with somebody else being in charge	- Responses refer to people other than the participant - Negative responses only – participant feels unhappy having others in control of them or not in control of others
Esteem	Self-Esteem – positive	Feeling valued by self and others, worthy, acknowledged and respected by others	- Responses refer to the self (participant) - Positive responses only – different to self-trust which includes trust in own clinical abilities this is a more general sense of positivity towards self
	Self-Esteem – negative	Feelings of self-blame, unworthiness, unable to help others, incompetent	- Responses refer to the self (participant) - Negative responses only

	Other-esteem – positive	Positive views about the worth of other people – people seen as good, kind, resilient, not to blame	- Responses refer to people other than the participant e.g. clients, family, friends, colleagues - Positive responses only
	Other-esteem - negative	Negative views about the worth of other people, disrespect towards others	- Responses refer to people other than the participant - Negative responses only – different to other trust which specifically questions the motives of others, this is a more general negative view of others
Intimacy	Self-intimacy - positive	Enjoy spending time alone, improved or seeking self-awareness	- Responses refer to the self (participant) - Positive responses only – participant may use time alone as a coping strategy or mention enjoying this time
	Self-intimacy - negative	Isolated, dislike being alone, feelings of emptiness when alone, try to avoid being alone, lack or avoid self-awareness	- Responses refer to the self (participant) - Negative responses only
	Other-intimacy – positive	Feeling connected with others, sense of being understood by others, seek others out to talk, deep relationships with others	- Responses refer to others in relation to the participant - Positive responses only – participant feels connected to others
	Other-intimacy - negative	Feeling alienated and disconnected from others, perceive others as not understanding or wanting to understand, others viewing their work as a trauma-therapist with disdain e.g. 'how can you do it?'	- Responses refer to others in relation to the participant - Negative responses only
Safety	Self-safety – positive	Feeling personally safe and secure, not in danger from self or others, able to protect self	- Responses refer to the self (participant) - Positive responses only – could take precautions but see as a positive if feel able to protect self
	Self-safety – negative	Feeling personally vulnerable and open to danger from self or others, taking more precautions to maintain their own safety e.g. self-defence classes, safety alarms, not going out in dark, more cautious, see life as more fragile, unable to protect self	- Responses refer to the self (participant) - Negative responses only - precautions based around fear, feel unsafe
	Other-safety – positive	Feeling others such as loved ones or people in general are safe from harm	- Responses refer to people other than the participant - Positive responses only
	Other-safety - negative	Worrying about the risk of harm or danger to loved ones or people in general, seeing life as more fragile, taking precautions to maintain the safety of others	- Responses refer to people other than the participant - Negative responses only
Trust	Self-trust – positive	Belief that the individual can trust their own judgements and perceptions	- Responses refer to the self (participant) - Positive responses only
	Self-trust – negative	Belief that the individual cannot trust their own judgements and perceptions	- Responses refer to the self (participant) - Negative responses only
	Other-trust – positive	Belief that they can trust other people – less cynical of others, seeing others' intentions as positive, can depend on others	- Responses refer to others in relation to the participant - Positive responses only
	Other-trust – negative	Belief that they cannot trust other people – more suspicious, more cynical of others, seeing others' intentions as negative, feel abandoned or disappointed by others	- Responses refer to others in relation to the participant - Negative responses only

Appendix K – Extract from a Worked Transcript (participant 5)



R: umm from what we're just done on the grid we're just going to build on this by asking you some questions about your experience as a therapist working with clients that have suffered trauma...umm did completing the grid sort of bring anything to mind? We're you thinking of anything in particular?

P: umm I thought that you've got a confounding variable in that umm I'm about to go into hospital so I am tired (laughs) and I'm very busy because of that, so apart from that...umm in relating, in relation to the trauma work (2) I suppose it made me realise that I think that...clients who are experiencing posttraumatic growth, the fact that they've been through the trauma in the first place means that they might not be at the same level as somebody who hasn't ever had the trauma. Although some of them couldn't even...I know from my clinical work some of them can surpass that, but apart from that...that's the main thing that kind of struck me I suppose

R: ok yeah...umm before you started working with umm trauma, what did you...what were your expectations? What did you imagine the work would be like?

P: oh umm (3) that's a really long time ago (laughs) umm (3) I think I thought it would be all doom and gloom and it was going to be really heavy going all the time and I was just going to hear about horrible thing after horrible thing and it wasn't going to be any fun and I wasn't going to get the same kind of satisfaction I would out of other types of work, and the truth is completely the opposite...umm I enjoy it more than most other bits of work I do.

R: yeah and what would you say it is about that sort of work that has sort of changed your expectations in a way?

P: I like seeing the progress. I do EMDR and I see progress really quickly and I see progress with people who...I do EMDR with clients with a learning disability as well who wouldn't have been able to engage in say CBT for trauma, and actually it means they can access it, process it, deal with it and move on, where previously they wouldn't have been able to. So I feel quite a lot of satisfaction in my work and it's not as distressing as...I kind of thought it would be.

R: hmm yeah, so you kind of had this idea that it would be...really negative and it would be focussed on all the negative things but I guess seeing that change and the positive experience of clients-

P: yeah and I guess sometimes it is, in that sometimes you are bogged down in the...awful stuff because that's the trauma work but then you get through it and I think it's that reward at the end. You see results quite quickly sometimes which is lovely. Very rewarding as a psychologist (2)

R: umm and do you ever clients that maybe don't...if they don't move through it as quickly or that might be stuck, is that a different experience?

P: yeah sometimes. It's sometimes frustrating because you think what else can I be doing to help them through it. You're thinking ok what else...should I be doing something different? Are they just stuck? Should they be doing something different? What...what do I need to change in order to enable them to move through it? When actually, the reality is, that sometimes you just need to give

them time to do it, in their own time. It's a big step for some of the clients I've worked with it's huge that they've even asked for help, and disclosed it. So...I think just having a little patience works wonders.

R: yeah umm if you could try and bring to mind a session with a client whose struggling with their traumatic experiences. You can either use someone recent or someone that's just stuck in your mind. Can you describe your experience within a session like that? What that's like for you?

P: umm...you feel their despair. Umm...I've had clients that have dissociated due to their...trauma, and they just...they can't even go close to it, and to try and bring them down...it...your adrenaline starts going sometimes...because you've got somebody that is highly distressed in front of you. Umm...but as you're able to manage their distress you calm down as well. Well that's my experience any way, but it can be (2) it can be a bit nerve wracking the first time it happens because (2) well with a particular client I suppose the first time you don't know how they're going to react...and (3) you're not sure how far it's going to go, or how much they haven't told you. Because you can only work with what they've told you so...and they're not going to tell you everything. They'll tell you a lot but you might not have got all...everything that might be bothering them. And I think...you can sometimes come out exhausted. Or I can come out exhausted, very, very tired and...like I've held onto all of their distress for the entire hour (2) at the end of it they're feeling much better but I'm shattered (laughs) umm, doesn't always happen. It can be very positive actually...if I've had somebody dissociate...bring them down and actually manage to get through some of that within the session, so it feels a really upbeat session. It feels really positive. It feels like we've managed the situation. We've both got through that and...I've supported them through it so it...it feels very collaborative but then there are other times where you just feel like you've been bombarded for an hour, which is quite overwhelming sometimes.

R: yeah (3) umm and how do you cope sort of after session where you do feel like you've been bombarded?

P: (laughs) cup of tea if I've got time, and umm if there's somebody around in the office, there's a few of us that do trauma work here and we'll sometimes just go and have 5 minutes with each other, because our supervision is great, but it's every 6 to 8 weeks so, and it's group supervision, so you can't always hold it for 6 to 8 weeks. Sometimes you just need a cup of tea and...be able to come down and to chat about it. And once you've done that normally you're fine. Umm, it's not always possible, sometimes you've got back-to-back appointments. Sometimes something else happens. Sometimes you're the manager on call and you've just got to deal with something else that's happened, so that's not always easy. Umm, but normally there's somebody about to have a cup of tea with (laughs)

R: yeah have you noticed any difference in yourself if you've had that opportunity to sort of spill it all out with somebody and have a cup of tea and then if you have had to sort of get on with your day, get on with what you have to do, when it gets to the end of the day?

P: yeah. I'm more tired. I'm more stressed, and I'm more agitated. And if I don't manage to deal with that, just for 2 minutes, it doesn't take long. I just need somebody else to hear...just to hear it and almost share it with them as opposed to just hold it all myself...umm

R: so it's a bit like the client's given it to you and then if you give it to somebody else it kind of takes a bit of that off-

P: yeah it's lessened it. Each time you give it to somebody else it lessens it slightly (laughs) umm...ahhh you know we are...we do look out for each other in this team. We've got a good team

here. And there's a few of us that do EMDR in particular, so we tend to get the...kind of the more high end trauma cases, so we look out for each other a bit. And if we've had a rough session, we have 5 minutes with each other and we...we do try and do that. Umm but yeah if I don't do it...I probably stomp around a little bit more (laughs) cos I feel a bit more overwhelmed by all the other tasks I've got to do that day

R: and what about when you get home?

P: umm (2) I'm probably more tired. It takes me a long time to drive home so...I release some of that stress on the drive home I think. But yeah, sometimes...when I get home I can think I don't want to do loads of things. I don't...or I might think...I might not want to walk the dog that night or something when actually I know if I do do that I feel a lot better. But sometimes it makes you feel you don't want to. It makes you lethargic. You can be a little bit more grumpy but that doesn't happen all the time.

R: yeah so it takes a little bit of motivation away?

P: yeah. It's not all the time, it's just...on occasions....yeah.

R: umm and what about when you were training? So you mentioned like the first time, you'd really like, listened to someone's trauma that was really...probably a bit more difficult. Was that during training or was that before or after?

P: oh it would be before training (3) yeah it would be before training, and I never really sat cos a few of my assistant jobs they weren't going to involve kind of trauma work and then one assistant job did and...to have somebody talk about all the awful things that have happened in their life and be so emotional about it in front of you, I did feel a little bit like 'oh my word what do I do here?' and I didn't have the resources. I was a bit green and (2) yeah I...now I look back and I think 'oh I could have done something differently there' but actually the client was alright and they just needed somebody to validate their experience and hear it, which is what I did, but...yeah it can make you think that you should be doing more.

R: yeah

P: but I've since learnt to listen to that a little bit better and cos I think that actually...that's their stuff that I'm picking up on, not mine.

R: yeah and would you say you felt well supported during training? What was your supervision and things like?

P: (2) umm in some of my placements it was great. In some it was terrible. It was...rubbish...umm which I pointed out at the time but umm no in...in some placements I felt really left on my own, and just told to get on with it. And I was...in that particular placement I was only a first year and I thought that was a bit rough. Umm in some of my placements it was excellent and...there was always someone to support me umm even when I didn't feel like I needed the support it was there...so, really varied actually. Yeah, depending on who you get.

R: did you notice any differences in, kind of, coping strategies you would then use if your supervision was a bit rubbish or if it was good?

P: umm I honestly can't remember, we're talking years ago (laughs) umm I don't know. I think there was a lot on anyway at the time umm I'm sorry I can't remember.

R: umm and then...if you can think about a client whose been really affected by their trauma and being with them, how would you say...if you could either bring to mind a specific client or people in general how do they sort of view themselves? What their kind of view of themselves tends to be?

P: ok the person I'm thinking about for that thought they were totally defective. They thought that they had no right to be on this earth. They...everything was their fault. They didn't deserve...to be who they were, to have a nice life, to enjoy themselves, to laugh, to be a teenager. They didn't believe any of that stuff, because of what had happened.

R: and what's that like for you trying to work with somebody...or hear that?

P: umm (4) I don't know...it...I...I...you can feel it. You can feel their pain sometimes but actually that just spurs me on a little bit because...I think 'no you do. You do deserve to be here' umm it makes me want to help them more and...it makes me realise though that sometimes I have to take things a little bit slower, like at their pace. If they're not ready to hear certain things or they can't...can't take them on board but umm (4) it makes me feel sad for them. It...I don't like the word pity it sounds awful, but actually it is nothing, it's...it's empathy. Nothing like that should have ever happened but it did. And that's awful. And we need to do something to help them, kind of...to be part of life and want to be part of life again.

R: yeah so it's difficult but it acts as kind of like a push and a motivator for you?

P: yeah. Yeah it does.

R: so I guess that kind of ties into the next question of how that's impacted your experience of working with them? Do you find when someone's got a view of themselves you have to alter the way that you work with them or...?

P: I think you have to be (2) you just have to go at their pace. You have to almost be kinder than you would normally because they can't be kind to themselves, so you have to...give them additional kindness (laughs) that sounds bizarre but it...it's almost, you have to help them feel validated, feel heard, because that's part of them starting to feel like a person....again. And once they can start to feel like they have a voice, then they can start to move through something. Umm (3) I don't know. I'm sure there's lots of other things that I do but...that are far more technical than that. But I feel I go slower...with them, cos they need more time. If the service allows it (laughs).

R: yeah I was just going to ask that. How does your service, kind of, fit in? Do you feel there's a pressure sometimes?

P: there's always a pressure to stick to a pathway. There has to be. And I understand it entirely. Umm but there are times when individuals don't stick to...well you can only have 12 sessions. It's unlucky. They need help, and they're going to get it, but...actually there is support here for that, but there has to be a very good reason for why you haven't stuck to what is normally offered. Which is fair and it's so everybody gets something equitable but...yeah, not everyone fits in that.

R: yeah so it's kind of that pressure of feeling like you have to go a bit slower with somebody but then also the pressure of you can't because of services and things?

P: it's not that I can't. I can I just have to prove why (2) umm and if it's ever questioned, I'm lucky that I'm in a position where...I'm one of the management team so I'm not questioned in quite the same way. If I make a decision it's...it tends to be alright. I'm questioned by my line manager and I have to evidence why I'm doing something but not quite in the same way as if I was one of the

nursing staff, which I'm...they will have just as many complex cases as I will (2) umm but they will probably be under slightly more scrutiny. Umm is that fair? Probably not but it is real (2)

R: hmm yeah...umm now if you can bring to mind a client who is starting to process their trauma and develop that sense of, like, personal growth through that umm in the way that they see themselves and the world. can you describe that experience, what that's like?

P: umm it's really rewarding, I really like seeing the look on their face umm when they suddenly realise something wasn't their fault. It's wonderful. It's like the best moment ever. They umm...I'm thinking of a particular person and she just, kind of, looked round the room cos, EMDR things can happen like that quite quickly, and she just goes 'I have never thought of it like that, oh my word' and she was grinning and giggling. Because she had never considered that all of that wasn't her fault.. She'd just assumed it was because it had happened so many years ago. And...I love that look. It's great. And for them to just...they suddenly...their posture changes. And their head goes up. And the shoulders go back. And they, kind of, float out your room at the end. And it's lovely. It's a really nice feeling, and that'll stay with you.

R: yeah so it's quite an immediate thing?

P: yeah. Yeah. It is, but it'll stay with you for the day as well. Everyone can tell when somebody's had a nice session with somebody cos they kind of float back into the room, into the office up there as well. So, everybody else kind of picks up on it as well I think.

R: yeah and what's that like for your identity, I guess, as a therapist?

P: oh it's very re-affirming. It's...it's great. It's umm...huh there's lots of times in this job where you don't get a lot of thanks and you get a lot of grief sometimes. You get people shouting at you. And it's one of those really good times where you're like 'I've had a really good session, they feel better because of it' and you think, that's why I do it. That's why I do my job. Yeah, it's a good moment. And I think actually I...I a comment from a lot of us that have trained in EMDR now is...we like it because it's fast. But we also like it because we get something back from it as well and that feels a bit selfish but actually it's...it gives you that quick...hit of reinforcement that sometimes you need...in a stressful job, that you're doing something and it's working and it's doing good. And we all came into it for that reason...so yeah.

R: that's good. Umm have you noticed any differences in yourself umm when you're working with clients that are still really struggling with their trauma compared to those that have got through that moment of growth and...realising it's not their fault?

P: (2) umm...no there's the immediate effects after the session...but no it'll all depend on far more things than whether I'm working with someone...whose experiencing trauma or not. Cos most of the time I'll always have somebody that's struggling at the same time I've got someone whose nearly at the end of their work and is about to be discharged so (2) no I don't think that's gonna impact on me...as a person, particularly that much.

R: yeah but is that, kind of, a conscious thing where you try to balance your caseload between-?

P: no it's literally just how it works in that you will normally have people that are in different stages of their therapy so you will have people that are doing really well and people that are struggling on your caseload at the same time. It's quite unlucky if you've got a whole caseload that's struggling. And my caseload is very varied any way cos I do other work apart from just trauma work. And so...it would never just be all people that are struggling with trauma. That would be way too heavy.

R: have you got specific things that you use or-?

P: I'll go out with my other half, go out with the dog umm lots of outdoors things helps. Like being outdoors is a real antidote to this kind of work. Umm (4) anything that I enjoy. Going to the cinema is wonderful, if you can, because you're totally kind of engulfed by something else. You get absorbed into it so you can't possibly think about anything else. Umm, but otherwise any kind of, any kind of activity where you have to think about it, so umm I used to snowboard, and that was great cos you physically can't, I'm terrible at it, but you can't concentrate on anything else cos you're gonna fall over otherwise. Which I quite like (laughs). So it works.

R: yeah and you just said something about you might think about the client just having such an awful life and then you might feel guilty, can you talk a little bit more about what you mean by that?

P: umm (2) like why should it happen to them? It shouldn't...it (sighs) but that's a wider thing. Those are wider questions in some ways because that...I don't believe that people should have to live through awful things happening to them and poverty and abuse and everything else. Those things should not have happened. And so then I feel responsible for that somehow, which is, I know, clearly ridiculous because I didn't hurt them. I didn't make them go through that situation but...I feel like I want to help more than I do. So you feel guilty for that. Even though rationally I know that that's ridiculous and I am helping by doing my job.

R: so do you get a lot of those kind of questions like 'why did this happen to this person?'

P: no, not lots, just...every now and then. No, it's not why did it happen. It's 'it's not fair it happened to them'. I don't particularly think about the why at all. Maybe that's bad but I don't. it doesn't enter my head. It appears in my head in clinic but not outside of it at all. I just think 'that's really unfair, what have they had to live through that?' it...it shouldn't have happened. You know, and then you think (2) there are lots of bad people in the world. When actually then you can rationalise that again and think actually loads of things have happened to those people and there's a reason they behaved in the way they behaved etc but then you go round and round in circles and it becomes work. And you need to just shut off.

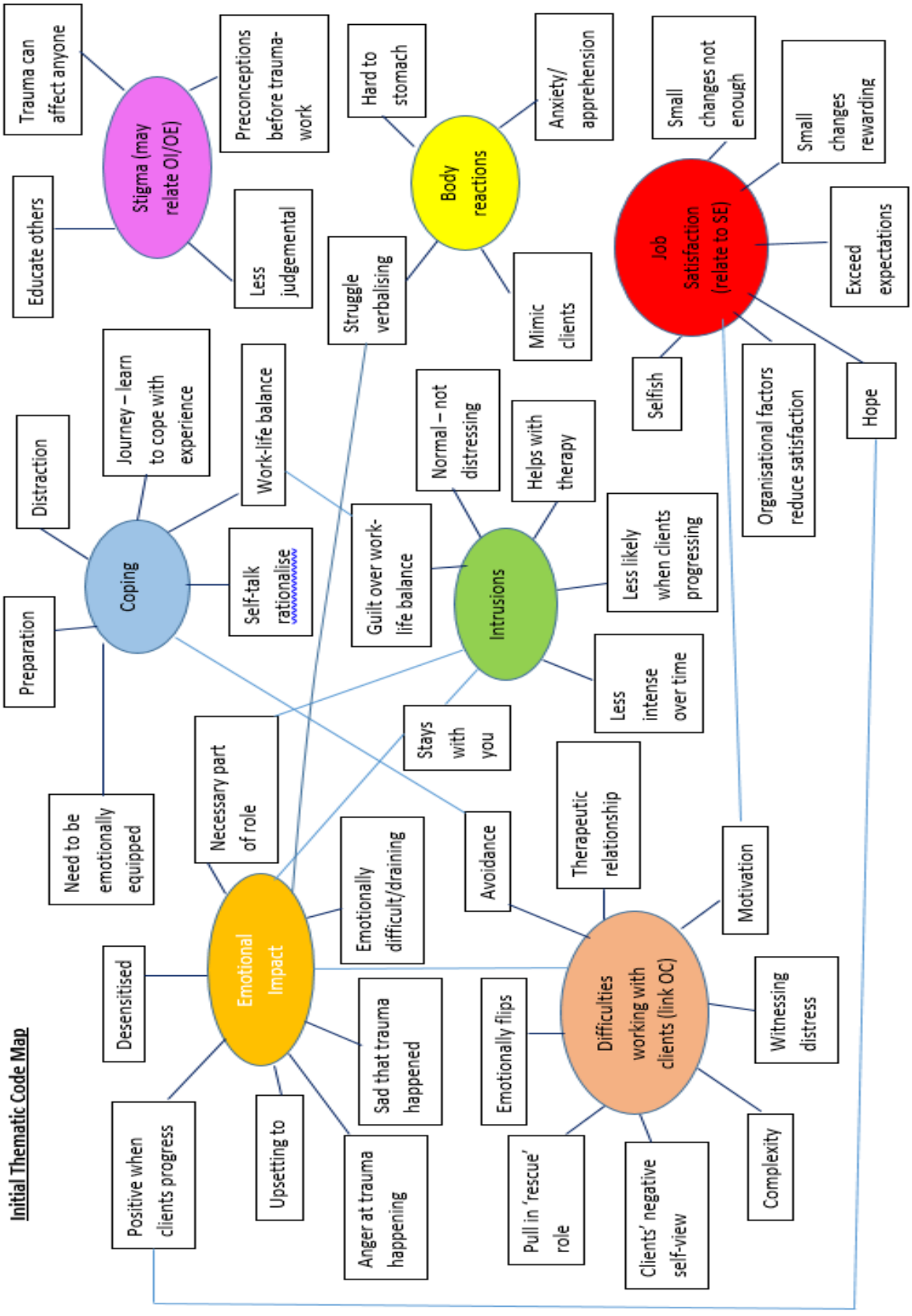
R: yeah so you try and distract yourself?

P: yeah, otherwise you end up in some sort of work spiral. It's not good.

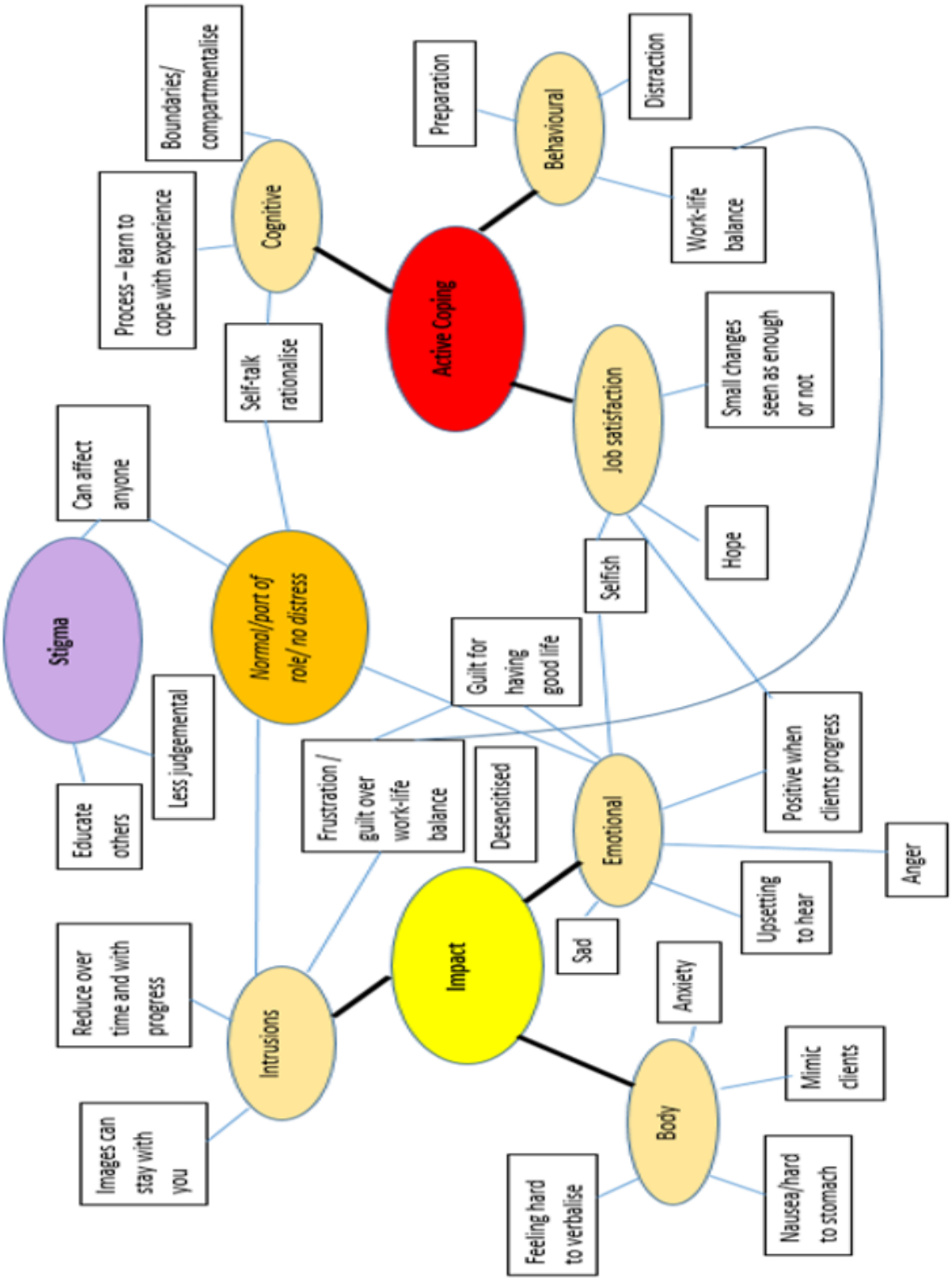
R: umm what do you think, I guess we've kind of touched on this but what's the most positive thing about working with trauma? What kind of drew you to wanting to work with trauma?

P: umm (2) I was interested in EMDR as a technique, particularly, and I liked that it was quick and I liked that you didn't have to talk about everything, because there are lots of clients that I would see that don't want to tell you what happened, and they can tell you a little bit but they don't want to tell you what happened. Which therefore makes them useless to do exposure-work. You can't do it. It...they can't go there. They're not resourced enough to be able to do it. So I really liked the idea that there was a type of therapy that A worked umm I kind of understood the biology of it which I enjoy and then...I liked that they didn't actually have to tell you everything and it could still work cos I thought that was quite empowering for the clients because some of the kids...don't have the words. And then some of them do have the words but don't want to share it, and it's just too much. And I'd rather they got some help rather than no help because if the option is I either tell you everything or you don't get help, there needs to be a middle ground and...EMDR is it for me. I know it won't be for everybody but I really like that. Umm (2) and also it could be the biggest thing that's happened to them that could really effect their life and if you deal with it early, that's why I work

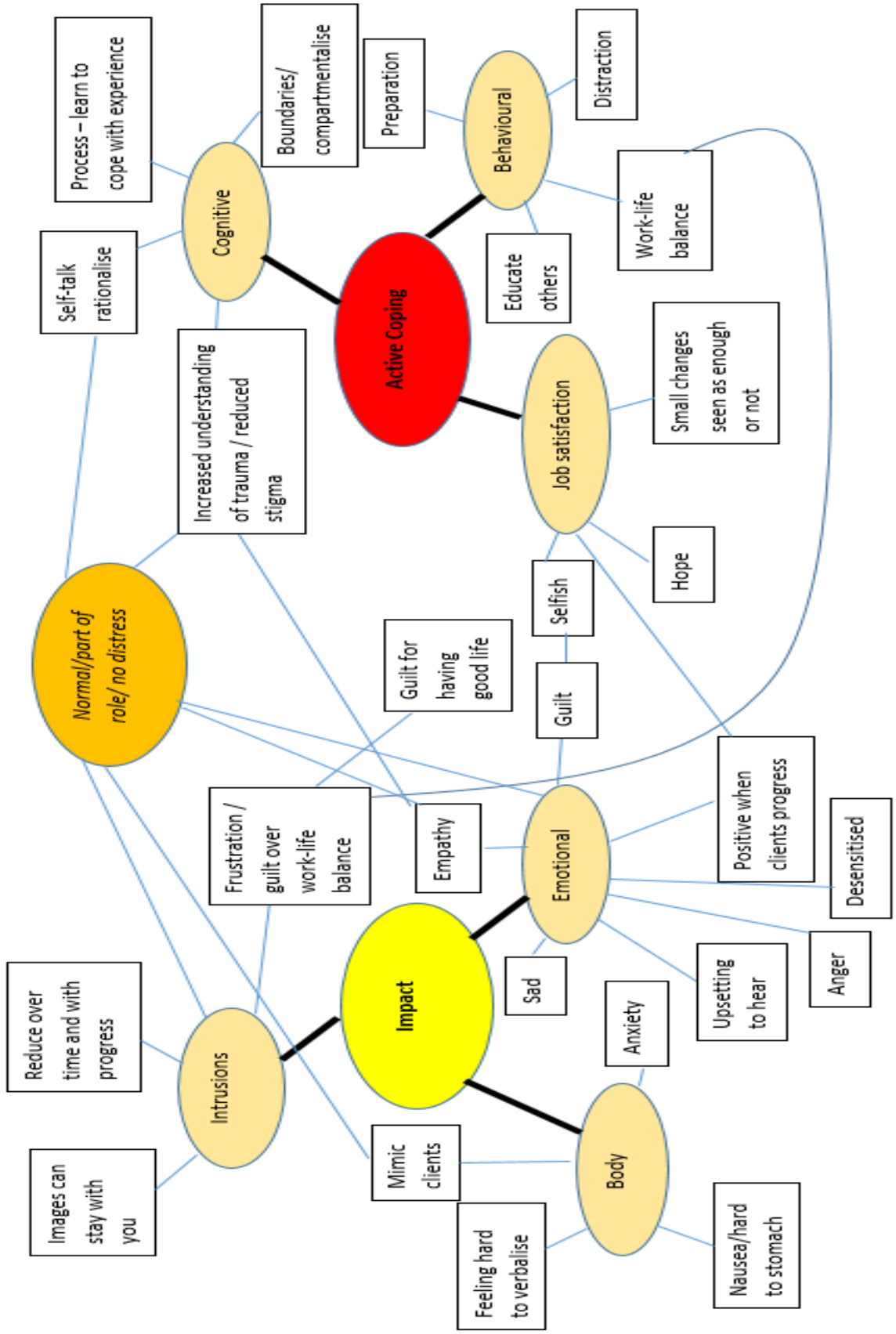
Appendix L – Initial Thematic Map (containing all codes)



Appendix M – Refined Thematic Map



Appendix N – Final Thematic Map with Corresponding Codes



Appendix O – Further examples of data Extracts for each theme – Inductive Thematic Analysis

Participant	Theme/Sub-theme	Extract
14 - trainee	Impact – Intrusions - Normalisation	'*you might have an image of something that they shared or something umm but that's probably normal…I would just see that as being normal that you're going to think about stuff that people tell you'* – this highlights the normalisation process that occurs as a result of making sense of intrusive thoughts about clients out of work.
19 - trainee		'*I'm not too hung up on them really. Umm (2) it's sort of, I think from doing a lot of work from people around me with intrusive thoughts I've come to…I don't judge them'* this trainee talks about using her therapeutic experience to make sense of intrusive thoughts, reducing any impact they have.
9 - qualified		'*oh I wonder how she's doing'...I don't mind. I think it would be unusual if I didn't have any thoughts'* this qualified therapist talks about how she views thoughts about clients outside of work as such a normal part of the role it would feel strange if she did not experience them.
10 - qualified		*'rather than a getting caught up in it...I think it's a natural thing. It feels like to me it's a natural part of the process. If you're involved in people's life stories that…I don't know, I just can't…can't see how you can shut off after an hour. Umm, as soon as they walk out the door it's like they don't exist'* again this therapist talks about how it is a normal part of working empathically with people.
15 - qualified		'*clients in mind in between sessions is something that is inevitable umm (2) and is necessary for…umm therapy to continue, to be effective'* this therapist extends normalisation of intrusions to conceptualise them as something necessary for effective therapy, applying a positive attribution to this experience.
6 - qualified	Intrusions – guilt/frustration	*"horrible…because of the…thoughts that I was having…frustrating as well because it then takes over my personal time*' – this therapist talks about feeling frustrated by intrusions impacting on her home life
8 - qualified		*'it's hard cos you…I think there's an awareness you don't want to be thinking about clients out of work. I like my work to be separate to my home life so…I do notice…I perhaps try not to and try to ignore that'* this therapist also talks about wanting to keep work and life separate, so finds she tries to ignore intrusive thoughts but finds this hard
16 - qualified	Bodily – negative - sick	*'quite a strong disgust reaction, which I think I concealed in the session, but I was quite aware of, but I was quite aware of after the session. It made me feel quite sick'* - this therapist describes a strong physical reaction to the client's trauma experience as well as an active effort to conceal this from her client. She seems to contain this during the session then allow herself to experience it after. She went on to talk about what she did to cope

		with this experience, leading onto the theme 'active coping'
8 – qualified		*'I didn't want to be sick but I had a kind of a…a…a reflex, reflux reaction that umm so I felt myself swallowing an awful lot, trying to control…the kind of anxiety'* – this therapist also talks about making an effort to contain the physical sensations felt within the session, highlighting the demands placed on therapists working with trauma to act as a container for clients.
19 - trainee		*'actually hearing a person who's had that done to them…it just…it's not comfortable and I suppose yeah, it's a real…just a small level of nausea'* - this therapist highlights the discomfort, although does not experience such a strong physical reaction as the others describe.
5 - qualified	Emotional - sad	*'it makes me feel sad for them. It…I don't like the word pity it sounds awful, but actually it…it's empathy. Nothing like that should have ever happened but it did. And that's awful'* – this therapist describes her sadness for the things that happened to a client, but relates this to empathy, which is an essential part of therapy. She highlights the negative emotional impact on herself of this therapeutic process.
9 - qualified		*'I think I'm more (2) part of me feels sad in some respects…that umm…becoming aware of how prevalent childhood abuse is'* – this therapist relates her sadness to the realisation of trauma prevalence in general rather than to direct client experience, a more global effect of working with those who have experienced childhood abuse.
3 - trainee		*'I think some people's lives are generally very sad. There are no answers for some of the things that have happened to some people'* – this trainee talks about not being able to make sense of the trauma that her clients experience, resulting in sadness that these things happen.
16 - qualified	Emotional – hard to hear	*'I'd feel quite tired after sessions. Felt like I'd been kind of pulled around a bit kind of emotionally'* - this therapist relates the emotional impact of trauma work to physical reactions of fatigue.
9 - qualified		*'somebody was describing in quite graphic detail, and they were struggling with that, and it's quite…that was quite hard to hear'* – this therapist highlights how the level of detail required for trauma work can be emotionally difficult to listen to.
1 - trainee		*'I found it really hard to listen to umm...I used to cry quite a lot after the sessions…like umm because I'd be quite upset'* – this trainee reflects on the emotional release after containing her reaction to client trauma within sessions.

12 - trainee		*'you do take on…some of the feeling that goes with it…like that you hear it… to a certain extent you do experience it. Umm and that that's difficult and that particularly if, like if you're seeing a number of people…that's a difficult kind of like burnout-type scenario'* – this trainee discusses feeling the emotions that clients are feeling and how this can have a negative effect if she is seeing a number of clients due to the high level of emotions felt.
19 - trainee		*'to put that into words umm…it requires more verbal detail than perhaps they've ever even said out loud which…you know I didn't expect that that would happen umm so I heard a lot of things in detail that I didn't expect to hear. Umm…and…sometimes got like a little bit emotional'* – this trainee reflects on how listening to the details of client trauma was more upsetting than she had expected prior to training.
14 - trainee	Emotional - desensitisation	*'I've never been really, you know, been kind of…very…very badly effected by something that I've heard. That could just be a desensitisation'*
19 - trainee		*'I suppose, once you've heard it once or twice, even the different stories, once you've got used to thinking 'oh ok I am going to hear really…really horrible stuff' you sort of manage…you get prepared for that I suppose'* – this trainee reflects on desensitisation as a positive experience which helps her prepare for listening to client trauma.
10 - qualified		*'I'm fairly unshockable now umm some of the stories I've had have kind of…gone beyond what I had imagined would happen in real life'* – this therapist relates the desensitisation to his expectations and a change in his worldview.
17 - trainee	Emotional - normalisation	*'although it does have a negative impact on you emotionally I think that's all part of the process so I wouldn't necessarily class that as…one of the most negative things. It's not pleasant to experience but…it's part of the work and I think you learn from it as well'* – this trainee discusses the negative emotional impact but normalises it as part of the work and takes a positive from it in terms of therapist development.
15 - qualified		*it can feel, at times, unbearable…umm…but by giving it words, by bringing it out and by having someone that is bearing witness to it then that….is hard but necessary* – this psychiatrist also discusses the negative impact as being a normal and required aspect of therapy.
9 - qualified	Active coping - job satisfaction - hope	*'hopeful and looking forward to the point at which…they're going to have worked through it and they're at that desired place, with that positive belief. Umm (2) and…I guess that…thinking about that helps*

		through this bit, because it's kind of, umm (3) yeah being able to see into the future' – this therapist discusses holding previous clients' progress in mind as a way of helping her cope with clients who are still struggling with their trauma.
8 – qualified		*'it gives you more hope, when you see the therapy working so, even when I'm with somebody who's still kind of in that place where they're just not…able to move forward or it's just not happening and it's taking a bit longer and we're having to…work a bit harder, there is still that hope'* - this therapist discusses a similar way of using hope as a coping strategy.
12 - trainee		*'someone that kind of is making progress, it feels a bit more like…kind of because they're looking a bit more to the future that you can too…you feel kind of more hopeful going in'* – this trainee talks about the hope felt when they see positive progress in clients.
3 - trainee		*'why you do the job because you want to help people through their journey and see people at the end of it'* – this trainee uses hope as motivation for her role.
18 - trainee	Active coping – job satisfaction - rewarding	*'you go through the kind of tough times…seeing them kind of work through that and do something with that...to…feel a bit better about themselves…so…is rewarding'* – this trainee recognises the difficult aspects of her work but finds satisfaction in watching clients make progress.
5 - qualified		*'I thought it would be all doom and gloom and it was going to be really heavy going all the time and I was just going to hear about horrible thing after horrible thing and it wasn't going to be any fun and I wasn't going to get the same kind of satisfaction I would out of other types of work, and the truth is completely the opposite…umm I enjoy it more than most other bits of work'* – this clinical psychologist discusses her prior expectations of trauma work being difficult and unenjoyable but how experience has led to it being the most rewarding work she does.
10 - qualified		*'the shift for people is a lot, lot slower than I had first, you know, before I was ever working in psychology, it's a lot slower than I thought it would be. Umm…but still rewarding at the same time'* – this psychologist explains that changes are slower than he had expected but how he is still able to take some satisfaction from this.
16 - qualified		*'when therapy works out, seeing the difference that makes to somebody's life, umm and how debilitated they…perhaps were and seeing them make that progression...I think it can be really rewarding. Umm (2) although hard work'* – again this therapist recognises the

		difficulty of the job but is also able to take a positive from this related to observing client progress.
3 – trainee	Active coping – job satisfaction - selfish	*'guess that's the selfish bit in that I get enjoyment out of supporting people and helping people'* – this trainee feels selfish for the enjoyment she feels from helping clients.
5 - qualified		*'feels a bit selfish but actually it's…it gives you that quick…hit of reinforcement that sometimes you need…in a stressful job, that you're doing something and it's working and it's doing good.'* – this therapist talks about observing client progress as a motivator for her job but feels selfish for hanging on to this.
10 - qualified		*'it's definitely the, selfishly, the best bit of the job, because I get to be part of someone's…the good bit of someone's journey. Umm and I'm feeling like I might have, in some way, contributed towards that'* – this therapist feels selfish for recognising their part in client progress.
2 - trainee	Active coping – behavioural – work-life balance	*'I've had to be quite strict with myself umm to keep the balance umm'* - this trainee talks about the importance of having work-life balance but how this can be difficult to keep due to the previously discussed 'rescue-role' triggered by the work, so having to keep strict boundaries.
1 - trainee		*'activities and stuff in the evening so I go home from work then go and do something else, it's almost like taking my mind of it kind of thing (4) yeah I think those are the main sort of ways I guess I tried to cope with being upset'* - this trainee discusses the value of distraction with activities she enjoys at home in helping her cope with the emotional demands of work.
18 - trainee		*'I try and have what I feel like is a decent enough balance of work and life. Like I (3) I don't know how much, I don't know, I think over the years anyway I think I've got better at…you know not kind of taking stuff home'* – this trainee reflects on how her ability to maintain a work-balance has become better with experience.
9 – qualified		*'I think work-life balance and all of that kind of stuff helps'* – this clinical psychologist sees work-life balance as helpful in coping with the emotional demands of trauma work.
15 – qualified		*'recognising the differences between work and outside of work, and the importance of trying to keep that boundary as much as possible, umm for your own wellbeing'* – this therapist sees work-life balance as being important for his wellbeing.
13 - trainee	Active coping - cognitive	*'pop up in my head umm (2) and I guess how I managed that at the time was to…kind of remind myself of…of their histories'* - this trainee manages intrusive thoughts about client self-harm by engaging in a process of

		meaning-making to understand why they use this to cope and reduce her distress of thinking about them doing this.
7 – qualified		*'I sort of developed strategies to be able to, kind of, disconnect. And I guess I only really, kind of, learned them following doing the work'* – this therapist talks about how she only realised she needed to develop ways of coping by experiencing the distress of trauma work.
6 – qualified		*'stay rational (laughs) and then think well actually rational tells me this but yeah I do cope with it like that'* – this therapist refers to balancing the automatic negative vicarious trauma thoughts with more rational thoughts.
4 – qualified		*'when you get those kind of thoughts it's just justifying it in your own head'*
15 – qualified		*'kind of defuses the contextual and emotional umm…consequence of that thought. So it's like 'oh well that's why it is''*- this therapist engages in a similar process of making meaning of the thoughts she is having to diffuse distress
16 – qualified		*'reminder of…that's her life not mine…and going about kind of my daily tasks…the differences I guess between my life and hers would help me with that kind of separation'* – this therapist spoke about reminding herself that her life was separate from her clients to help reduce the distress she experienced.

Appendix P – Extracts from Reflexive Diary

1st March 2016

I was nervous about doing my first interview today. I was worried that I would forget how to do a rep grid or that I would struggle with the interview and eliciting more information from her. However, she was very welcoming and we had an informal chat about our experiences of training as she was also in her second year but on another training course. Our course started research a lot earlier it seems as her research was still in the stage of development. She spoke about needing participants at a later date, which made me think about motivation for participation and whether the shared stress of recruitment was her reason for taking part. She spoke a lot about varied experiences of supervision and the impact this had on her experiences of trauma work. This introduces a potential confounding variable which may impact VT experiences, although this is something I remember being covered in the literature and it does relate to the 'intimacy' belief within CSDT in terms of being able to talk openly with others about experiences. She also spoke about comparing herself to supervisors and worrying about her skills, whether they are good enough or qualified enough to help people who have experienced trauma. This is something I could relate to as what seems like a common worry for trainees, based on my own cohort.

17th March 2016

Just met with my third participant (trainee). She spoke about something which resonated with my beliefs about trauma work. She saw the word 'trauma' as a broad concept relating to all mental health problems, not just PTSD. Anything which a client experiences as distressing can be conceived as trauma. I guess it's the case of 'small t' 'big t' that is discussed in trauma literature. Most of the VT literature focuses on therapist exposure to 'big t' traumas that are difficult to hear, military combat, abuse, violence and natural disasters. Maybe I should have made this clearer in my recruitment in terms of looking at the effects of listening to 'big t' traumas. Although it made me wonder whether there is a difference between the two. Obviously 'big T's' are more shocking to hear and probably more gruesome, but 'small t's' also connect with the client's emotional pain so could also result in VT. They are also more relatable everyday things that therapists may be more likely to have experienced which may trigger reminders of their own distress. I'm not sure if any literature exists on 'small t's' and VT but it made me think about the impact different trauma experiences may have, and how it may vary the VT effects. She also spoke about the difficulties of working with someone who has a very negative view of themselves and the difficulties associated with this which I can relate to. It's very sad to hear somebody talk about themselves as worthless when you can see their strengths and resilience.

2nd September 2016

Feeling quite overwhelmed by the amount of data that I have. I recall a participant speaking to me about this and feeling like I was asking too much of people with the three different methods of data collection. It now feels like she may have been right! I need to focus back on the main aims of my research which was to look for evidence of vicarious trauma relating to the belief areas of CSDT across different methods of data collection and bring this together. I am unsure how to bring all the findings together but have research supervision coming up so I can discuss this with my supervisor. Currently feel a bit lost in the data and unsure where to start, but also don't want to lose valuable data that people have taken their time to share with me.

5th September 2016

Just had research supervision, my supervisor agreed that I probably have enough data for more than one paper. The importance of clear research aims is now apparent as I have a plan of what I need to do to answer my research questions. There are many other interesting analyses which could be applied to the rep grids but they are not directly related to my research question so I will put them to one side for now. I still feel overwhelmed by the amount of work I have to do but we have gone over the coding agenda for the directed coding analysis and I feel like this is workable as it gives me something to look for in the data rather than going in blind. However, I'm now concerned about how 'inductive' my later thematic analysis can really be as I will have already been guided by theory and previous research when coding the transcripts. You can't just switch off that knowledge when doing the thematic analysis. However, I guess the aim of the TA is to identify any important factors discussed by participants which are not covered by existing theory so maybe it isn't so problematic.

10th October 2016

Me and my supervisor had both coded another transcript separately as another check of reliability. The agreement was better this time but there were still areas we disagreed on. We were able to discuss these and reach a consensus but it became clear that some areas of the CSDT theory have considerable overlap, making it difficult to code them. We reflected on why this may be. The areas that we confused the most were control and esteem. Often it appeared one part of the quote related to one which then affected the other, so if somebody felt in control over therapy they felt better about themselves as a therapist. I guess this has implications for CSDT and measures like the TABS which treat each area as mutually exclusive but they do appear to overlap and affect each other.

Appendix Q – Author Guidelines for 'Traumatology'

Retrieved from: http://www.apa.org/pubs/journals/trm/?tab=4 (on 28/12/16)

Prior to submission, please carefully read and follow the submission guidelines detailed below. Manuscripts that do not conform to the submission guidelines may be returned without review.

Submission

Submit manuscripts electronically through the Manuscript Submission Portal.

Brian E. Bride, PhD, MSW, MPH
Georgia State University School of Social Work
General correspondence may be directed to the Editor's Office.

In addition to addresses and phone numbers, please supply email addresses, as most communications will be by email. Fax numbers, if available, should also be provided for potential use by the editorial office and later by the production office.

Manuscript Preparation

Manuscripts submitted to *Traumatology*® should be prepared in accordance with the *Publication Manual of the American Psychological Association*, 6th Edition (2010).
Review APA's Checklist for Manuscript Submission before submitting your article.

Formatting

Double-space all copy. Manuscripts should be 30 pages and under (not including references and tables/figures). Other formatting instructions, as well as instructions on preparing tables, figures, references, metrics, and abstracts, appear in the *Manual*. Additional guidance on APA Style is available on the APA Style website.
Below are additional instructions regarding the preparation of display equations, computer code, and tables.

Display Equations

We strongly encourage you to use MathType (third-party software) or Equation Editor 3.0 (built into pre-2007 versions of Word) to construct your equations, rather than the equation support that is built into Word 2007 and Word 2010. Equations composed with the built-in Word 2007/Word 2010 equation support are converted to low-resolution graphics when they enter the production process and must be rekeyed by the typesetter, which may introduce errors.
To construct your equations with MathType or Equation Editor 3.0:
Go to the Text section of the Insert tab and select Object.
Select MathType or Equation Editor 3.0 in the drop-down menu.
If you have an equation that has already been produced using Microsoft Word 2007 or 2010 and you have access to the full version of MathType 6.5 or later, you can convert this equation to MathType by clicking on MathType Insert Equation. Copy the equation from Microsoft Word and paste it into the MathType box. Verify that your equation is correct, click File, and then click Update. Your equation has now been inserted into your Word file as a MathType Equation.
Use Equation Editor 3.0 or MathType only for equations or for formulas that cannot be produced as Word text using the Times or Symbol font.

Computer Code

Because altering computer code in any way (e.g., indents, line spacing, line breaks, page breaks) during the typesetting process could alter its meaning, we treat computer code differently from the rest of your article in our production process. To that end, we request separate files for computer code.
In Online Supplemental Material
We request that runnable source code be included as supplemental material to the article. For more information, visit Supplementing Your Article With Online Material.
In the Text of the Article
If you would like to include code in the text of your published manuscript, please submit a separate file with your code exactly as you want it to appear, using Courier New font with a type size of 8 points. We will make an image of each segment of code in your article that exceeds 40 characters in length. (Shorter snippets of code that appear in text will be typeset in Courier New and run in with the rest of the text.) If an

appendix contains a mix of code and explanatory text, please submit a file that contains the entire appendix, with the code keyed in 8-point Courier New.

Tables

Use Word's Insert Table function when you create tables. Using spaces or tabs in your table will create problems when the table is typeset and may result in errors.

Submitting Supplemental Materials

APA can place supplemental materials online, available via the published article in the PsycARTICLES® database. Please see Supplementing Your Article With Online Material for more details.

Abstract and Keywords

All manuscripts must include an abstract containing a maximum of 250 words typed on a separate page. After the abstract, please supply up to five keywords or brief phrases.

References

List references in alphabetical order. Each listed reference should be cited in text, and each text citation should be listed in the References section.
Examples of basic reference formats:
Journal Article:
Hughes, G., Desantis, A., & Waszak, F. (2013). Mechanisms of intentional binding and sensory attenuation: The role of temporal prediction, temporal control, identity prediction, and motor prediction. *Psychological Bulletin, 139,* 133–151. http://dx.doi.org/10.1037/a0028566
Authored Book:
Rogers, T. T., & McClelland, J. L. (2004). *Semantic cognition: A parallel distributed processing approach.* Cambridge, MA: MIT Press.
Chapter in an Edited Book:
Gill, M. J., & Sypher, B. D. (2009). Workplace incivility and organizational trust. In P. Lutgen-Sandvik & B. D. Sypher (Eds.), *Destructive organizational communication: Processes, consequences, and constructive ways of organizing* (pp. 53–73). New York, NY: Taylor & Francis.

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