UNIVERSITY OF DERBY

WORKING WITH PSYCHOLOGICAL TRAUMA:

AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS OF TRAUMA-FOCUSED CBT AND EMDR

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Just one more piece of research before I'm done...
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Abstract

Purpose: The Diagnostic and Statistical Manual of Mental Disorders (DSM-5*)* criteria for post-traumatic stress disorder (PTSD), acknowledged repeated or extreme indirect exposure to aversive details of traumatic event(s) in the course of professional duties, can lead to symptoms of PTSD. This has led to discussions around impact and prevalence of vicarious trauma in psychological therapists treating trauma clients. This study considers how therapists delivering trauma-focused cognitive behavioural therapy (CBT) and eye movement desensitisation and reprocessing (EMDR) make sense of their experiences and protect themselves from any negative effects of the work. Furthermore, it considers if there is a distinction in therapist experience between the two modalities.

Methodology/Method: An Interpretative Phenomenological Analysis (IPA) was conducted to explore how trauma-focused CBT and EMDR therapists engaged in trauma work, interpreted and made sense of their experiences; with a view to identifying any protective practice that informed clinical practice and helped ameliorate vicarious trauma. Recorded, semi-structured interviews were conducted with CBT and EMDR therapists (N=11). Before analysis, interviews were transcribed verbatim and sent to individual participants for validation of their authenticity. Data was analysed using descriptive, linguistic and conceptual comments to identify an initial seventy nine emergent themes. When refined, four master themes of ‘Nature of Trauma’, ‘Participant sense of self and managing the process of hearing trauma narrative’, ‘Participant experience of delivering the trauma models’ and ‘Protecting and sustaining the participant sense of self’ were identified to answer the research question and are discussed herein.

Findings: This study forms part of the growing body of evidence towards understanding therapist vicarious traumatisation. It both supports and challenges findings of previous studies. It also introduces new concepts in relation to the vicarious trauma phenomenon. Whilst there are clear limitations associated with making generalisations from an IPA study, the findings from the study suggest EMDR may be a protective factor against the negative effects of hearing repeated trauma narrative. Furthermore, certain strategies such as time management, comprehensive trauma training and specific trauma supervision, may also reduce the negative effects of hearing trauma narrative. Finally, regardless of the difficulties faced, therapists enjoy their trauma work and feel a great sense of professional satisfaction.

Implications/Recommendations: Indications from the findings of the study are that therapists working within primary care in particular, are becoming increasingly pressurised by cuts to funding within mental health services. Recommendations are that those components of trauma work which promote therapist wellbeing

should be supported. In particular, realistic timeframes within which to work, good quality training and supervisors, ideally external to the workplace, who can provide trauma-specific supervision.

Chapter 1: Introduction

1.0. Introduction To The Study

I initially assumed my interest in trauma work started when I began primary care work. Having reflected on my doctoral journey, now I believe this interest started many years before and has been an ongoing development. My introduction to trauma was in 1987, when I joined the Special Constabulary. Throughout my eleven years service there were constant reminders of how people responded and dealt with traumatic situations. After resigning from the force, I felt I had a huge gap to fill and began working with a local rape and sexual abuse service in a voluntary capacity. From this work, I went on to train and qualify as a counsellor.

Through continual professional development and the arrival of the government initiative, ‘Improving Access to Psychological Therapies’ (IAPT) service (Department of Health, 2007a), I trained and qualified as a cognitive behavioural therapist. The National Institute for Clinical Excellence guidelines for Post-Traumatic Stress Disorder recommends the use of trauma-focused cognitive behavioural therapy (CBT) or eye movement desensitisation and reprocessing (EMDR) when treating traumatised clients (NICE, 2005). Through my primary care work within an IAPT service, my interest in trauma work developed further and I was fortunate enough to train in EMDR.

An important quality strategy in Interpretative Phenomenological Analysis (IPA) is to ensure transparency. I am thus stating my position in this study. I have eighteen years mental health experience. I am an accredited therapeutic counsellor with the British Association for Counselling and Psychotherapy (BACP), an accredited cognitive behavioural therapist with the British Association for Behavioural and Cognitive Psychotherapies (BABCP) and an EMDR therapist trained to level 3. I work in private practice with adults and children aged seven and above. I also work in primary care with adults and adolescents over sixteen. My primary care work is on a part-time basis for two days a week with a private company who are a National Health Service (NHS) provider. Although trained in both trauma

modalities, my preference is towards EMDR. This stems from personal experience of working with trauma clients and witnessing their post-traumatic growth. Throughout the research process, I have been sensitive to my preference. To ensure transparency, I have discussed this and any other potential influences that have arisen within doctoral supervision and have been aware of these when making interpretations within the analysis phase of the study.

My motivation for carrying out this research developed from my personal experience of trauma work and its impact on my professional and personal life. Any psychological, physiological and behavioural changes experienced by me over the course of my trauma work, similar to those changes discussed by my participants within this study, have been supported with in-house individual and group supervision provided by my employer and enhanced by private supervision funded by myself, with an emphasis on self-care.

My thesis was born from issues arising in my CBT/EMDR clinical supervision group meetings. Frequently on the agenda was the difficulty of balancing client care whilst taking care of ourselves. Our discussions led me to consider how other therapists support themselves when working with difficult trauma cases. During these discussions, increased stress levels and feelings of responsibility for the recovery of our fragile clients were frequently explored. Often anxiety stemmed from having doubt in appropriate treatment timeframes or the courage to therapeutically hold our trauma clients as they revisited their darkest moments; and the fear that as therapists we may somehow 'make them worse'. This fear was sometimes based upon our personal belief systems, clinical skills or how we as individual therapists, felt we may be supported or judged by our employers, other professionals and our clients. On reflection, my CBT/EMDR group supervision has been particularly invaluable in supporting the isolation that comes from lone working. Listening to colleagues discussing their individual difficulties has not only given me food for thought and new ways of working with clients, but an insight into the coping strategies of others.

Whilst I am very aware of my preference towards EMDR and try not to let this influence client treatment choice, I questioned why I preferred this method over trauma-focused CBT. Was there anything about how I or the client was affected during the treatment process that either consciously or sub-consciously maintained my preference? Does hearing sensitive material make the job harder? What protective practices in general help maintain therapist wellbeing? Many of my questions could not be answered by a review of the current trauma literature alone. I therefore decided to undertake this piece of innovative research to add to the body of research in this field.

My doctorate journey truly started on the train home from the Derby University induction days. Armed with various text books, I was hopeful these would give me a framework with which to start the process. Whilst reflecting on what I was about to embark upon, my usual feelings of excitement and apprehension when starting a new venture arose. I was comforted by the relative ease with which my peer group had gelled and reassured by their voiced concerns that I wasn't on my own.

On reflection, the journey has been a long and difficult process. At times, I have struggled with confidence, writing styles and the isolation that comes with distance learning. I have revelled in the joy at getting through the ethics board on first submission and being commended by the committee for my 'exemplar' application. I have learnt the important of using doctoral supervision, enjoyed the camaraderie with peers and most of all, felt proud that I've come so far.

The literature review for this study highlights the difficulties faced by therapists engaged in trauma work. Studies that contribute to existing knowledge and inform clinical practice are important in understanding these difficulties further. The aim of my thesis is to explore the experiences of CBT and EMDR therapists engaged in trauma work, with a view to identifying protective practices that may inform clinical practice and help ameliorate vicarious trauma. The study is an original piece of research which is qualitative in design, independent of any employed position and

self-funded. Interpretative phenomenological analysis (IPA) (Smith, Flowers & Larkin, 2009) is used for this study. IPA is concerned with detailed examination of the lived human experience.

All decisions to participant in the study were on a voluntary basis. Participants were firstly recruited through an independent primary care provider for whom I work two days a week. From this, a snowballing strategy was used to identify further participants. In addition, a request for participants was placed through the EMDR UK & Ireland members email service, 'jismail'. All participants who identified themselves as interested in taking part in the study were included in the study. All participants were using one or both of the recommended treatment modalities with NICE guidelines for PTSD (NICE, 2005) and had between three and twenty years of mental health experience.

Prior to the main study, a pilot study was carried out to evaluate the method. Results from the pilot study are discussed within the thesis. Three participants took part in the pilot and a further eight took part in the main study. Recorded, semi-structed interviews were used as a framework to collect data from a purposive sample of therapists (participants) working with a trauma caseload. This allowed for the exploration of each participant's unique and individual experience of trauma work (Smith & Osborn, 2003). Interview transcripts were transcribed verbatim and sent to participants for validation of authenticity. This was to ensure they reflected an accurate account of what was discussed. Once clarification was received, data was analysed using the suggested IPA process and emerging themes explored (Smith, Flowers & Larkin, 2009:79-107).

1.1. Nomenclature

Throughout the thesis, the term '*participant*' will be reserved specifically to signify those therapists who took part in this study, unless otherwise stated. The terms '*trauma therapist'*, '*therapist*' and '*counsellor*' will be used in general terms to signify any professional who is qualified to work therapeutically with clients

presenting with a psychological trauma. This is irrespective of the amount of trauma clients within their caseload and includes those whom have participated in previous studies that have contributed to existing trauma literature.

The term '*distress*' will be used to describe any reported upset, worry, discomfort or disturbance disclosed by participants of this or previous studies, that may have occurred within the duration of their therapeutic work with trauma clients. The use of the term distress does not imply any particular level of impact on the therapist or participant.

The terms '*client*' or '*patient*' will be used to signify any individual who has experienced psychological trauma symptoms and been referred for a course of treatment.

1.2. Structure Of Thesis

The result of my doctoral journey is presented within this thesis. Headings and sub-headings throughout the following chapters are formatted based upon the five level guidelines of the American Psychological Association (APA) to aid the reader. The remaining thesis is divided into the following six chapters:

***Literature Review**.* This chapter describes the systematic process taken to identify and critically review the existing literature and presents the key findings of the literature review.

***Research Design**.* This chapter addresses the issues of the methodology and method chosen for the study, sets out the chosen approach and introduces the research question.

***Study Development And Presentation Of Findings**.* This chapter discusses the process taken to develop the main study. It includes the development of the pilot, interview schedule and analysis coding before moving to present its findings.

Analysis Of Findings*.* This chapter discusses the four master themes identified within the findings. Interview extracts from participants are used to evidence findings.

Discussion. This chapter discusses the study findings and reflects upon the personal learning of the researcher, the evaluation of the research design and the research question posed, implications for practice, recommendations for future research and dissemination strategies.

Conclusion*.* This chapter summarises the researcher's conclusions relating to the theoretical and methodological aims of the study.

The following chapter *Literature Review* starts by considering the background to the study and the development of the medical classification for PTSD. It moves to discuss psychological reactions to trauma and the protective practices that therapists use to help reduce any negative effects of working with trauma caseloads.

Chapter 2: Literature Review

2.0. Overview

In the introduction, the case has been made for the value, originality and importance of this research study. In this chapter, the literature in respect of psychological reactions to trauma, will be critically reviewed and a synthesis developed. Furthermore, consideration will be given to how these reactions may impact upon CBT and EMDR therapists engaged in trauma work. The objectives of the review are:

1. To understand if vicarious trauma exists and is defined.
2. To identify the multi-faceted elements of vicarious trauma and compare how it differs to its related concepts.
3. To identify the impact on psychological therapists of working directly with trauma clients.
4. To explore if there are any pre-disposing factors of vicarious trauma.
5. To explore what protective factors help ameliorate vicarious trauma.

The systematic process for the identification of the literature will be presented. Following is the review organised within the context of seven main themes. These are: (i) The background for the study, (ii) Historical diagnosis of post-traumatic stress disorder (PTSD), (iii) Symptoms of PTSD and current recommended treatment, (iv) Existing literature on vicarious trauma and its related concepts, (v) Negative and positive effects of trauma work upon therapists, (vi) Pre-disposing factors of therapist vicarious trauma, and (vii) Protective practices that aid amelioration of vicarious trauma.

2.1. Literature Review Search Terms and Databases

Prior to the search, relevant databases that may be helpful were identified through the university library service and common databases suggested by Aveyard (2010). The initial focus of the search was Google Scholar to help generate key search terms and the university academic online library electronic databases.

Initial databases identified and considered the most appropriate were: British Library, Cochrane Library, Cumulative Index to Nursing and Allied Health Literature (CINAHL), Allied and Alternative Medicine (AMED) and PubMed. Keywords relating to the subject under review were identified to help retrieve relevant articles. Initial keywords used to undertake a broad search were: cognitive behavioural therapy, CBT, eye movement desensitisation and reprocessing, EMDR, post-traumatic stress disorder and PTSD. Search limiters were: English language only and a search date from 1989. The language was limited so all papers could be read, understood and reviewed. The search date was limited due to Francine Shapiro not developing EMDR until 1987, so the likelihood of any research before this time is small.

It soon became apparent through reading abstracts and general screening, that many papers were not relevant to the research being undertaken. This was due to their focus being on clients rather than therapists experiences and physical trauma rather than psychological. To try and approach the literature search in a more systematic and comprehensive manner, search terms that were logical and relevant to the research question were developed. These terms were reviewed throughout the review as understanding and confidence grew in the search process. Keywords were revised to include the words, 'mental health' and 'therapist'. Whilst consideration was given to inclusion of the word 'counsellor' and 'clinician' in the search terms, a decision was taken not to incorporate them. This was due to initial searches including the keyword 'counsellor', producing the same data as that of 'therapist'. The use of the keyword 'clinician' was found to be unhelpful as this provided overwhelming data in relation to those working in other medical professions, unrelated to mental health.

To generate the chances of further relevant literature being identified, the search strategy was widened to include Medline, PsychInfo and Science Direct and EBSCO HOST. From all the databases identified, those that yielded poor or overwhelming search results were excluded. EBSCO HOST, a medical database, was found to encompass many of the relevant databases previously searched

independently and was subsequently used as one of the main databases to avoid duplication. Using a funnelling strategy, keywords and limiters helped to identify the most appropriate literature to clearly address the search review objectives (Appendix A). Keywords were reviewed and updated to include variations of the word vicarious trauma, ‘secondary traumatic stress’, which was often found to overlap in the literature with vicarious trauma, ‘mental health’, ‘therapists and both ‘qualitative’ and ‘quantitative research’. Search limiters were narrowed by language, date and subject. The search date was widened to 1985 to ensure nothing immediately prior to 1987 was excluded. In addition to databases previously identified, further literature was sourced through the online Mendeley Library database, hand searching, scrutinising reference lists from previously identified literature and recommendation by colleagues, supervisors and university peers.

2.2. Data Extraction

When identified, literature was screened in the first instance by simply reading the title of the paper and the abstract where available. Full text copies were obtained where available, through online databases, libraries or colleagues. The Critical Appraisal Skills Programme (CASP) has developed eight appraisal tools (eg: Appendix B), specific to research, to help researchers make sense of evidence. (CASP, 2010). Primarily, those tools aimed at qualitative studies, systematic reviews and randomised controlled trials were used by the researcher to aid screen literature for credibility and relevance to answering the research question (Polit & Beck, 2005; Aveyard, 2010; CASP, 2010).

From the literature search, twelve papers were identified that met the inclusion criteria and gave relevant insights into the research question. The identified studies included quantitative, qualitative and mixed methods research, a primary research paper and systematic reviews. These are all summarised in Table 1 (page 10). In addition, themes in this literature are explored and mapped as a first stage process that will lead to further additional explorations of the literature.

Table 1: Summary of initial studies identified within the literature review and relevant themes upon which the review will be expanded and built.

Author(s) & Date	Type of Data	Country	Themes
McCann & Pearlman (1990)	Qualitative article – primary paper	USA	Burnout, countertransference. Cognitive schemas and imagery systems. Beliefs, expectations and assumptions of the world change. Disruptions in imagery.
Pearlman & MacIan (1995)	Quantitative study	USA	(188 participants) Effects of trauma work on therapists. Trauma history versus no personal trauma history, experience and disrupted schemas. Affected by experience or amount of ‘survivors’ in caseload. Personal therapies. Training, supervision, self-care.
Schauben & Frazier (1995)	Mixed methods study	USA	(148 participants) Higher percentage of dv survivors in caseload = disrupted beliefs, symptoms of PTSD, self-reported vicarious trauma symptoms. Historical therapist victimisation. Positives of work. Coping strategies. Support. Training.
Steed & Downing (1998)	Qualitative study	Australasia	(12 participants) Negative affects – physiological, emotional, professional, interpersonal. Overwhelming imagery, dreams and intrusive thoughts. Increased vigilance safety. Changes in trust. Positive – self-care, continuing professional development (CPD), boundaries, support.
Sexton (1999)	Qualitative review	Australia	Transference, secondary traumatic stress, burnout, vicarious trauma - Client work, organisational implications, managing vicarious trauma.
Iliffe & Steed (2000)	Qualitative study	Australia	(18 participants) Loss of confidence, taking too much responsibility, respect for clients, impact of hearing traumatic material, changes to cognitive schemas. Challenging aspects of counselling. Burnout. Lack of training. Therapist coping strategies.

Author(s) & Date	**Type of Data**	**Country**	**Themes**
Way, Vandeusen, Martin, Applegate & Jandle (2004)	Quantitative study	USA	(347 participants) Therapist trauma history. Negative, positive and professional strategies. Therapist experience. Supervision. Training. Self-care.
Lonergan, O'Halloran & Crane (2004)	Qualitative study	USA	(8 participants) Self-care techniques identified, holidays, discussing material with colleagues, managing caseloads, training, supervision, regular exercise and developing interests outside work. Negative and positive effects.
Harrison & Westwood (2009)	Mixed methods study	Canada	(6 participants) Prevention of vicarious trauma. Countering isolation, self-awareness/mindfulness, expanding perspective, self-care, realistic expectations, supervision, personal therapy, empathy, professional satisfaction, creating meaning.
Ben-Porat & Itzhaky (2009)	Mixed methods study	Israel	(214 participants) Secondary trauma, vicarious trauma. Negative changes – physical, relationship, view of the world. Positive – personal growth, appreciation of personal life, heightened awareness.
Jordan (2010)	Qualitative review	USA	Vicarious trauma. Burnout. Managing caseloads, personal trauma history, professional trauma, training, supervision, support, self-care, resilience.
Culver, McKinney & Paradise (2011)	Multi-level mixed methods study	USA	(30 participants - phase 1. 5 participants - phase 2) Negative psychological symptoms. Disruptions to safety, esteem, perceptions of self, world, frame of reference. Reporting of trauma. Type of trauma. Challenging clients. Therapist experience. Training. Coping strategies. Stress of time/resources/funding for work.

Results generated from the literature search highlighted potential for a negative impact on some psychological therapists engaged in work with traumatised clients. The following section discusses the background to this study together with the history, diagnosis and treatment of PTSD. It moves to discuss vicarious trauma, its related concepts and the impact of working with trauma clients.

2.3. Background To Study

British physician, John Erichsen (1818-1896) first identified the syndrome of trauma in railway accident victims (Kanno, 2010). Since then, understanding of trauma within the field of mental health has developed considerably and its long term effects on the nervous systems of trauma victims have been recognised (Matus, 2001). Psychological reactions to trauma have been described over the past one hundred and fifty years by names such as ‘psychic shock’, ‘traumatic neurosis/hysteria’ (Matus, 2001), ‘shell shock’, ‘old sergeant syndrome’ and ‘combat fatigue’ (Graham, 2011). Potential for a negative impact when working directly with clients suffering from PTSD or trauma related symptoms has been discussed within the psychological literature for at least three decades (American Psychiatric Association 1980; McCann & Pearlman, 1990; Sexton, 1999; Canfield, 2005). Identified as an occupational hazard in need of attention for mental health workers (Neumann & Gamble, 1995; Simonds, 1997; Baird & Kracen, 2006; Tiegreen & Newman, 2009), increasing discussion regarding therapist reactions has emerged within the trauma literature (McCann & Pearlman, 1990; Stamm, 1995; Pearlman & Saakvitne, 1995a; Sexton, 1999; Trippany, White Kress & Wilcoxon, 2004; Canfield, 2005). To understand the difficulties therapists may be faced with when treating a traumatised client, we first need to understand the diagnosis, symptoms and recommended treatment for post-traumatic stress disorder.

2.4. History and Diagnosis of PTSD

It has been argued that classification systems for disease and medical problems are essential in the practice and research of medicine, including mental disorders

(World Health Organisation (WHO), 1994; American Psychiatric Association (APA), 2013). Classification systems provide clinical descriptions and diagnostic guidelines, helping professionals to identify and more accurately diagnose patients. Specific to mental health and PTSD, they provide a socially constructed framework that is comprehensive and standardised (Figley, 2012). Unfortunately, the plethora of classification systems such as the International Classification of Disease (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM) can be confusing at times and conflict with each other (WHO, 1994; APA, 2013). In the following sections, the relevant systems for PTSD will be critically reviewed and synthesised.

2.4.1. PTSD classifications

The World Health Organisation (1948-2015) provides current international guidelines for PTSD within the International Classification of Diseases, Tenth Revision (ICD-10) (WHO, 1994) (Appendix C). The American Psychiatric Association (1921-2015) provides a set of alternative but similar guidelines for PTSD within the Diagnostic and Statistical Manual of Mental Disorders, the most recent being the DSM-5 (APA, 2013) (Appendix D). Whilst classification of PTSD is important within the field of mental health, acknowledgement is given that not all persons who experience a traumatic event go on to develop PTSD. Moreover, NICE guidelines for PTSD state that up to 30% of people who experience a traumatic event may develop PTSD, either immediately after the event or many years later (NICE, 2005). Use of either classification may come down to personal preference, training or standard workplace practice. In this study, the DSM classification will be discussed. This is on the grounds that it is used by the researcher's workplace and is the one most often used in PTSD research (Krans, Näring, Holmes & Becker, 2010; APA, 2013; Chen, Zhang, Hu & Liang, 2015).

DSM-I and DSM-II. In 1952, the APA and the United States Public Health Service developed the Diagnostic and Statistical Manual, Mental Disorders (DSM-I) (Kanno, 2010). Based upon psychiatrists experiences of working with World War II soldiers whose symptoms reduced once they had left combat, the DSM-I

categorised trauma as a Gross Stress Reaction (APA, 1952). The DSM-I acknowledged that a stressor such as combat or civilian catastrophe could generate reactions and symptoms in a normal person under great or unusual stress (APA, 1952). The use of the term ‘reaction’ reflected the view of Adolf Meyer, psychiatrist and president of the APA, ‘that mental disorders represented reactions of the personality to psychological, social, and biological factors’ (APA, 2014:Post-World War II). During the height of the Vietnam War Tet Offensive in 1968, the second edition of the DSM (DSM-II) was published (Kanno, 2010). Its content was similar to the DSM-I, except that it eliminated the term ‘reaction’ (APA, 2014).

DSM-III. Trauma research increased in the 1970s due to Vietnam War veterans returning home with reports of hyper-arousal, intrusive recollections and other stress-related symptoms, that weren’t at that time recognised as war related stress (Haley, 1974, 1978; Figley, 1978). Scientific data collected from Vietnam veterans led to development of the DSM-III (APA, 2014). While the earlier diagnosis of Gross Stress Reaction defined the stressors producing symptoms as only combat or civilian catastrophe, DSM-III introduced a number of important methodological innovations, and was developed with the additional goal of providing a medical nomenclature for clinicians and researchers (APA, 2014).

The DSM-III expanded its definition of stressors to include rape or assault, military combat, natural disasters and accidental or deliberate man-made disasters (APA, 1980). Finally published in 1980, the DSM-III formally recognised PTSD as an anxiety disorder. However, due to a number of inconsistencies and instances where the diagnostic criteria was not entirely clear, a taskforce was appointed to revise the DSM-III, leading to a further publication of DSM-III-R in 1987 (APA,1987) (APA, 2014).

DSM-IV. Since 1987, research in this area has grown considerably. In 1994, after the culmination of six years work involving numerous professional organisations, over one thousand individuals and careful consideration of mental disorder research, the DSM-IV (APA, 1994) was published (APA, 2014). It contained

numerous changes to classification, diagnostic criteria and descriptive text (APA, 2014). Further revisions were made in the year 2000 (APA, 2000:2-5). The DSM-IV criteria for PTSD (Appendix E) acknowledged learning about traumatic events can lead to symptoms of PTSD (APA, 1994:424). This has led to discussions around the potential that such symptoms may arise in therapists exposed to narratives of traumatic events (Sabin-Farrell & Turpin, 2003).

DSM-5. In 2013, after the culmination of a fourteen year revision process, the APA published its latest revision of the DSM of Mental Disorders for PTSD (DSM-5) (APA, 2013). Dubbed, 'The Psychiatrist's Bible', DSM-5 attempts to define all recognised mental health conditions and their symptoms (NHS choices, 2013). Although criticism has arisen due to possible conflict of interest between the pharmaceutical industry and the DSM-5 taskforce and the potential that it medicalises patterns of behaviour and mood (NHS choices, 2013; Lacasse, 2014); there are positive changes to the PTSD classification. Compared to the DSM-IV (Appendix E), the diagnostic criteria for DSM-5 (Appendix D), is much clearer in detailing what constitutes a traumatic event and pays more attention to the behavioural symptoms of PTSD, such as re-experiencing, avoidance, negative cognitions and mood and arousal (APA, 2013). More importantly, the classification category of PTSD has changed from an anxiety disorder to a specific 'Trauma and Stressor Related Disorder' in which the onset has been preceded by exposure to a traumatic or adverse environmental event (Friedman, 2013).

2.5. Symptoms of PTSD

During trauma, the brain doesn't have time to process memories as the natural coping mechanism becomes overloaded. This results in disturbing experiences remaining 'frozen' in time and unprocessed in the limbic system of the brain. Two limbic system structures, the amygdala and hippocampus, play important roles in memory. The amygdala is responsible for determining where and what memories are stored and it is thought that this determination is based on the severity of emotional response that an event invokes (Cherry, 2014). The hippocampus is important in memory and learning, sending memories out to the appropriate part of

the cerebral hemisphere for long-term storage and retrieval when necessary (Cherry, 2014). Within PTSD, the traumatic experience remains unprocessed within the limbic system and continues to be experienced in a ‘raw’ and emotional state. When triggered by often harmless, obvious or subtle cues which have been associated with the original trauma, a person ‘relives’ the trauma and experiences the same cognitive and physiological symptoms as they experienced during the original trauma (Schiraldi, 2009). Their ability to live in the present can become inhibited through experiencing flashbacks, nightmares, hypervigilance, startled response, increased arousal levels, emotional numbing, avoidance, anger and anxiety (NICE, 2005).

2.6. Treatment of PTSD

Two distinct categories of trauma have been identified and further refined (Terr, 1991; Scott & Stradling, 1994; Rothschild, 2000). The first category is ‘Type 1-PTSD’, for clients who have experienced a single traumatic event, and the second ‘Type 2-PTSD’, for those who have been repeatedly traumatised (Terr, 1991). Central to resolving the impact of trauma is being able to remember and reprocess the trauma, to reduce the distress and update the brain with the new information (Foa & Rothbaum, 1998; Shapiro, 2001). Part of the recommendations within NICE guidelines is the implementation of a course of trauma-focused psychological treatment of trauma-focused cognitive behavioural therapy (TF-CBT) or eye movement desensitisation and reprocessing (EMDR) (NICE, 2005:4). For treatment to be successful, potential clients need to be thoroughly assessed before treatment commences, to ensure their primary symptoms relate to trauma and their support networks are in place.

2.6.1. Trauma-focused CBT

A key requirement of trauma-focused CBT is the therapist’s ability to tolerate listening, being emotionally responsive to the client and talking about their traumatic experiences whilst they ‘relive’ events and update any trauma hotspots frozen in time. Hotspots are memories of specific moments of peak emotional distress during a traumatic event (Grey & Holmes, 2008). Therapy sessions

usually last around ninety minutes and focus on exposure to the emotional experiences such as fear or horror that a client has experienced during their traumatic event. Such events can be very graphic and distressing. During exposure, clients are guided to describe the trauma in the first person, present tense, as if it were happening now. They are encouraged to give as much detail as possible as they relive the event, including any visual, auditory, physical, emotional and cognitive information (Foa & Rothbaum, 1998). The rationale for exposure is that repeated exposure to avoided situations or unwanted negative emotions provides disconfirming information critical for changing maladaptive thoughts and beliefs together with evidence that negative emotion can be tolerated and allowed to decline naturally (Clark, 2013). Throughout the exposure session, the therapist works with the client to update information through cognitive restructuring. This enables the brain to process any new information which relieves any distressing memories associated with the trauma and reduces PTSD symptoms.

2.6.2. EMDR

EMDR, originated and developed by Dr Francine Shapiro in 1987, helps create connections between the brain's memory networks. When using the eight phases of EMDR treatment, the brain processes any traumatic memories utilising the body's natural healing ability (Shapiro, 2001). As a brief synopsis of treatment, a client is asked to hold any upsetting material in mind, such as a distressing image and link it to any negative thoughts and feelings they may be experiencing. With limited narrative taking place, eye movements, similar to those during rapid eye movement (REM) sleep, are recreated by watching a therapist's finger move back and forth across the client's visual field in short bursts. This process is thought to emulate the psychological state we enter into during REM sleep, where new associations between things are made very rapidly (Neuro Innovations, 2016). If any difficulties are reported such as eye pain or irritation, an alternate form of bi-lateral stimulation using tactile or auditory stimuli which tracks from left to right and back again, can be used (Shapiro, 2001; Neuro Innovations, 2016). The treatment is repeated throughout the duration of the ninety minute session with the client briefly reporting back to the therapist any changes in thoughts, images and feelings

during each set of movements. Throughout the duration of the treatment, the memory loses its painful intensity and becomes a neutral memory of an event in the past. Once emotional distress is sufficiently reduced, the installation of a positive or preferred thought takes place. As well as specific trauma memories, other associated memories may also heal at the same time, which can lead to rapid improvement.

2.7. Treatment Efficiency

There is a wealth of research concerning the effectiveness of the use of trauma-focused CBT and EMDR for PTSD (Shapiro, 2001; Jaberghaderi et al., 2004; NICE, 2005; Bradley et al., 2005; Seidler & Wagner, 2006; Bisson & Andrew, 2007 and Foa, Keane, Friedman & Cohen, 2009; Ho & Lee, 2012). However, due to the numerous variants of CBT and no clear evidence for its efficacy the literature can be conflicting (Chen et al., 2015). Similarly, due to the controversy around EMDR where inconsistency around the method or effectiveness of eye movements is questioned, there is also conflicting literature (Devilly & Spence, 1999; Herbert, Lilienfeld, Lohr, Montgomery, O'Donohue, Rosen, & Tolin, 2000; Davidson & Parker, 2001). A recent systematic review and meta-analysis concerning the treatment effectiveness of trauma-focused CBT and EMDR (Chen et al., 2015), sets out a more comprehensive review on some of the existing literature. Findings of that review and meta-analysis suggest EMDR was slightly superior to trauma-focused CBT for treating adults with PTSD. However, the authors suggest caution when drawing final conclusions due to the poor quality and limited number of studies included in their review.

2.8. Vicarious Traumatisation

The phenomenon of vicarious traumatisation has become a significant concern for therapists engaged in providing services to traumatised clients. Defined as the collective, transformative effects of empathic engagement with traumatised clients, McCann and Pearlman (1990) were the first to highlight concerns of *vicarious trauma.* The risks of working directly with traumatised individuals have been discussed within psychological literature (Pearlman & MacIan, 1995; Stamm, 1995;

Arvay, 2001; Sabin-Farrell & Turpin, 2003; Buchanan, Anderson, Uhlemann & Horwitz, 2006). The concept of vicarious trauma has been used to describe such risks.

2.9. What Are The Multi-Faceted Elements Of Vicarious Trauma?

The concept of vicarious trauma was first introduced over twenty five years ago. Believed to be a normal reaction to stressful and at times, traumatising work with clients, (just as PTSD is viewed as a normal reaction to an abnormal event); McCann and Pearlman (1990) provided a theoretical framework (Figure 1, page 20) based in constructivist self-development theory, for understanding the complex and distressing effects of trauma work on therapists (Pearlman & Saakvitne, 1995a). Representative of PTSD, vicarious trauma results in physiological, intrusive and avoidant symptoms and has a sudden onset of symptoms which may not be detectable at an early stage (Chrestman, 1995; Pearlman & MacIan, 1995; Schauben & Frazier, 1995; Trippany et al., 2004).

Just as trauma can alter its victims, therapists working within this field can also find themselves permanently altered by the experience (McCann & Pearlman, 1990). People construct their reality over the course of their lifespan through the development of cognitive structures which are used to interpret events (McCann & Pearlman, 1990). Described as schemas (Piaget, 1971), cognitive structures include an individual's beliefs, assumptions and expectations about the self and the world. Through exposure to hearing traumatic material, McCann and Pearlman's theoretical framework for vicarious trauma, sets out the disruptions to schemas and imagery a therapist may experience and links it to the associated emotions and thoughts (McCann & Pearlman, 1990). They describe these as:

Dependency/Trust. When working with victims of trauma, therapists may be exposed to trauma narrative of clients that may have been deceived, betrayed or violated. This can disrupt a therapist's schemas about trust, resulting in suspicion, cynicism and distrust.

(Figure 1)

McCann, L. and Pearlman, L.A. (1990). ‘Vicarious Traumatization: A Framework for Understanding the Psychological Effects of Working with Victims.’ *Journal of Traumatic Stress*, 3, pp.131-14.

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Safety. Images involving a loss of safety, threats or harm to innocent people, may challenge a therapist's schemas within the area of safety; particularly if they have a strong need for security. Therapists working with victims of random violence or accidents may experience a sense of heightened vulnerability and awareness of the fragility of life.

Power. Clients who have been victimised may find themselves in situations of helplessness, vulnerability or paralysis. Exposure to these situations can evoke concerns for the therapist about their own sense of power or efficacy in the world. Alternatively, a therapist may express a heightened sense of awareness of a lack of control over life events, leading to feelings of helplessness, despair or depression.

Independence. Therapists may identify with trauma survivors, such as rape victims who may experience of disruption in their independence through a loss of personal control and restriction of freedom. For those therapists with a strong need for independence, identification with the client can be particularly difficult.

Esteem. The authors refer to esteem as the need to perceive others as benevolent and worthy of respect. Clients who are violated or harmed through the acts of other human beings may experience diminished esteem for others. This feeling may be reflected in the therapist leading to cynicism, pessimism, bitterness and a sense of anger at other people and the world in general, as they consider the malevolence of others.

Frame of reference. Traumatised individuals can repeatedly reflect on the question, "Why me?" Therapists may also find themselves in the position of trying to understand why their client experienced a traumatic event. This may become destructive if it takes the form of victim blaming or the focus of the therapy becomes more about the motives of the assailant or perpetrator. Furthermore, the authors suggest therapists may experience a sense of disorientation if their

schemas are continually challenged by client reports of traumatic experiences, resulting in unease.

Intimacy. Trauma victims can experience a profound sense of alienation from other people and the world in general. Therapists may also experience a sense of alienation and separateness.

Disruptions in imagery. Like trauma victims, therapists may experience their clients' fragmented traumatic images without context or meaning, resulting in a variety of uncomfortable and negative emotions. Whilst the authors suggest the alteration to a therapist's memory system is generally transient, they believe these changes can become permanently incorporated into the memory system.

Within trauma research, vicarious trauma is seen as a traumatic reaction to specific client-presented information. Such aforementioned changes and disruptions to a therapist's basic sense of identity, world-view, spirituality and cognitive frame of reference (Pearlman & Saakvitne, 1995a), have been described as the hallmark of vicarious trauma (Pearlman, 1999).

Vicarious trauma occurs only among those who work specifically with trauma survivors, due to them being exposed to emotionally shocking images of horror and suffering, characteristic of serious trauma (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995a; Iliffe & Steed, 2000; Trippany et al., 2004). It is the result of an accumulation of experiences across many therapy situations (Sexton, 1999) described as:

> '...the cumulative transformation in the inner experience of the therapist that comes about as a result of empathic engagement with the client's traumatic material...' (Pearlman and Saakvitne, 1995a:31)

Since vicarious trauma was first described, further studies have been undertaken which agree and build upon initial findings (Schauben & Frazier, 1995; Pearlman & Saakvitne, 1995a; Steed & Downing, 1998; Iliffe & Steed, 2000). Whilst the

phenomenon is difficult to operationalise and measure, this study aims to contribute to the growing body of knowledge linked to understanding and ameliorating the effects of therapist vicarious trauma and concepts related to the phenomena (Sabin-Farrell & Turpin, 2003; Kadambi & Truscott, 2004; Kadambi & Ennis, 2004).

2.10. Concepts and Theories Associated with Vicarious Trauma

There are a number of theories and closely related concepts that have been linked to and used interchangeably with vicarious trauma and it is important to bear this in mind whilst reviewing the literature. Before considering how vicarious trauma is similar or different to other theories or concepts, consideration must be given to both the notion of theory and nosology as defined below.

Unlike a hypothesis, which can be wrong or misleading and is made on the basis of limited evidence needing further investigation, theories provide a concise, coherent, systematic and accepted system of ideas, intended to explain facts or phenomena (Bradford, 2015). Nosology is a branch of medicine that deals with the classification of diseases, such as the Diagnostic and Statistical Manual of Mental Disorders (APA, 2013) which defines what causes them, the mechanism by which the disease is caused or the symptoms related thereto (Smolik, 1999; Robison, 2015). However, such classifications can be confusing as they may change with time.

As noted, more recently the term vicarious trauma has been used to describe the phenomenon (McCann & Pearlman, 1990). However, the terms '*burnout*' (Maslach, 1982); '*secondary traumatic stress'* and '*compassion fatigue'* (Figley, 1987, 1995, 2002); and '*countertransference*' (Freud, 1910; Wilson & Lindy, 1994) have been previously used to characterise therapists reactions to client trauma. These concepts will be considered and linked to the current study.

2.10.1. Burnout

The body of literature on burnout thoroughly describes the phenomena and prescribes preventative and treatment interventions for helping professionals (Gentry, 2002). The term burnout was introduced by Freudenberger (1974) after he observed symptoms of exhaustion, fatigue and various somatic complaints displayed by his staff members working in crisis intervention, free clinics and self-help groups. Burnout is more commonly a consequence of the social environment in which people work and therefore not mutually exclusive to healthcare. Contributing factors for burnout are work overload, lack of control, insufficient rewards, and unfairness, breakdown of community and value conflict (Maslach & Leiter, 1997). Such factors may lead to either an individual not functioning at their full potential or terminating their employment altogether.

Different to vicarious trauma, burnout is a process that develops gradually and progresses in intensity over time rather than being due to trauma and the suffering of a specific patient (Figley, 1995). It has been described as a syndrome that can result in general psychological stress and physical fatigue, and which commonly occurs through working with difficult clients requiring intense care (Maslach, 1978; Pines & Maslach, 1978; Figley, 1999). It has been defined as:

> '…a state of physical, emotional and mental exhaustion caused by long term involvement in emotionally demanding situations…' (Pines & Aronson, 1988:9)

The multi-dimensional theory of burnout (Maslach, 1982, 1998) provided a theoretical framework for professionals and continues to influence literature linked to the field. Burnout is described as having three core dimensions; '(1) emotional exhaustion, (2) depersonalization, defined as having a negative attitude towards clients, a personal detachment or loss of ideals and, (3) a reduced personal accomplishment and commitment to the profession' (Bell, Kulkarni & Dalton, 2003:463). The underlying consensus within literature, is that these core dimensions can lead to symptoms such as depression, boredom and loss of compassion and discouragement (Bermak, 1977; Freudenberger & Robbins, 1979; Farber & Heifetz, 1982; Deutsch, 1984; Maslach, Schaufeli & Leiter, 2001).

Although accepted burnout can occur in persons in any profession, therapists are particularly vulnerable to it because of their personal isolation, ambiguous successes and the emotional drain of remaining empathic (McCann & Pearlman, 1990). Related to a feeling of being overloaded, secondary to client problems of chronicity and complexity, burnout unlike vicarious trauma, does not lead to changes in trust, feelings of loss of control, issues of intimacy, esteem needs, safety concerns and intrusive images (Trippany et al., 2004).

2.10.2. Secondary traumatic stress/Compassion fatigue

The term secondary traumatic stress (Figley, 1985), is often used interchangeably within the literature with compassion fatigue (Figley, 1995). Compassion fatigue has been described as ‘a more user-friendly term for secondary traumatic stress disorder’ (Figley, 2002:3). Similar to vicarious trauma, it refers to those individuals in the helping professions exclusively (Elwood Mott, Lohr & Galovski, 2011). Comparable to views of McCann and Pearlman (1990) when describing vicarious trauma, secondary traumatic stress/compassion fatigue symptoms are considered a normal reaction to engagement with traumatic material (O’Halloran & Linton, 2000; Elwood et al., 2011). As within vicarious trauma, secondary traumatic stress/compassion fatigue can occur as a direct result of exposure to emotionally shocking stories or material, rather than exposure to the actual trauma itself as within PTSD (Figley, 1995). Therefore, a traumatising event experienced by one person may become a traumatising event for a second person, such as a family member, friend or therapist (Canfield, 2005). However, secondary traumatic stress/compassion fatigue, like burnout, focuses on external symptoms unlike vicarious traumatisation, which focuses on the internal experiences and the gradual change in the therapist’s worldview (Ben-Porat & Itzhaky, 2009). The onset of symptoms can be rapid and typical of PTSD sufferers but there is a faster recovery than compared to the concept of burnout (Sexton, 1999). Left untreated, secondary traumatic stress can develop into secondary traumatic stress disorder where symptoms become more chronic (Jenkins, Mitchell, Baird, Whitfield & Meyer, 2010).

2.10.3. Countertransference

Countertransference differs from vicarious trauma as it is present in every therapeutic relationship, rather than being a cumulative consequence of trauma work (Adams & Riggs, 2008). Sigmund Freud (1910), developed the concept of countertransference from his earlier work around transference, whereby patients unconsciously transferred or projected their feelings from influential people in their early life onto their therapists in their adult life. He recognised this process not only happened for patients but also for the therapists they were working with. Whilst initially seen as having a negative impact on successful treatments and an obstacle for therapists to overcome (Freud, 1910; Reik, 1937; Fleiss, 1953), since the 1950s, it has been viewed differently. No longer seen as an impediment to treatment but rather a therapist's conscious and unconscious response, and an important tool in understanding unconscious and interpersonal issues in the client's everyday life (Heimann, 1950; Pearlman & Saakvitne, 1995a; Reidbord, 2010). Rather than long-term schematic changes, its effects are relatively short-term within the therapy session (Figley, 1995; Harrison & Westwood, 2009). Countertransferential responses outside the therapy session can be due to pre-occupation of clients and their recovery and may be particularly noticeable for those therapists new to trauma work (Neumann & Gamble, 1995).

Due to the overlap in the literature, the distinct differences between the concepts of vicarious trauma, burnout, secondary traumatic stress/compassion fatigue and countertransference are summarised in Table 2 (page 27). Literature exploring the effects of vicarious trauma and its related concepts was reviewed to explore how working directly with trauma clients impacts upon psychological therapists either physically, emotionally, behaviourally, interpersonally or work-related. Various themes emerged from the literature review which are discussed under separate headings to aid the reader.

Table 2: A summary of distinct differences between the effects of vicarious trauma and its related concepts.

Vicarious Trauma	**Burnout**	**Secondary Traumatic Stress/ Compassion Fatigue**	**Counter-transference**
Sudden onset of symptoms which may not be detectable at an early stage. Cumulative process.	Develops gradually. Progresses in intensity over time.	Sudden onset of symptoms which may not be detectable at an early stage. Cumulative process.	Usually only present during the therapy session itself.
Physiological, intrusive & avoidant symptoms representative of PTSD.	Emotional exhaustion, erosion of idealism, reduced sense of accomplishment & achievement.	Physiological, intrusive & avoidant symptoms representative of PTSD.	Changes in emotional & behavioural responses within the therapist to the client.
Specific to working with trauma survivors.	Occurs as a result of prolonged work with any group in any profession.	Specific to working with trauma survivors.	Present in all therapeutic relationships.
May result in permanent changes. Focus on internal symptoms. Disruptions in basic sense of identity, world-view, spirituality & cognitive frame of reference.	Effects may be long lasting. Can lead to depression, boredom, loss of compassion and discouragement.	Effects may not last as long as burnout. Focus on external symptoms. Can lead to secondary traumatic stress disorder if untreated.	Temporary, short-term effect.

2.11. Negative Effects of Working in Trauma Field

Constructivist self-development theory and recent research suggest therapists experiencing vicarious traumatisation is significant both on a personal and professional level (Trippany et al., 2004). Any detrimental effects on therapists can result in negative treatment effectiveness and workplace organisational dynamics, which could inevitably lead to a negative impact on client care quality (Sexton 1999; Raquepaw & Miller, 1989). This is significant for the client and could have important implications for organisations and therapist wellbeing.

2.11.1. Empathic engagement

Empathy is a complex psychological construct whereby the therapist accurately senses the feelings and personal meanings a client is experiencing; setting aside without prejudice, any views and values they hold themselves and communicate this understanding to the client (Rogers, 1975; Loggia, Mogil & Bushnell, 2008). Described as a 'gateway of vulnerability' (Badger, Royse & Craig, 2008), it has been suggested that empathic engagement can make therapists more susceptible to the detrimental effects of vicarious trauma or secondary traumatic stress (Pearlman & MacIan, 1995; Figley, 1995; Pearlman & Saakvitne, 1995a; Jenkins & Baird, 2002; Badger et al., 2008). Although Crumpei and Dafinoui (2012), found no relationship between clinical empathy and secondary traumatic stress, therapists did suffer intrusive and avoidant symptoms. Results of their study suggest that compassion and emotional contagion should be avoided. In contrast, other studies (Figley, 1995; Steed & Downing, 1998; Harrison & Westwood, 2009) discussed later (page 39) found empathic responses beneficial to therapists and clients.

2.11.2. Therapist stress

The effects of secondary trauma and self-reported stress amongst therapists were explored by Chrestman (1999). Questionnaires assessing personal and professional history, psychological symptoms, cognitive schemata, coping behaviours and behaviour changes were sent to participants. Whilst, the study is vague about what counts as 'extreme', participants reported such things as

debilitating anxiety, increased symptoms of intrusion and avoidance, increased symptoms of dissociation and sleep disturbance. Therapist distress was found to be significantly different from those therapists who did not experience secondary exposure (Chrestman, 1999). However, unlike vicarious trauma, for many therapists the distress caused after secondary exposure to trauma appeared to be acute rather than chronic (Chrestman, 1999). Whilst most of them recovered, a few therapists described symptoms which resulted in treatment and in some cases career changes. Whilst locating therapists who have left the profession would be problematic and beyond the scope of this research, future research in this area could be useful to identify the exact reasons for change.

Studies by Farber (1979) and Deutsch (1984) found that clients who expressed suicidal ideation, were the most stressful for therapists to work with. Whilst this may be common within the field of mental health and not specific to the area of trauma work, it is an area for concern as this may increase the risk of therapist vicarious traumatisation or burnout. Possibly seen by many as just an inevitable part of working in the field of mental health, expressed suicidal ideation does raise questions as to whether the stress around the welfare of the client is in fact secondary to the welfare of the therapist. Within both studies, the five client behaviours causing therapists the most stress were: (i) suicidal statements or suicidal ideation, (ii) expressions of anger towards therapist or aggression and hostility, (iii) severe depression or agitated anxiety, (iv) apathy or lack of motivation/apathy and depression, and (v) premature termination of therapy (Farber, 1979; Deutsch, 1984). Further studies may be needed to try and identify the reasons why these behaviours can be so stressful for therapists. Speculatively, this may be due to feelings around therapist responsibility and the ‘successful’ recovery of the client. By identifying which components of client suicidal ideation led to increased therapist stress, specific training or supervision needs can be developed to address this whilst supporting therapist wellbeing.

The effects of listening to traumatic material, vicarious trauma and cognitive disruptions experienced by 12 female therapists working with sexual abuse/assault

survivors were investigated by Steed and Downing (1998). Whilst all therapists reported negative effects from the work, they were unable to differentiate whether these effects were down to the trauma therapy or unresolved personal issues. A significant limitation within the study was the participants inability to recall beliefs and cognitive and emotional functioning prior to starting in the field of trauma work.

2.11.3. Negative impact on personal life

Therapists can become permanently altered by their experiences, as they begin viewing the world through a trauma lens (McCann & Pearlman, 1990; Neumann & Gamble, 1995). However, as a relatively new phenomenon, this may be difficult to measure and further research could identify how this change manifests itself. Whilst the impact upon therapists within their professional life is clear within literature (Deutsch, 1984; Chrestman, 1999; Baird & Kracen, 2006), the effects of trauma work are often carried outside the therapy room and are evident in their personal lives.

Several studies acknowledged a negative impact on therapists personal lives, which may be short or long in duration. Examples of therapist changes were; increased vulnerability (Neumann & Gamble, 1995; Eidelson et al., 2003), somatic complaints and sleep disturbance (Neumann & Gamble, 1995; Iliffe & Steed, 2000), hypervigilance regarding safety (Steed & Downing, 1998; Eidelson et al., 2003), intrusive images (Steed & Downing, 1998; Iliffe & Steed, 2000), intrusive thoughts (Neumann & Gamble, 1995; Steed & Downing, 1998) and increased stress levels (Iliffe & Steed, 2000; Eidelson et al., 2003).

Whilst many negative aspects of trauma work were highlighted, Barrington and Shakespear-Finch (2013), suggested the initial shock of the work was more impactful for therapists whose distress levels reduced over time. The authors argued this was because therapists were able to process the traumatic stories, rework their beliefs and effectively incorporate the traumatic material. This resulted in their psychological distress and initial shattering of beliefs quickly ameliorating as they made sense of their experience and grew from it. Their findings concur

with those of Chrestman (1999), who argued most therapists reported acute rather than chronic, negative changes when working with trauma.

2.12. Positive Effects of Working in Trauma Field

Vicarious trauma is cumulative and the result of repeated engagement with traumatic material. Whilst much of the research has focused on the negative impact of working with trauma, there has also been some attempt at balancing the argument with studies highlighting the positive.

A consistent finding throughout the literature review was that many therapists appeared to cope well with the demands of their work. However, this may be difficult to gauge accurately for a number of reasons, such as shame or those therapists that haven't coped may have left the profession. Through understanding therapist wellness and resilience, it might be possible for significant protective or mitigating factors to be identified that could balance current understanding of how they can be affected by clinical practice (Kadambi & Ennis, 2004).

Second-hand exposure to traumatic material can enrich therapists' self-understanding and their ability to understand others, enable them to form new or deepen existing relationships and enhance their appreciation of life (Herman, 1995). Moreover, therapists have reported gains in their empathy, compassion, tolerance and sensitivity, improved interpersonal relationships, deepened appreciation for human resilience, greater appreciation of life, a desire to live more meaningfully and a positive spiritual change (Arnold, Calhoun, Tedeschi & Cann, 2005).

In a similar vein, many other studies identified the positives of working with trauma reported by therapists. Examples were; witnessing clients growth (Iliffe & Steed, 2000), a renewed sense of purpose (Eidelson et al., 2003), hopefulness (McCann & Pearlman, 1990), a greater connection with clients (Steed & Downing, 1998), and family (Ben-Porat & Itzhaky, 2009), and positive changes in their general sense of identity and beliefs about others (Harrison & Westwood, 2009).

2.13. Are There Any Pre-Disposing Factors Of Therapist Vicarious Traumatisation?

The literature regarding pre-disposing factors, whilst not extensive, falls under two main themes. These are: (i) personal trauma history and (ii) therapist clinical experience.

2.13.1. Personal trauma history

Whilst some studies have considered how therapists may be pre-disposed to becoming vicariously traumatised if they have suffered a personal trauma, (Pearlman & MacIan, 1995; Schauben & Frazier, 1995; Way, Vandeusen, Martin, Applegate & Jandle, 2004), the evidence has been fairly inconclusive.

A research synthesis of 16 publications on vicarious trauma and secondary traumatic stress found persuasive evidence for vicarious trauma predictors in therapists with a personal history of trauma (Baird & Kracen, 2006). However, the authors fail to address the evidence for therapists with no personal trauma history. Furthermore, findings suggested there was reasonable evidence both for and against secondary traumatic stress (page 25), a close concept of vicarious trauma, in therapists with a personal trauma history.

Therapists new to trauma work who are survivors of interpersonal violence or childhood abuse, may identify more closely with clients and find their responses to client countertransference more difficult (Neumann & Gamble, 1995). However, whilst the authors suggest that coping with transference dynamics of trauma clients can be difficult for even the most experienced of therapists, they fail to evidence how they know therapists who are survivors themselves and new to the work, have a ‘common feeling’ of being ‘thrown into a maelstrom with no lifeline’ (Neumann & Gamble, 1995:342). Whilst Neumann and Gamble (1995) specifically explored countertransference and trauma, it could be argued responses may be no different from that of any therapist, experienced or not, identifying with their clients particular presentation, as suggested by Freud (1910).

A pioneering study examining vicarious trauma compared therapists with a trauma history, against those with no trauma history (Pearlman & MacIan, 1995). Whilst results failed to support a clear link between therapist exposure to trauma via their caseload and any subsequent disruptions in cognitive schemas (Kadambi & Ennis, 2004); results showed therapists who were less experienced and had a personal history of trauma, reported the most difficulties. Findings suggested therapists were more affected over a period of time and by the number of trauma survivors within their caseload. However, as therapist difficulties could have stemmed from various other influencing factors such as lack of experience, supervision or training, findings must be interpreted with caution.

A cross sectional survey based upon retrospective self-report was carried out by Way et al., (2004), in which models of coping strategies were tested that helped minimize traumatic effects on therapists treating survivors of sexual abuse and/or sexual offenders. Three quarters of participants had experienced one form of maltreatment during childhood and just over half reported multiple forms of maltreatment. Upon analysis, results found the groups did not differ significantly in levels of vicarious trauma and maltreatment history was not found to be associated with trauma effects. Similar to the study by Pearlman and MacIan (1995), there was also a low return rate for this study. Unfortunately, due to the low return rates in both studies, this leaves unanswered questions as to why more participants did not respond. One plausible explanation is that potential participants who had suffered a personal trauma felt uncomfortable disclosing personal information and chose not to take part in the study. Qualitative data could have helped both these studies by determining such things as the type of personal trauma, how their participants managed any personal triggers and what part of the work had the biggest impact and why? This could provide valuable information to further help understand and minimise the effects of vicarious trauma.

2.13.2. Clinical experience

An exploratory study based on a phenomenological philosophy was carried out by Iliffe and Steed (2000), considering counsellors' experience of working with

perpetrators and survivors of domestic violence. Almost all participants identified feelings of loss in confidence, powerless, inadequacy, ineffectualness, stress and anxiety when starting in the field of domestic violence, as well as experiencing changes in visual images and physical symptoms. Two thirds of participants reported having experienced symptoms of burnout, with a lack of training and isolation reported as secondary contributors. Whilst a lack of training could be seen as both ethically and morally wrong, as most of their counsellors had only received an average of three and a half days domestic violence training, this could also have influenced the study's findings. A second, longitudinal study would have been useful to identify whether further training and a greater clinical experience went on to help their counsellors cope with the demands of the job.

In a study involving 116 self-selected professionals working with traumatised clients within a range of settings, McLean, Wade and Encel (2003) hypothesized that therapist endorsement of unhelpful beliefs would contribute significantly to both vicarious trauma and burnout. Furthermore, they believed therapists who were less experienced, had a recent personal trauma history, worked with children or had more contact time with traumatised clients, would have increased distress. Results suggested that amongst other things, less clinical experience may render therapists more prone to secondary traumatisation, burnout or emotional exhaustion. Those therapists who had less experience appeared to be more susceptible to the symptoms of intrusion and avoidance, backing up similar findings by others (Neumann & Gamble, 1995; Chrestman, 1999; Iliffe & Steed, 2000; Way et al., 2004). Again, because of the nature of self-selection biases which may influence results, the different work settings and the relatively short time frame over which this study was done, results should be considered with caution.

Countertransference responses common to therapists working with survivors of chronic childhood trauma were explored by Neumann and Gamble (1995). Consideration was given to the negative impact responses may have. Specifically, its focus explored issues pertaining to those therapists who were relatively new to the trauma field. Throughout the paper, the authors highlight several important

points to consider in relation to the professional development of psychotherapists such as self-care and organisational issues. No evidence was given by Neumann and Gamble (1995) to support the suggestion that therapists with less experience may become pre-occupied with clients and engage in 'rescue fantasies,' whilst questioning their levels of competence. Furthermore, whilst countertransference and vicarious trauma are closely linked within the paper, the article fails to cite an evidence base to support the many sweeping statements offered by the authors for the negative responses that therapists may experience.

2.14. What Protective Factors Help Ameliorate Therapist Vicarious Traumatisation?

Increasingly from the literature, it appears the question is not whether therapists will be exposed to the negative effects of working with trauma, but rather how they respond when this happens (Munroe, 1999). As well as the positive effects of working in the trauma field discussed earlier, several other themes were identified within the literature from the review process, regarding the protective factors that help ameliorate vicarious traumatisation.

2.14.1. Self-care

Mental health professionals are regularly engulfed by client pain and disability, rountinely confronted by conscious and unconscious hostility and ethically bound to confidentiality about the most troubling presentations and occasionally heinous crimes (Norcross, Guy & Laidig, 2007). Therapists may become so busy contemplating and attending to the needs of their clients that their own needs for maintaining a healthy lifestyle become secondary (Petker, 2016). Sustaining the personal self is a serious obligation even though many in the caring professions may battle with feelings of selfishness when trying to meet their own needs (Skovholt & Trotter-Mathison, 2016). Self-care is an 'ethical responsibility' of the therapist (Neumann & Gamble, 1995). It begins with the recognition and preparation for the inevitable hazards of therapeutic work (Norcross et al., 2007).

Whilst not always specific, the daily self-care strategies highlighted within the literature review which helped restore a sense of meaning, connection and hope included such things as; resilience (Skovholt & Trotter-Mathison, 2016), personal therapy (Norcross & Guy, 2007), exercise, healthy eating and sufficient sleep (Steed & Downing, 1998), volunteer work (Eidelson et al., 2003), professional development (Skovholt & Trotter-Mathison, 2016) creative activities (Pearlman, 1999), faith (Neumann & Gamble, 1995), managing caseloads (Lonergan, O'Halloran & Crane, 2004), setting boundaries (Norcross & Guy, 2007), training (Gentry, 2002), supervision (McLean et al., 2003), and peer support (Pearlman & MacIan, 1993). Each of these activities in their own way can help balance some aspect of the role of trauma therapist (Pearlman, 1999). Holistic self-care, amongst other things, was identified as a protective factor for therapists within a study by Harrison and Westwood (2009). However, as most participants in the study were raised in a religious tradition and now primarily practice a sense of spirituality outside the context of organised religion, this raises questions as to how representative of therapists working within the trauma field this is. It also raises questions as to whether therapists raised in a non-religious tradition, could be more likely to suffer vicarious trauma.

2.14.2. Supervision

Clinical supervision can provide an opportunity to process horrific stories, graphic imagery and destruct re-enactments, which are an inevitable part of trauma work regardless of the level of experience (Sexton, 1999). Many studies have highlighted the importance of supervision and acknowledge it as a protective factor against therapist vicarious trauma (McCann & Pearlman, 1990; Iliffe & Steed, 2000; Bell et al., 2003; McLean et al., 2003; Adams & Riggs, 2008). Its primary aim is to develop therapeutic competences and ensure practice conforms to ethical and professional standards (Roth & Pilling, 2008).

It has been suggested there are four key components of trauma therapy supervision; (i) a solid theoretical grounding in trauma therapy, (ii) attention to conscious and unconscious aspects of the therapeutic relationship, (iii) attention to

countertransference and parallel processes, and (iv) education and exploration of manifestations of vicarious trauma (Pearlman & Saakvitne, 1995a). The supervision competences framework offered by Roth and Pilling (2008) maps out the standards a supervisee should expect and underpins those activities a supervisor should attend to. However, not just the responsibility of a supervisor, it is also necessary to consider the possible effect on the supervisory relationship of any issues impeding upon the supervisee's ability to be transparent about any problems they may be experiencing. If both parties openly identify any beliefs that interfere or threaten the integrity of the supervision process, potential problems can be quickly addressed and prevented (Westbrook, Kennerley & Kirk, 2007).

A small study by Van Minnen and Keijsers (2000), acknowledged the difficulties some trauma therapists face when discussing problems due to a sense of shame about not coping. Significantly more non-trauma therapists worked within a supervision setting, whilst trauma therapists talked with colleagues in an informal setting. This reflected the findings of Pearlman and MacIan (1993), in which 85% of trauma counsellors reported discussion with their colleagues as their most common method of dealing with vicarious trauma.

It is vital that organisations foster an environment in which work-related stress is accepted; where the focus is to seek solutions rather than attribute blame; and in which support and tolerance are clearly evidenced (Catherall, 1995). However, it is important to remember this is not just an organisational issue and individual therapists must remain professionally accountable for addressing any personal trauma reactions they may be experiencing in an honest and open manner, through regular work-based or external supervision.

2.14.3. Training

Therapists working in the trauma field are particularly vulnerable if they lack a strong foundation in the theory of trauma (Williams & Sommer, 1999). Traditional counselling and psychotherapy training hasn't equipped therapists to deal with substantial trauma and its long term effects (Danieli, 1994). Whilst mindfulness

training may help therapists, '…tolerate ambiguity, embrace complexity, recognise limits, and differentiate between empathic and sympathetic over-identification…' (Harrison & Westwood, 2009:215); an important aspect prior to starting trauma work is adequate preparation and trauma training. Reflected in all literature reviewed and the most important consideration to help prevent burnout and vicarious traumatisation, was therapeutic self-awareness. Through continual professional development, training or education, therapeutic self-awareness can develop and deepen, thereby helping to ameliorate the effects of vicarious trauma (Neumann & Gamble, 1995; Iliffe & Steed, 2000; Way et al., 2004; Pross, 2006; Adams & Riggs, 2008; Chrestman, 2009).

Whilst a competency framework compiled for delivering effective CBT treatment includes three different models specific to PTSD (Roth & Pilling, 2007), there are also various online, college or university courses that offer training in the recognition or treatment of PTSD for professionals working with trauma. Although aimed at different levels of competency (eg. training certificate, diploma, masters degree) these courses may not always be adequate in equipping therapists to work in this specialised field (Williams & Sommer, 1999). Care should be taken to ensure any training course undertaken also includes regular supervised skills practice with a suitability qualified trauma-specific supervisor, education of the symptoms and potential impact of vicarious trauma, self-care strategies (Skovholt & Trotter-Mathison, 2016) and for individuals working within organisations, that the course will be recognised and supported by their employers.

Another consideration for organisations and individual therapists to reflect upon, may be limiting training. Overwhelmed therapists, recently trained in specific trauma techniques such as EMDR or Traumatic Incident Reduction (French & Harris, 1998) may have an inflated sense of skill and practice beyond their level of competency (Gentry, 2002). This can lead to negative outcomes for both clients and therapists in terms of treatment and welfare. New skills need to be consolidated and competence levels increased, prior to undertaking further training to ensure they do not impact negatively on existing clinical practice.

2.14.4. Empathy

As previously discussed (page 28), to show empathy is to walk in another's shoes to understand, accept and gain insight to something they have experienced, without judgement (Rogers, 1975). Contrary to the earlier discussion which suggested empathic engagement could make therapists vulnerable to the effects of vicarious trauma (Raquepaw & Miller, 1989; Sexton 1999), empathic responses can give better treatment results, recovery and patient satisfaction (Figley, 1995). An empathic response to vicarious trauma, may be a mechanism through which positive change occurs (Brockhouse, Msetfi, Cohen & Joseph, 2011). In a study by Harrison and Westwood (2009), intimate empathic engagement sustained participants in their work through being able to get very close to their client's story, experience and perspective, without fusing their own. This aspect of the work was found to be nourishing for both therapist and client. However, the study failed to address how therapists maintained their interpersonal boundaries and how this was measured. Additionally, the study failed to address the evidence for the authors' claim that clients felt nourished, although in part therapists recognised it as beneficial, and leaves these questions open to interpretation. An earlier study, (Steed & Downing 1998), argued some therapists reported a greater appreciation of their clients and recognition of their strength and resilience, whilst others reported a greater depth of compassion. However, due to several limitations with sample size, variables and reliability, the study cannot be generalised.

2.14.5. Professional satisfaction

An assumption by Stamm (2002), was that the quality of a professional's interaction with colleagues and work satisfaction (compassion satisfaction) played a critical role in reducing compassion fatigue and mitigating burnout, the concepts of which are related to vicarious trauma (Conrad & Kellar-Guenther, 2006). Child protection workers in the study by Conrad and Kellar-Guenther (2006), despite having a high risk of compassion fatigue supported Stamm's (2002) theory, reporting higher compassion satisfaction and significantly lower levels of burnout and compassion fatigue. One cause of burnout when working with the traumatised is their low level of social recognition through things like job titles, opportunities for

continuing professional development and salaries, which could play a major role in the psychological health of the helper, especially within the professional establishment (Pross, 2006). This reflects findings by Maslach and Leiter (1997), where amongst other things sustainable workload, feelings of choice and control, recognition and reward, respect and valued work were considered important to help ameliorate burnout.

2.14.6. Organisational responsibilities

Therapists working in organisations may feel more constrained within their clinical practice than those working in private practice. An important responsibility for organisations is to recognise and understand the impact of doing trauma work upon its staff and healthier workplaces have been identified in government initiatives (DoH, 1998). Too often, work settings and their training programmes, can directly or indirectly, have a negative impact on those working with trauma clients, leaving them feeling weak, de-skilled or emotionally unstable (Rosenbloom, Pratt & Pearlman, 1999). Resignation due to vicarious trauma can result in high staff turnover (Sexton, 1999). This can be helped by work environments promoting continuing education and qualifications, varying caseloads, encouraging creativity and flexibility, and recognising that individuals are not solely involved with treatment or evaluation of patients (Chrestman, 1999; McLean et al., 2003; Pross, 2006). Moreover, anyone overseeing trauma counsellors including supervisors, managers and administrators, should consider the impact of vicarious trauma and take an active role in preventing this (Neumann & Gamble, 1995; Trippany et al., 2004).

2.14.7. Dual focus

It has been acknowledged within trauma research that learning about a traumatic event without being personally involved can induce symptoms, leaving therapists susceptible to developing intrusive images of their client's trauma (eg. APA, 2000; Trippany et al., 2004). New research is emerging drawing on existing memory work (James et al., 2015), exploring the theory of reconsolidation as a way of making established memories malleable and vulnerable to disruption, following

reactivation (Medical Research Council, 2015). Although in its developmental stage, this builds upon previous studies by Holmes and Bourne (2008) and Krans et al. (2010). Holmes and Bourne (2008) found that intrusions to directly perceived trauma could be modulated by completing a task. To complement their study, Krans et al. (2010) investigated whether intrusive visual images could develop from listening to a traumatic verbal report. Results suggested that frequency of intrusive visual images, developed from verbal traumatic information, could be modulated by employing a dual task such as modelling clay during reliving sessions, to prevent the development of intrusions. It could be argued that EMDR, one of the recommenced treatment modalities for PTSD, uses a protective factor of a dual task when implementing eye movements or tactile stimuli such as hand-taps during repossessing. Whilst speculative, the findings raise questions as to whether therapists using EMDR, are less at risk of vicarious traumatisation than those delivering trauma-focused CBT.

2.15. Summary of Literature Review Chapter

Research and literature focusing on the impact of trauma work on professionals such as social workers, disaster workers, trauma therapists etc., indicated that these groups are at risk for PTSD, burnout, vicarious traumatisation or secondary traumatic stress/compassion fatigue (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995a; Myers & Wee, 2002). Figures show between 34% and 85% develop vicarious trauma and/or high rates of traumatic stress symptoms which impact on their professional and private lives (Lobel, 1997; Cornille & Meyers, 1999; Conrad & Kellar-Guenther, 2006; Perron & Hiltz, 2006; Adams et al., 2006; Bride, 2007; Mathieu, 2012).

Much of the literature reviewed, discussed the effects of working with trauma generally (McCann & Pearlman, 1990; Steed & Downing, 1998; Sabin-Farrell & Turpin, 2003; Kadambi & Ennis, 2004; Trippany et al., 2004; Neumann & Gamble, 1995; Harrison & Westwood, 2009). It addressed both positives and negatives of trauma work and considered whether there were any pre-disposing factors to vicarious trauma, or similarities with its related concepts of burnout, secondary

traumatic stress, compassion fatigue and countertransference. Many of the research studies reviewed had similar limitations with low response rates, small sample size, which although cannot be generalised can be built upon and participants being ‘self-selected’ trauma therapists which may influence results.

With an average of 44% of ‘helping professionals’ working with trauma survivors being affected, vicarious trauma and secondary traumatic stress/compassion fatigue, appeared prevalent. Research identifying any protective practice that can help reduce prevalence is important to support psychological therapists in their trauma work, inform practice and contribute to the existing knowledge base. Whilst not exhaustive, an apparent gap has been identified that contributes to the studies carried out to date. Whilst research and literature is emerging around vicarious trauma, no studies were identified concerning whether delivering the recommended treatment modalities for PTSD (NICE, 2005), had any influence on reducing therapist vicarious traumatisation. This study aimed to research how therapists experience working with trauma using the recommended treatment modalities of trauma-focused CBT and EMDR. It also sought to identify any protective practices against vicarious trauma, whilst considering the issue of any potential pre-disposing factors.

The following chapter discusses the research design that was adopted for this study. It discusses key points around methodology and method and introduces the main types of human science research and the research question.

Chapter 3: Research Design

3.0. Overview

This chapter will guide the reader through the research process undertaken for this study and discuss methodological issues and describe the methods used. Starting with the methodology section the chapter will:

1. Consider the main types of human science research.
2. State the research question.
3. Discuss epistemology and research methodology considered the most appropriate in order to answer the research question.
4. Justify the choice of methodology.

The chapter will move to the method section which will set out the process undertaken to carry out the study. This discussion will focus on:

1. Ethical considerations.
2. Participant recruitment.
3. Data collection.
4. Data analysis.
5. Quality assurance and rigour.

3.1. Methodology Section

3.1.1. Types Of Research In The Human Sciences

Table 3 (page 44), clearly defines two main types of research in the human sciences, namely objectivist and subjectivist and was used as a framework when considering which approach to take. In order to find the most appropriate approach for this research, consideration was given to both the aims and objectives of the research and the methodology best suited to answer the research question.

Table 3: A summary of distinct differences between objectivist and subjectivist, human science research. (Adapted from Crotty, 1998)

Aspect	**Issue**	**Objectivist**	**Subjectivist**
Ontology	The study of being. What "is real?"	*Realism*. Real social world with real structures. Social world exists independent of consciousness.	*Nominalism*. No real structures in the world. Described by concepts.
Epistemology	The theory of knowledge embedded in the theoretical perspective. What can we know and how can we know it?	*Positivism.* Search for regularities and causal relationships.	*Anti-positivism.* Objective knowledge impossible – emphasis on understanding.
Methodology	The strategy, plan of action, process or design. How can we approach investigation?	*Nomothetic.* Search for general theories/laws that cover a whole class of cases.	*Idiographic.* Study of individual cases for detailed insight.
Method	Techniques or procedures used to gather and analyse data.	Use of standardised measures e.g. survey, questionnaire, experiments, observation.	Spoken or written word or images e.g. interviews, focus groups, text analysis.

3.1.2. Research Question

How do CBT and EMDR therapists working with the recommended treatment modalities for PTSD, make sense of their experiences and protect themselves from any negative effects of the work? Is there a distinction in therapist experience between the two modalities?

3.1.3. Ontology

Ontology is the study of being (Crotty, 1998). It is concerned with the nature of existence (what is real) and the structures of that reality (Crotty, 1998; Plowright, 2011). The two ontological perspectives are *realism* and *nominalism*. The principles of realism are that universals or abstract concepts have an objective or absolute existence and exist outside an individual's perception. In contrast, the principles of nominalism suggest that only particular objects exist and universals or

general ideas do not exist at all but are merely names to consider the things that exist.

3.1.4. Epistemology

Epistemology is a philosophical term which refers to assumptions we make about what knowledge is, how knowledge is generated, what we know and how we know what we know (Crotty, 1998; Coyle, 2012). Epistemology is concerned with the discovery of *how* and *why* problems occur. More recently, a period of epistemological transformation has taken place within psychological professions (Gilkinson, 2009). The 'third wave/third generation' in psychology, moves away from objectivism and the belief that knowledge about reality can only be discovered through observation and measurement, independent of human understanding. Postmodernist and constructivist approaches, focus on the understanding and meaning for the individual (Heidegger, 1962; Gadamer, 1989; Charmaz, 2003; Smith et al., 2009). These approaches argue there is no meaning without a mind, so meaning is not discovered but constructed based on past experience, personal views and cultural background (Crotty, 1998).

Constructivist theory is based upon the premise that individuals develop meaningful systems to understand their world and own experiences (Raskin, 2002; Burck, 2005). There are many forms of constructivism/constructionism within the literature and terminology is often inconsistent and used interchangeably. Examples include; personal constructivism (Kelly, 1991a/1991b), radical constructivism (Von Glasersfeld, 1991), hermenuetic constructivism (Raskin, 2002), psychological constructivism (Chiari & Nuzzo, 1996) and social constructionism (Vygotsky, 1978).

As stated previously, research around the psychological and social difficulties associated with PTSD has grown considerably in the last three decades. It could be argued that psychological trauma is a sociocultural construct determined by the social context in which it occurs (Figley, 2012). Although historically the concept of

trauma was used in medicine to depict a wound, the term adapted and became a metaphor for the psychological difficulties experienced following an intense event (Figley, 2012). During the many phases of recognition and legitimisation of psychological trauma, conceptualisation and treatments have been affected by the sociocultural and political climate (Figley, 2012). For clarification, this study defines 'constructivism' as focusing on how individuals make sense of the activity in question and 'constructionism' as focusing on how meaning is generated and communicated collectively, with an emphasis on the hold our culture has on an individual (Crotty, 1998).

3.1.5. Qualitative Methods Considered

Unlike quantitative approaches, which seek a more objective, measured approach based in positivism, qualitative research generally adopts an idiographic approach without seeking to make generalizations (Dallos & Vetere, 2005). There are several aims to qualitative research which have been described as interactive, humanistic, emergent and interpretative (Creswell, 2009). These are: to understand individual or group meaning, examine institutional and social practices and processes, identify barriers and facilitators to change and discover reasons for success or failure of interventions (Elliot, Fischer & Rennie, 1999; Starks & Brown Trinidad, 2007; Creswell, 2009).

Within the qualitative tradition of enquiry, phenomenological approaches appeared to be the most suitable to adopt in the current study. This was due to the approaches position with regards to the value it gives to the belief that individuals are unique and therefore studied from their own subjective experience. This approach also fitted with the researcher's epistemological standpoint and tapped into their core therapeutic counselling training in Carl Rogers (1902-1987) humanistic approach of Client Centred/Person Centred theory.

Counselling psychology is based on the humanistic principals of empathy, congruence and unconditional positive regard (Rogers, 1961). It prioritises the client's subjective and intersubjective experience, focuses on growth and enhances

the potential and uniqueness of the client (Radu, 2013). The central truth for Rogers was that the client knows best (Mearns & Thorne, 1999:1). Rogers believed for a person to thrive, they need an environment that provides them with genuineness (openness and self-disclosure), acceptance (being seen with unconditional positive regard), and empathy (being listened to and understood) (McLeod, 2014). Within this research, the relationship between the researcher and the participant mirrors that of the client/therapist relationship within the therapy room. It is important therefore to consider all of Rogers (1961) humanistic principals and engage in an approach that is sympathetic to these.

3.1.5.1. Phenomenology

Phenomenologists are interested in the meaning and common features of a lived experience and seek to provide a detailed account of such. Comprehended through embodied experience or perception, meaning is created through the experience of moving through space and across time (Starks & Brown Trinidad, 2007). With its roots in early twentieth century European philosophy, phenomenology is an approach that is widely used for investigating experiences within health research (Starks & Brown Trinidad, 2007; Pringle, Drummond, McLafferty & Hendry, 2011). It has also been described as a 'powerful tool' for human science (Mortari & Tarozzi, 2010:10). In contrast to positivism, phenomenology sees reality as both relative and subjective and attempts to examine how people think and interpret phenomena. It has a particular interest in the basics of social existence and stems from the philosophical concerns of 'being-in-the-world' (Heidegger, 1962) and an interest with the lived experience of human beings within 'life-world' (Husserl, 1970).

Husserl (1859-1938), the founding principal of phenomenological inquiry, first argued for experience to be examined in the way that it occurred and in its own terms (Husserl, 1970; Laverty, 2003; Smith et al., 2009). In order to suspend judgement or bias about a particular phenomenon and see it clearly, Husserl proposed we should 'bracket out' any past experiences or pre-suppositions about the nature of the phenomena (Husserl, 1970; Laverty, 2003; Osborne, 1994;

Pringle et al., 2011). He argued that 'life-world' is understood, 'as what individuals experience pre-reflectively, without resorting to interpretations' (Dowling, 2007:132). Therefore, it is experience as it is, before applying ways to understand it, explain it, or think about it (Crotty, 1998).

Within phenomenological literature, bracketing is suggested as a method which encompasses; pre-conceptions (Glaser, 1998, 2010), pre-suppositions (Crotty, 1998), beliefs and values (Beech, 1999), biases (Creswell & Miller, 2000), emotional sensitivity (Drew, 2004), assumptions (Charmaz, 2006), and thoughts and hypotheses (Starks & Brown Trinidad, 2007). Furthermore, within phenomenological research, 'the implementation of bracketing can help mitigate any adverse effects of unacknowledged pre-conceptions related to the research; increase the study's rigour; and protect the researcher from the cumulative effects of examining what may be emotionally challenging material' (Tufford & Newman, 2010:81).

In contrast, Heidegger (1889-1976), who began his career as a student of Husserl's, questioned Husserl's philosophy and went on to distance himself from his approach. Through his major work *Being and Time* (1962), Heidegger questioned the possibility of knowledge outside of an interpretative stance (Smith et al., 2009). Heidegger's hermeneutic phenomenology, like Husserl's phenomenology, is concerned with human experience as it is lived. However, Heidegger challenged Husserl's construction of phenomenology, as a purely descriptive philosophy (MacKey, 2005).

Heidegger referred to phenomenology, which seeks to uncover understanding of the meaning of 'being' as hermeneutic and designated it an interpretive, rather than descriptive process (Heidegger, 1962). The word hermenuetic, 'derives from the Greek word *hermeneuein* which means to interpret or to understand' (Crotty, 1998:88). Schleiermacher was one of the first to write systematically about hermeneutics theory of interpretation, as a generic form and offered a holistic view of the interpretative process (Smith et al., 2009). Hermenuetic inquiry has the

potential to uncover meanings or intentions that are hidden within the text (Crotty, 1998). Schleiermacher believed in order to understand the writer as well as the text, by engaging in detailed, comprehensive and holistic analysis, you could understand, ‘the utterer better than he understands himself’ (Schleiermacher, 1998:266). As such, interpreters may uncover explicit awareness of meanings and assumptions that the authors themselves fail to articulate (Crotty, 1998).

Heidegger introduced interpretation as both a concept and method of phenomenology (Heidegger, 1962). He believed there were many ways for a human to be-in-the-world but most significant was the awareness of one’s own ‘Being’ across time and space (Heidegger, 1962). Heidegger embarked on the phenomenology of human ‘Being’ or the state he named as ‘Dasein’ (Heidegger, 1962), which translated from German literally means ‘being there’ (da sein). Whilst Husserl’s primary concern was focused around psychological processes such as individual perception, awareness or consciousness; Heidegger was more concerned with existence itself, activities and relationships we experience, together with the lens through which the world appears to us and is made meaningful (Heidegger, 1962; Smith et al., 2009).

Heidegger’s student, hermeneutic theorist Gadamer, also believed modern science theories failed to generate understanding of human beings and their activities (Gadamer, 1989). Developing Heidegger’s work further, Gadamer (1975) believed that rather than distorting biases that hinder understanding, our pre-conceptions provide a necessary frame of reference from which our initial perspective on a given phenomenon can develop (Thompson, Pollio & Locander, 1994). Gadamer argued hermeneutical understanding is based on historical understanding that mediates past (tradition) and present (interpretation) (Crotty, 1998). He described this process as ‘a fusion of horizons’ (Crotty, 1998:101). Like Heidegger, Gadamer believed the horizon of the present cannot be formed independently of the past (Crotty, 1998) and advocated a return to humanistic tradition (Turner, 2003).

Phenomenological research typically uses interviews or extended conversations as the source of data (Rudestam & Newton, 2007). However, as phenomenologists are interested in the meaning and common features of a lived experience, major themes are identified and represented from the participant's account, to provide a detailed description of the authentic experience (Denscombe, 2007). Although phenomenology has been criticised as lacking scientific rigor compared to other methodologies (Rawson, 1999; Denscombe, 2007), a study with a phenomenological oriented stance, provides rich, complex, detailed data and is suited to small scale research (Dallos & Vetere, 2005).

After consideration of all elements needed for undertaking human science research, a qualitative, phenomenological approach with its focus on understanding, meaning and experiences of participants, was deemed to be the most appropriate methodological fit to meet the aims of this research study. This approach recognises and values an individual's perception on a subject, which reflects an important aspect of the therapeutic relationship in the researcher's role as a therapist. This led to further consideration of the more recent methodology/method, Interpretative Phenomenological Analysis (Smith, Flowers & Larkin, 2009).

3.1.5.2. Interpretative phenomenological analysis (IPA)

IPA is an approach to qualitative, experiential and psychological research which has been growing in popularity since it was first introduced (Smith, 1996; Smith et al., 2009). It has been used extensively in health psychology, clinical and counselling psychology, as well as social and educational psychology. Various studies have been used to give participants a voice that may otherwise have gone unheard (Knight, Wykes & Hayward, 2003; Larkin, Watts & Clifton, 2006; Marriott & Thompson, 2008; Smith, et al., 2009; Fox & Diab, 2015).

IPA has been described both as a methodology (Smith, 1996, 2009; Brocki & Wearden, 2006; Biggerstaff & Thompson, 2008; Hefferon & Gil-Rodriguez, 2011)

and method (Knight et al., 2003; Larkin et al., 2006) due to boundaries or terminology used becoming blurred or interchangeable. Although IPA is phenomenological and concerned with detailed examination of the lived human experience, it is based upon and draws concepts from three key areas of the philosophy of knowledge (Smith et al., 2009). These are phenomenology and hermeneutics as previously discussed and idiography.

Idiography is concerned with the detailed study of a particular phenomenon using thorough and systematic analysis. Edmund Husserl was known for encouraging phenomenologists, 'to go back to the things themselves' and IPA research is similar in this regard (Smith et al., 2009:1). IPA studies seek to gain detailed knowledge about what the experience is like for *this* person and what sense *this* person is making of what is happening to them, in a particular context (Smith et al., 2009). As a consequence, IPA studies usually have small, purposive, homogenous samples which do not seek to make generalisations.

As previously noted, there has been some criticism of qualitative approaches as they do not have a hypothesis to support or challenge, are not generalisable (Rawson, 1999), and one researcher may analyse or interpret data differently than another (Silverman, 2006). Furthermore, when only brief extracts of participant transcripts are chosen by the researcher for inclusion in the write-up, this does not allow sufficient information for the reader to make up their own mind on the subject under discussion (Silverman, 2006) and could have the potential for bias.

IPA has received some criticism and questions have been raised about the approaches authenticity and reliability. Criticism has been in regard to its focus being on *how* people experience a phenomenon, rather than a focus on *why* they experience it (Willig, 2008). It has been argued that IPA has limitations with regard to its role of language, suitability of accounts, explanation versus description, and genuineness as a phenomenological method (Willig, 2008). Furthermore, as language is constructed to describe an experience rather than informing a

researcher about the actual experience, participant accounts may be constrained by their ability to express and articulate their thoughts, emotions and behaviours in detail (Willig, 2008).

The practice of Husserlian 'bracketing' within interpretation, which could be seen as controversial, has also been questioned (Biggerstaff & Thompson, 2008). Bracketing involves suspending any pre-suppositions or judgements that a researcher may have, to focus solely on data obtained from the research. Heidegger questioned the possibility of knowledge outside an interpretative stance (Heidegger, 1962). Within phenomenological research, bracketing usually relates to the researcher examining their own prejudices to allow them to include the views of their participants (Dowling, 2007). One method might include the researcher writing memos throughout the data collection and analysis process, in order to examine and reflect upon their engagement with the data (Cutcliffe, 2003). Although not differentiating between descriptive and interpretive phenomenology (Dowling, 2007), Donalek (2004:516) argued, 'research is not truly phenomenological unless the researcher's beliefs are incorporated into the data analysis'. To prevent resurfacing of buried emotions or experience (Drew, 2004), various authors have argued the case for the bracketing process to be explicit, clear and honest (Beech, 1999; Creswell & Miller, 2000; Starks & Brown Trinidad, 2007). Others have questioned the need for researchers to set aside any assumptions or experience within an interpretative approach and suggested initial bracketing in IPA is superseded, with the inclusion of the researcher's own reflexivity as the analysis continues (Biggerstaff & Thompson, 2008).

Carl Rogers encouraged therapists engaging in client centred/person centred therapy to offer their clients 'unconditional positive regard' (Rogers, 1957; 1961). Although crediting Standal (1954) for coining the term, Rogers defined it by individually explaining its key elements (Haugh, 2001). He defined unconditional as 'having no conditions of acceptance'; positive as 'a warm and caring acceptance of a person'; and regard as 'having regard for each aspect of the client's experience as being part of that client' (Rogers, 1957:95-103). A therapist offering

unconditional positive regard, in some respects similar to Husserl's concept of bracketing, attempts to set aside prior pre-conceptions, assumptions and attitudes that may filter their perceptions and help create meaning. This practice helps the therapist accept their client's unique experience without judgement and gives 'permission' for them to voice their own feelings and experience.

Coming from a humanistic background as a person centred counsellor, the researcher believes the researcher's role reflects this within IPA. When seeking to gain detailed knowledge from participants about their own subjective experience, the initial process of trying to set aside prior pre-conceptions, assumptions or attitudes, enables the participant's voice to be heard. This echoes Rogers (1957) definition of regard and respects participants own feelings and experiences. However, the possibility of knowledge outside an interpretative stance has been questioned (Heidegger, 1962). Within this study, to enhance self-awareness, understanding, aid the analytical process and develop research ideas, the researcher kept reflective memos to record details of ideas and thoughts as they emerged.

3.1.5.3. Justification for choice of IPA

There is a growing body of IPA research studies within the mental health field validating its significance within psychological research. For those new to the area of research and IPA, there are comprehensive guidelines for undertaking a good quality study which allow and encourage the flexibility of the method (Smith et al., 1999; Smith & Osborn, 2008; Smith et al., 2009; Smith, 2011).

IPA fits within the researcher's epistemological standpoint and reflects their humanistic counselling philosophy. Its approach is committed to the examination of how people make sense of their life experiences in a personal and social context. Whilst it does not demand too much of participants time, except for an initial interview and subsequent validation of the interview transcript, the approach allows for the exploration of participant viewpoints of the subject under discussion

and represents them whilst offering a picture of their dominant beliefs as main issues and themes (Dallos & Vetere, 2005).

Although there is criticism of qualitative approaches and IPA with regard to its generalisability, focus, participant ability to articulate thoughts and emotions and bracketing/reflexivity, the researcher has considered this (Rawson, 1999; Silverman, 2006; Willig, 2008; Biggerstaff & Thompson, 2008). The criticisms whilst acknowledged, were balanced against the advantages of the approach and the rich description of the phenomenon in question that could be gained. Furthermore, as participants are qualified therapists helping clients' articulate thoughts and emotions on a daily basis, the researcher upon reflection felt confident they would be able to articulate these within their interview. As previously stated (page 53), to address the concept of reflexivity, the researcher kept a record of ideas and interpretations as they emerged.

Suited to small scale research and consistent with the research aims, IPA was adopted for a pilot study. The appropriateness of the methodology/method for the main study was evaluated within the pilot, by testing out the interview method, questions and analysis technique. Due to the successful outcome of the pilot, IPA was again adopted for the main study. For the purposes of this thesis and guided by the human science research framework used for the study (Table 3, page 44), IPA will be referred to as both the methodology and method used to gather and analyse data for the study and be discussed further throughout the method section.

3.2. Method Section

Ethical guidelines for human research in Britain are published by the British Psychological Society (BPS). The Code of Human Research guidelines state research should be designed, reviewed and conducted in a way that ensures its quality, integrity and contribution to the development of knowledge and understanding (BPS, 2010). Student research is expected to comply with the codes four principles of; respect for the autonomy and dignity of persons, scientific

value, social responsibility, and maximising benefit/minimising harm. Following its guidelines, two university academic staff were appointed to oversee the research process and act as research supervisors.

3.2.1. Ethical Considerations

Any time there is involvement with human behaviour ethics are an integral part of the process (Figley, 2012). Ethical guidelines are necessary to clarify the conditions under which psychological research can take place (BPS, 2010). The guidelines aim to protect any research participants, the reputation of psychology and the psychologists (researchers) themselves (McLeod, 2007). Ethical principles underpin all research to ensure researchers carry out their studies in an open, honest way and with the protection of their participants in mind.

A request for ethical approval to carry out a small pilot study followed by a larger main study as part of a Professional Doctorate was submitted through the University of Derby, Nursing and Allied Health Professional Research Ethics Committee. Ethical approval from the University of Derby, Nursing and Allied Health Professional Research Ethics Committee was received on the 22 May, 2012 (Appendix F). In the case of insufficient participants volunteering to take part in the study in the first recruitment stage, a second request for ethical approval was submitted through the University of Derby, School of Health Research Ethics Committee. This was to ensure a second phase of recruitment outside the parameters of the initial approval, could take place without delay if required. Ethical approval with clarification and conditions was received on the 13 June, 2013 (Appendix G).

Clarification was also sought from the Research and Development Directorate as to whether ethical approval also needed to be gained through the National Health Service (NHS) Ethics Committee (Appendix H). This was because participants although working for private companies, may be working with clients referred from the NHS. Confirmation was received on the 13 August, 2012 that approval was not needed through the NHS Ethics Committee (Appendix I).

3.2.1.1. Sample size

An appropriate sample size for a qualitative study is one that adequately answers the research question (Marshall, 1996). Within the literature, IPA sample sizes are suggested merely as guidelines. When undertaking an IPA study and considering sample size, this should be influenced by the following elements: (i) the depth and variety of the data obtained, (ii) the degree of commitment to the level of analysis and reporting, and (iii) any organisational constraints one may be operating under (Eatough & Smith, 2006; Smith et al., 2009).

Unlike quantitative approaches which strive for generalisations and generate data using standardised measures, qualitative research methods generally adopt an idiographic approach without seeking to make generalisations (Dallos & Vetere, 2005). Whilst not opposed to making general claims for larger populations, IPA is committed to analysing a small number of cases which may lead to such generalisations (Smith & Osborn, 2003). Whilst this might be a limitation in substantiating theory, it allows for a richer depth of analysis (Smith et al., 2009).

IPA was chosen for this study as its concern is to give a rich, detailed account of a participant's personal experience, which should be about depth rather than breadth (Reid, Flowers & Larkin, 2005; Smith & Eatough, 2012). It has been suggested that less is more in IPA and that fewer participants examined at a greater depth, is more preferential to a descriptive analysis of many participants (Reid et al., 2005). Researchers are encouraged to choose a sample size sufficient enough to examine any similarities or differences, without being overwhelmed by data generated by larger sample sizes which can be particularly time consuming during analysis (Eatough & Smith, 2006).

Whilst there appears no definitive answer to sample size, published IPA studies have included a range of sample sizes between one and fifteen or more (Smith & Osborn, 2003; Reid et al. 2005; Eatough & Smith, 2006; Smith & Osborn, 2007; Smith & Eatough, 2012). Aiming for sufficient study data and using this as a

guideline, two to three participants were initially sought to take part in the pilot study and a further eight to twelve participants were sought for the main study.

3.2.1.2. Participant consent and withdrawal from the investigation

Decision to participate in the study was voluntary. This was to help ensure participants did not feel forced or coerced into helping with the research (Denscombe, 2007). A letter (Appendix J, K) explaining the purpose of the study was provided to participants as part of an information pack, containing the interview schedule (Appendix L), consent form (Appendix M) and support information (Appendix N, O). In particular, the letter drew attention to what participants were expected to do, how they could withdraw from the study and confidentiality issues. The letter included contact details of the researcher, to afford the opportunity to ask any general questions including potential risks or benefits.

Consent forms for tape recording the interview were supplied to participants for signing prior to conducting any interviews (Appendix M). Sufficient time and information concerning the study and taped interviews was given for participants to consider whether or not to participate in the study and change their minds as necessary (Lee, 2009). Participants were also offered a time-limited right to withdraw consent at any time during data collection and analysis, together with opportunities to review transcripts for quality assurance and withdraw any comments made during their interview, which they did not want to appear in the public domain.

3.2.1.3. Confidentiality

Participants in psychological research have a right to expect the information they provide to be treated as confidential and, if published, remain unidentifiable as theirs (BPS, 2010). Participants were provided with details of the specific circumstances in which confidentiality would have to be breached (Appendix J, K). Anonymity was ensured by supplying all participants with an identifiable reference number for use in place of personal details within the research study. Unedited

data transcripts were only seen by the researcher and the participant who provided the data. Any data used for any wider purposes such as peer review or university supervision was edited to maintain participant and/or their client's anonymity.

3.2.1.4. Protection of participants

Health care research can require stringent ethical approval, especially if the research involves vulnerable patients. The 'traditional Hippocratic moral obligation of medicine, is to provide net medical benefit to patients with minimal harm, that is beneficence with non-maleficence' (Gillon, 1994:185). This moral obligation also applies to participants when conducting research, the aim of which must be benefit over harm.   It is essential that a researcher considers what constitutes a benefit for their research, may not necessarily be a benefit for research participants.

'Key processes and outcomes for the professional doctorate relate to research knowledge and skill generated from and within a practice setting, by the practitioner as opposed to an independent researcher' (Lee, 2009:146). Whilst this may bring the benefits of insider knowledge, it is not without its potential problems and researchers might struggle with role conflict (Brannick & Coghlan, 2007). Although there is a commonality that affords access that may be 'closed' to outsiders (Costley, 2010), dual roles can also result in role confusion when the researcher responds to the participants or analyses the data from a perspective other than that of researcher (Asselin, 2003).

Consideration was given to risks to the participant's personal social status, privacy, personal values and beliefs, personal relationships and adverse effects of the disclosure of sensitive material (BPS, 2010). An example of risk within this study might include concern being raised over a participant's professional practice when talking about their experiences of working with a vulnerable client group. This concern could lead to disclosure of unprofessional practice by the researcher and an onward investigation against the participant. Within research, the obligation to provide net benefit to participants also, 'requires us to be clear about risk and probability when we make our assessments of harm and benefit' (Gillon,

1994:185). Researchers must ensure that those taking part in research, are protected from physical and mental harm and will not be caused distress (McLeod, 2007). Potential risks were explored and discussed by the researcher with research supervisors within doctoral supervision. Participants were provided with clear guidance on what would happen should this occur within the study information pack and reminded of this before and after their interview took place. Ethical approval was applied for after the risks of the research study had been considered and addressed, in order to minimise the chances of this.

The research study excluded persons under the age of twenty one and those otherwise incapable of giving consent. The age of twenty one was chosen to reflect the minimum higher education training requirements needed to become a qualified therapeutic therapist. Participants were offered access to emotional support in case of distress, whether during or following the research study interview and each participant was asked to nominate designated contacts (Appendix M). In the case of any distress during the interview, participants were informed their interview would be stopped and their nominated person contacted for immediate support. This ensured clear boundaries between the researcher's dual role of researcher and psychological trauma therapist.

After the interview, participants were orally debriefed by the researcher in line with recommendations in the Code of Human Research Ethics (BPS, 2010) and reminded that they had the right to withdraw. Due to the majority of interviews taking place over the telephone (which may have offered some form of protection or detachment for participants), an overt approach to support participants was taken by the researcher by asking participants whether they would like their nominated support contacted. This was to minimise potential for unexpected, emotional distress arising out of the interview. Information and local contact numbers were given in the participant information pack for support during both office working hours and out of hour's services (Appendix N, O). Participants were advised that should they need advice with regard to any issue arising from participation in the study they would be signposted to a suitably qualified

professional who could assist them. Throughout the doctoral process, the researcher was supported by their university and clinical supervisors.

3.2.1.5. Data protection

The Data Protection Act (Parliament, 1998) regulates the processing of information relating to individuals including the obtaining, holding, use and disclosure of such information. The Act requires anyone who processes personal data must comply with its principles and ensure personal data is used fairly and lawfully; for limited, specifically stated purposes; used in a way that is adequate, relevant and not excessive; accurate; kept for no longer than is absolutely necessary; handled according to people's data protection rights; kept safe and secure and not transferred outside the United Kingdom without adequate protection (Parliament, 1998). Furthermore, the Act gives individuals rights of access in relation to personal data which affords participants asking for copies of personal data collected by a researcher (Research Ethics Guidebook, 2015).

In order to comply with the Data Protection Act (Parliament, 1998), participant anonymity was ensured by supplying all participants with an identifiable reference number for use in place of personal details within the research study. As the study developed, these were replaced with pseudonyms to aid the reader. Any identifiable details, including consent forms, were held separately from the tape recorded interviews by the researcher in a secure filing cabinet. Electronic data was password protected. Upon completion of the research study, any identifiable paperwork or taped interviews will be held securely by the researcher for a period of five years, after which time they will be destroyed.

3.2.2. Recruitment

To ensure the research question was both relevant and significant to participants taking part in the study, participants were a purposive, homogenous, self-selected sample of men and women, over the age of twenty one, living and working in England. The inclusion criteria encompassed anyone able to speak and understand English, anyone who was fully qualified in delivering CBT or EMDR

and had experience of working with trauma clients and anyone who was receiving current clinical supervision. The exclusion criteria encompassed any therapist with a current diagnosis of vicarious/secondary traumatization, any therapist who had been signed off work within the twelve months prior to interview due to their mental wellbeing, or any therapist otherwise considered unfit for work.

Participants were firstly recruited through a private primary care provider, with whom the researcher worked for on a part-time basis of two days a week. Permission was initially sought from the company to place some information about the proposed study on the company intranet (Appendix P). Expressions of interest to take part in the study were invited from potential participants. Once identified, the researcher provided them with; an explanatory letter containing information about the study for them to read and consider (Appendix J, K), the interview schedule (Appendix L), consent form (Appendix M), local support service information relevant to them (Appendix N, O) and a stamped self-addressed envelope.

If the potential participant was agreeable to taking part in the study, they were asked to return the signed consent form in the stamped self-addressed envelope provided. Upon receipt of this, contact was made by the researcher and an interview date and time arranged that was convenient to the participant. A snowballing strategy was used to identify further participants and build-up a reasonable sized sample who met the study criteria. In the case of insufficient participants volunteering to take part in the study in the first recruitment stage, a second recruitment phase was put in place to facilitate the chances of a reasonable final sample size. Information on the study in the second recruitment phase was through the EMDR UK & Ireland members email service, 'jismail' (Appendix Q).

Five potential participants initially identified themselves as having an interest in taking part in either the pilot or main study. One later excluded herself as having received further information about the study, she felt she did not meet the inclusion

criteria. Out of the remaining four participants, three took part in the pilot and one in the main study. A further four participants identified themselves for the main study through the first recruitment process which remained open to snowballing. To afford the opportunity of a larger sample size, the second recruitment phase was initiated which unfortunately yielded no further potential participants. However, during this phase, as a result of snowballing in the first recruitment phase, a further three participants identified themselves as interested in taking part in the study. All participants that identified themselves as suitable to take part in the pilot or main study were contacted and are represented within the study findings (Table 4, page 63).

Table 4: Summary of the eleven participants taking part in the pilot and main study.

Pseudonym	Study	Method of interview	Experience within field of mental health	Trained in TF-CBT or EMDR
Julie	Pilot	Face-to-face	0-5yrs	TF-CBT & EMDR
Susan	Pilot	Telephone	0-5yrs	TF-CBT & EMDR
Helen	Pilot	Telephone	5-10yrs	TF-CBT & EMDR
Paul	Main	Telephone	Over 20yrs	TF-CBT & EMDR
Angela	Main	Telephone	15-20yrs	TF-CBT & EMDR
Adrian	Main	Telephone	15-20yrs	TF-CBT & EMDR
Claire	Main	Telephone	15-20yrs	EMDR
Laura	Main	Telephone	0-5yrs	TF-CBT
Justin	Main	Telephone	15-20yrs	EMDR
Jenny	Main	Telephone	15-20yrs	TF-CBT
David	Main	Telephone	Over 20yrs	TF-CBT & EMDR

3.2.3. Data Collection

Interviewing is the most widely used form of data collection in qualitative research (Creswell, 2009) and my breadth of clinical experience as a therapist, assisted with the switch from therapist to IPA researcher. The main difference between interviewing as researcher and clinical therapist, was the offer of support with any emotional distress arising as a result of the interview. Within clinical work, therapists use clinical skills and immediacy to support clients with any distress as it arises. Furthermore, they facilitate the exploration of such emotional triggers with the offer of ongoing support. As a researcher, whilst ensuring ethical guidelines were met with regard to beneficence with non-maleficence, support with potential distress was not offered through my role of researcher but through signposting to the participants pre-selected support systems.

Semi-structured interviews, the main data collection for the study, were chosen as they are particularly suited to IPA studies and are useful for studying specific phenomena or supplementing and validating data derived from other sources (LaForest, 2009). Furthermore, they help facilitate rapport or empathy and produce rich data, the main concern of IPA (Smith & Osborn, 2007). Whilst it could be argued structured interviews may be more controlled and reliable, by deliberately limiting what participants can talk about in a set of pre-determined questions, they may be inhibited from covering aspects of the subject important to them (Smith & Osborn, 2007). When conducting semi-structured interviews, not dissimilar to how a therapist asks questions of a client in an attempt to gain understanding of their presenting problem, the researcher develops a framework of general questions designed to open up conversation about a particular topic (Cohen & Crabtree, 2006). Although the framework often includes a series of probes prepared in advance to help elicit certain information, probing should be responsive and in the moment and it is essential therefore the researcher listens attentively to what the participant is saying (Cohen & Crabtree, 2006).

The interview framework forwarded to participants for this study (Appendix L), allowed all parties to be prepared ahead of time and aid the flow of the interview.

Since the interview framework contained open-ended questions allowing for discussions to deviate from the initial framework, interviews were audio recorded to capture participant responses and aid data analysis. While possible to make notes to capture any participant answers rather than using audio, this approach was not used as it could have resulted in a loss of focus as a researcher, poor or inadequate note taking and detracted from the development of rapport between researcher and participant (Cohen & Crabtree, 2006).

Throughout both the pilot and main study, the interview framework remained the same and interview questions (Appendix L) were used only as prompts. During the design process, consideration was given to whether interview questions should be refined or added to, as various themes began to emerge from different participants. A conscious decision was taken to ask all participants the questions on the interview schedule without any adaptation following any prior interviews. Whilst having fixed interview questions may be seen as a very Husserlian approach in opposition to that of an IPA approach; the interview questions were broadly designed as overarching themes for discussion. This allowed for a more Heideggerian approach within individual participant interviews, whereby further questions evolved as the participant introduced new themes. Within the context of an IPA approach, this allowed participants to discuss what aspects of the phenomena were important to them, rather than being influenced by what another participant may or may not have experienced.

The interviews lasted between thirty and sixty minutes. The time was led by how long the individual participant needed to discuss their experience of working with trauma clients using the recommended treatment modalities within NICE guidelines for PTSD (2005:4). All interviews were offered on a face-to-face basis or by telephone, whichever was most convenient for the participant. Only one participant (Julie) preferred a face-to-face interview. Limitations of this are discussed in the Discussion Chapter (Limitations to the study, page 184). Figure 2 (page 66), summarises the steps taken by the researcher in the research design process up to the point of data analysis.

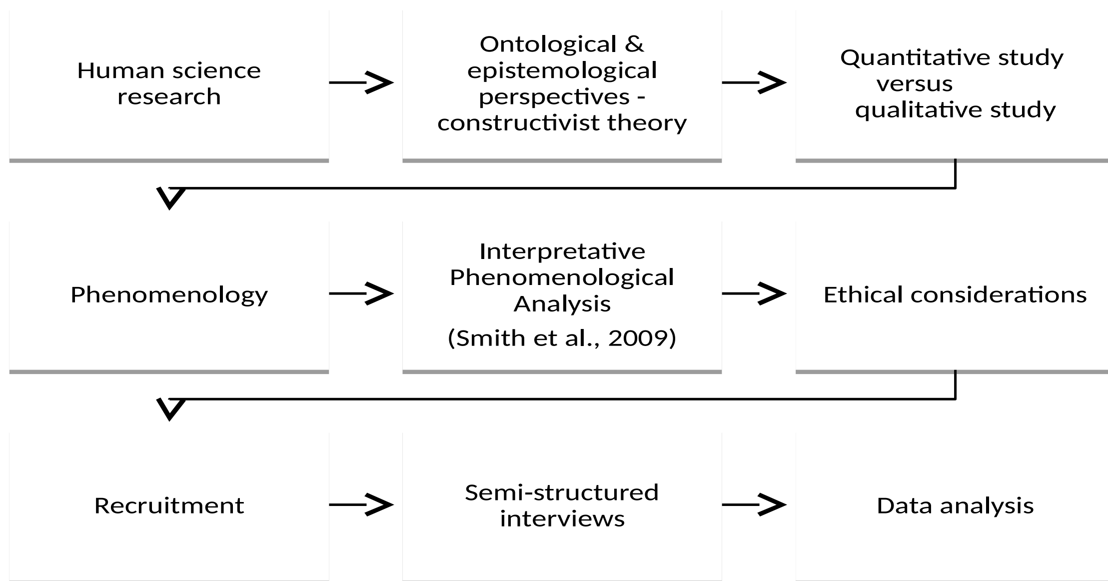


Figure 2: Summary of research design process to the point of data analysis.

3.2.4. Data Analysis

A common misconception about IPA is that it is descriptive, which can undermine its potential to 'explore, understand and communicate the experiences and viewpoints offered by its participants (Larkin et al., 2006:103). Although studies are firmly rooted in the evidence of the words of the participants, with direct quotes widely used to substantiate findings (Pringle et al., 2011), IPA unlike other qualitative methods, involves a 'double hermeneutic' interpretation process (Smith, 2004). During the data analysis stage, the double hermeneutic process has two aims. Firstly, trying to understand and represent the participant's world and what it is like from their perspective (Larkin et al., 2006). Secondly, recognising the central role of the analyst, in trying to interpret and make sense of participant experiences in a wider social, cultural or theoretical context (Smith, 2004; Larkin et al., 2006). IPA recognises that there is no direct route to experience and research is about trying to be 'experience close' rather than 'experience far' (Smith, 2011:10). Detailed analysis involves the researcher critically questioning participant text with questions such as, 'What is the person trying to achieve here? Is something leaking out that wasn't intended? Do I have a sense of something going on here

that maybe the participants themselves are less aware of?' (Smith & Osborn, 2007:53). An example of this can be seen an extract from the following extract:

> Linda: "…I just think I'm the fittest because there are three girls and I'm the middle one and I thought well I'm the fittest and I used to work like a horse and I thought I was the strongest and then all of a sudden it's just been cut down and I can't do half of what I used to do…" (Smith, 2004:44).

Using past tense and a horse metaphor to exaggerate her strength Linda acknowledges her lost identify with her former self since suffering chronic back pain (Smith, 2004: 44). This is further evidenced by the "…*cut down…*" metaphor which Smith (2004), described as conjuring up an image of grass being scythed and a symbol of how Linda currently feels. However, her identification with her former strong self, leaks out in her description "…*I'm the fittest…*" (Smith, 2004).

3.2.4.1. Steps to analysis

The analytic process for IPA is described in detail within Smith et al. (2009) and was used as a framework when analysing the study data. It is both iterative (cyclical) and inductive (seeks to supply strong evidence to make broad generalisations) (Larkin & Thompson, 2012). IPA researchers are encouraged to be innovative in the way they approach analysis (Smith et al., 2009). Whilst there is no clear right or wrong way, the clear guidelines provided by Smith et al. (2009) gave some structure to the process. This was particularly helpful having never undertaken IPA research before.

Participant transcripts were coded with a number (0812) and individual code of (F) or (T). Individual codes were given to the data to represent and identify either a face-to-face interview (F), or a telephone interview (T). A unique number for the individual participant was also allocated to help aid identification (0812F1, 0812T1, 0812T2 etc.).

To become immersed in the data, the first step was to repeatedly read interview transcripts thoroughly and listen to interview recordings. Following this process, a

hard copy of the transcript was made with wide margins either side to document initial exploratory comments and emergent themes, as the analytic process developed. The second step was to start the initial level of analysis using exploratory commenting to code the data for each individual participant (Appendix R). This was done in the three ways as suggested by Smith et al. (2009) and through highlighting specific text:

Descriptive comments – these comments focused on describing the content of what the participant was talking about. For ease of reference, these comments were coloured coded in black.

Linguistic comments – these comments focused on exploring the specific use of participant language. Examples of this included the use of metaphor, laughter, repetition or tone. For ease of reference, these comments were coloured coded in red.

Conceptual comments – these comments focused on engaging at a more interrogative or conceptual level. This level of analysis is more interpretative and can take time to reflect upon and refine. These comments may prompt consideration of further questions of the data. They can represent a shift in focus moving away from the participant, sometimes with questions leading to further understanding or sometimes leading nowhere. For ease of reference, these comments were coloured coded in green. In addition to the descriptive, linguistic and conceptual comments suggested by Smith et al. (2009), any comments made by the participant during the interview that were deemed of interest or importance were also highlighted in yellow.

Step three involved developing emergent themes from the coded data in step two (Appendix S). As the data set had now grown considerably and included exploratory researcher notes made as the data was analysed, the focus shifted from the original transcript, to working with the exploratory comments made. Steps four and five, involved searching for any connections across the identified themes.

Similar themes were grouped together where possible to form sub-ordinate themes. Where similar themes were not identified, the themes were left as individuals. Whilst mindful that many similar themes arose during the initial analysis, by respecting IPA's idiographic commitment, each case was analysed in its own merit to allow for new participant or researcher themes to emerge.

The final step involved looking for patterns across all cases. Themes were cross checked against others to look for any patterns across the data set. Where apparent some themes were duplicated but sat under a different, yet similarly named, sub-ordinate group, these groups were combined and renamed for consistency. Participant transcripts were coded line-by-line to provide a paper audit trail and ensure transparency and coherence for the various stages of analysis (Avis, 1997; Yardley, 2000). Extracts were identified to represent participants within the findings in their own terms and used as master themes for the thesis write-up (See Chapter 5: Analysis of Findings).

Throughout the analytic process, reflective memos recorded ideas and thoughts about concepts, acting as a record of the research to date and points of discussion within supervision. This self-reflective component was critical to highlight biases and assumptions and how they may affect the research process (Rudestam & Newton, 2007).

3.2.5. Quality Assurance and Rigour

The constructivist stance on validity within qualitative research evolved in the period between 1970 and 1987 (Denzin & Lincoln, 1994). Constructivists believe in interpretative, open-ended perspectives towards reality which are sensitive to the place and situation (Creswell & Miller, 2000). Four broad principles of sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance were used as a framework to assess the quality of the research (Yardley, 2000).

3.2.5.1. Sensitivity to context

Participants were offered the opportunity of taking part in the study through information published through the workplace, EMDR Association of UK and Ireland and snowballing. This 'third party' approach, allowed potential participants to remain autonomous when considering whether they would like to take part in the study before they approached the researcher. Interviews were offered either face-to-face or via the telephone to help participants feel as comfortable as possible. During the interview process, analysis and writing up of findings, sensitivity was given to raw data and the interpretation of how the participants made sense of their experience. The use of extracts from their interviews, helped give participants a voice whilst supporting the study findings.

3.2.5.2. Commitment and rigour

Semi-structured participant interviews allowed the researcher to listen closely for any aspects important to them. This enabled the researcher to respond with further reflexive questioning whilst the participant steered its direction. Following interview, transcribed transcripts were sent to participants to check for accurate capture of this and afford them the opportunity of adding or deleting any comments, before final analysis took place. Careful interpretative analysis of the data took place to ensure participants were fairly represented. Appropriate quotes to evidence this were selected for the write-up and to represent the identified themes.

To improve accuracy of the study, extracts of anonymised data were also made available to peer research students and a professional who is not working within the mental health field for the purposes of an independent audit (Appendix T). Transitioning from convergent thinking (the concept that there is one correct answer to a problem) to divergent thinking (the concept of thoughts and perspectives from multiple viewpoints) assisted with developing research ideas (Guilford, 1967; Ledwidge, 2014) and helped corroborate or challenge the researcher's findings. Where a different perspective was offered, the data was revisited and reviewed as a whole, to ensure its context was correct. Different

perspectives were considered where applicable, before final themes and interpretations were included in the write-up of the study.

3.2.5.3. Transparency and coherence

To ensure transparency and coherence, all stages of the research process have been described throughout this study and the researcher's position clearly stated. The researcher has also included evidence of a paper 'audit trail' throughout the thesis where possible and in particular, to evidence and represent the participants voices (Avis, 1997). To ensure transparency and quality assurance, after each interview was transcribed verbatim, it was sent to the individual participant to confirm the data obtained was an accurate and true account of the interview that had taken place. Only after confirmation was received from participants as to the transcripts accuracy, did analysis of the data take place.

3.2.5.4. Impact and importance

If further insight is to be gained into the reported difficulties therapists engaged in trauma work face when hearing trauma narrative, studies that contribute to existing knowledge are important. To help inform clinical practice and add to the existing knowledge base, this study sought to identify how therapists are affected and what they do to help sustain themselves in their work and alleviate any symptoms of vicarious trauma or its related concepts.

3.3. Summary of Research Design Chapter

The design and implementation of the research described in this thesis has been discussed. This has included consideration of the key areas of the methodology and method chosen for the study. The following chapter will address the development of the pilot, main study and analysis coding before presenting the findings.

Chapter 4: Study Development and Presentation of Findings

4.0. Overview

This chapter outlines the study development before presenting its findings. Three participants took part in a small pilot study prior to the main study, which involved a further eight participants. This chapter discusses how the pilot informed the main study and includes:

1. The importance of pilot studies
2. Rationale for conducting the pilot study
3. The development of the interview and interview schedule
4. The development of the analysis coding
5. Summary of pilot study findings
6. How did the pilot study inform the main study?
7. Summary of the main study findings
8. Summary of the combined study findings

4.1. Importance of Pilot Studies

Pilot studies are valuable in any area of research and are also an important component of training for postgraduate students (Yin, 2011). Within the area of health research, pilots play an important role as clinical studies inform medical practice (Lancaster, Dodd & Williamson, 2004). They can also open up opportunities to funding for larger research studies, which is vital if research is to develop and progress. Sometimes known as a feasibility study, a pilot is a miniature version of the main study (Van Teijlingen & Hundley, 2002; Arain, Campbell, Cooper & Lancaster, 2010).

Research judged to be poorly designed or conducted, wastes resources and devalues the contribution made by participants taking part in the study (BPS, 2010). Pilot studies should have ‘a well-defined set of aims and objectives to

ensure methodological rigour and scientific validity' (Lancaster et al., 2002:311). They are essential in testing out certain components of the research design including fieldwork procedures, data collection instruments or analysis procedures (Denzin & Lincoln, 1994; Silverman, 2010; Yin, 2011). Such components are trialled to test, refine and inform the planning of the main study (Thabane, Ma, Chu, Cheng, Ismaila, Rios, Robson, Thabane, Giangregorio & Goldsmith, 2010; Yin, 2011). This not only enhances the chances of a successful main study but it also assesses its feasibility (Van Teijlingen & Hundley, 2002; Thabane et al., 2010).

Within qualitative research, the relevance and appropriateness of pilot studies have been disputed (Pritchard & Whiting, 2012). Due to the approaches flexibility and the researcher being able to learn from the main study as they go along, Holloway (1997) suggested pilot studies may, in effect, be redundant. Furthermore, although Thabane et al. (2010) questioned a pilot's effectiveness if the results are not informative and merely waste the time and efforts of participants and researchers'; they also argued there is no such thing as a failed pilot. This is because of the benefits gained, by saving additional funding or community resources, if a larger study is found unfeasible after a pilot and does not go ahead.

4.2. Rationale for Conducting the Pilot Study

The aim of the pilot was to assess the suitability of IPA for the planned main study and to test its feasibility. Its suitability was tested and developed through its sampling technique, interview process, interview schedule and the analysis coding. It was hoped the pilot would be deemed successful enough to confirm the feasibility of a larger study, whilst providing unique and valuable insights from participants about their experiences of working with trauma. This was particularly important to gain a better understanding of the phenomenon of vicarious trauma and how this may impact upon those therapists engaging in trauma work.

4.3. Development of the Interview and Interview Schedule

Guided by the research question and knowledge of existing theory, a researcher should develop their own understanding of their chosen subject, so they can identify where their own contribution will be made (Kvale & Brinkmann, 2009). Good preparation is essential to ensure an efficient way of investigating a subject. Part of that preparation, involves 'thematising' the study to help identify subjects for initial investigation and to formulate relevant questions (Kvale & Brinkmann, 2009:106).

Qualitative interviews provide the opportunity to investigate participants' viewpoints and the meaning or understanding they attach to their experiences (Kvale & Brinkmann, 2009; Smith et al., 2009). The semi-structured interview schedule stemmed from questions arising from the reviewed literature together with the researcher's experience of trauma work. The schedule was sent to participants to consider prior to interview and was used as a framework for discussions.

At the start of each interview, the participant was reminded of the purpose of the study and that the interview was being recorded on the researcher's personal Olympus digital voice recorder. They were encouraged to describe their experience of working with trauma using trauma-focused CBT or EMDR and informed the interview schedule was merely a guide to help facilitate a free flowing interview. The schedule was made up of seven questions. Prompts were used when needed to help bring clarity or focus to participants if requested. Interview questions were:

1. ***Can you tell me about your experiences of working with trauma clients?***

This question was devised to enable participants to talk in general about their experiences of trauma work at the start of the interview. Its aim, as well as to identify rich data, was to help participants settle into the interview before moving on to more specific areas.

2. ***Has there ever been a time when you feel you have become affected in a negative way by this type of work?*** Although personal experience of clinical group supervision for the researcher and the literature review suggested therapists can be negatively affected by trauma work (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995a; Iliffe & Steed, 2000), it could not be assumed that this was the case for all therapists. Question 2 was included to gain clarification of whether any participant had ever been affected negatively. Its aim was to give participants the opportunity to discuss if and when they had, how they had been and whether this had negatively impacted professionally, personally or both.

3. ***What did you find was most upsetting/distressing?*** Question 3 evolved from question 2 and allowed for further detailed exploration of any negative impact reported and the meaning to which they gave it. Additionally, it gave participants the opportunity to discuss how their thoughts and feelings may have changed within the process.

4. ***Has this changed your practice in any way?*** This question sought clarification as to whether those participants who had been negatively affected, had gone on to change their clinical practice. Dependent upon participant response, this question was aimed at providing detailed data in relation to any positive or negative changes.

5. ***What treatment modality were you using at the time and do you think this had any significance? Why did you choose this treatment modality over the other?*** The purpose of the first part of this question was to clarify whether participants were using trauma-focused CBT or EMDR at the time of treatment and whether they considered this as having any affect upon themselves. During the researcher's clinical group supervision, often on the agenda was therapist wellbeing and the difficult job of balancing client and self-care whilst undertaking trauma work. For the researcher, as a therapist, having reflected upon times when negatively affected by trauma work, the effects of trauma-focused CBT have been felt more widely, over a longer period of time. Preference for one model over the

other raised questions for the researcher as to why therapists may choose to work with a particular model and sparked an interest in the current study.

Within the literature reviewed for this study, none was identified that explored whether the choice of treatment modality played a role in how therapists undertaking trauma treatment, are affected. If found significant, this would be an important factor to consider in working towards reducing vicarious trauma. For this study's originality and to add to the existing body of literature, this was an interesting area to explore. Although in hindsight, the second part of question 5 would have been more ethically sound if worded "Why did you *use* this treatment…", its inclusion was to gain further data to understand the rationale behind the participant's treatment choice.

6. ***What 'protective' practices do you put into place when working with trauma?*** Within the literature, several factors were identified that helped therapists cope with their work such as self-care (Neumann & Gamble, 1995; Steed & Downing, 1998) and supervision (Bell et al., 2003; Adams & Riggs, 2008). Question 6 was aimed at identifying any coping strategies used by participants to manage their trauma work, either professionally or personally. Furthermore, it was hoped this question may lead to understanding of how and why they believed these helped.

7. ***Can you tell me about any positives of working in this field?*** All of the literature sourced on vicarious trauma (McCann & Pearlman, 1990) discussed its negative effects. However, also acknowledged have been some of the positives reported connected to undertaking trauma work (eg: Steed & Downing, 1998; Eidelson et al., 2003; Ben-Porat & Itzhaky, 2009) (page 31). The final question of the interview was chosen with two specific aims in mind. The first was to identify, compare and offer a balanced view on any negatives of trauma work. The second, mindful of the ethical responsibilities as a researcher, was to minimise any risk for the participants taking part in the study (Gillon, 1994; BPS, 2010). By closing the interview on a positive note, this should help reduce any possible negative effects

from the subject under discussion and so aid participant emotional wellbeing. Throughout all interviews, remaining reflexive and curious to participant responses allowed for further questioning of individual emerging themes as they occurred. After the interviews, interview transcripts were sent to the individual participants for verification of their accuracy.

4.4. Development of the Analysis Coding

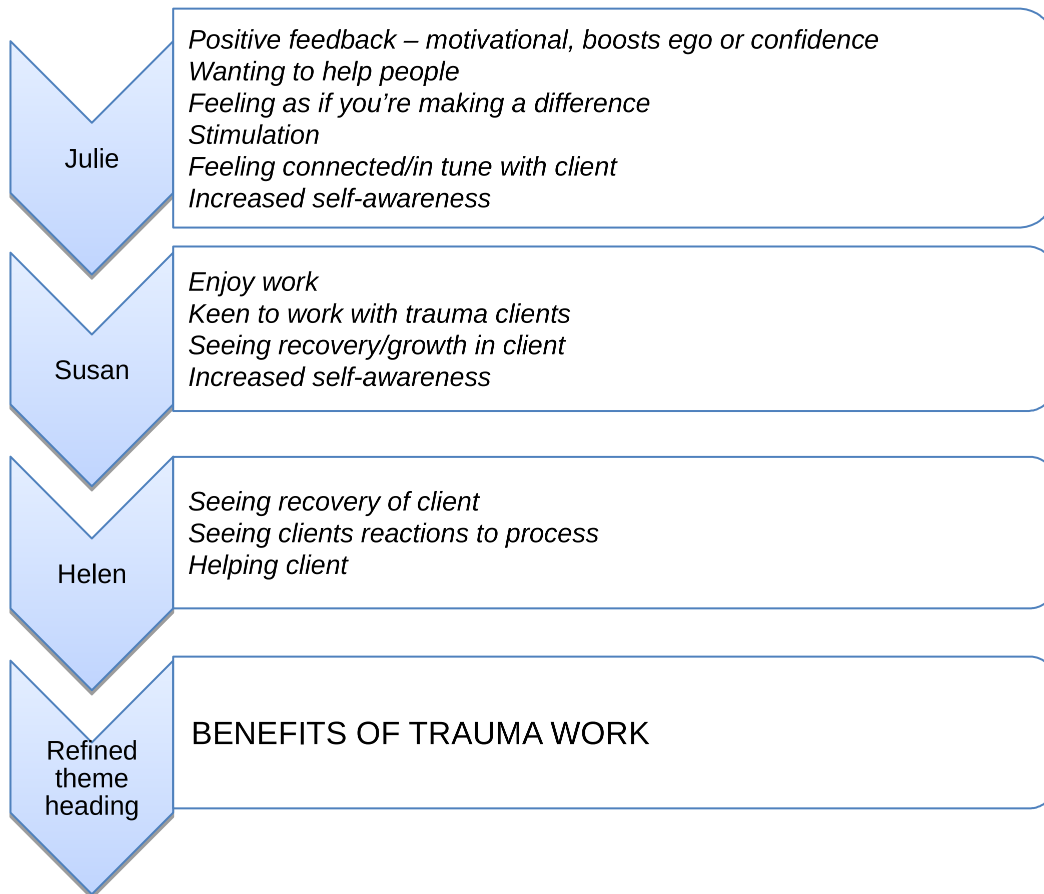
Within qualitative research, data analysis manages words and language and their inferred meanings (Miles & Huberman, 1994). Coding is where a researcher 'mines' the data and digs beneath the surface to discover any hidden treasures (Corbin & Strauss, 2008). It is an iterative, inductive process that reduces and organises data, from which the researcher constructs themes, essences, descriptions and theories (Walker & Myrick, 2006). After the interview transcripts accuracy was confirmed, using the analytical process described in Chapter 3 as a framework (page 67), data from the three pilot study transcripts were analysed and coded.

Individual participants were allocated a unique number and individual code (eg: 0812F1, 0812T1, 0812T2) to aid identification, to represent a face-to-face (F) or telephone interview (T) and protect their identity. During the process of the thesis write-up, the individual coding for participants was changed from its original form to help aid the reader. Instead of number codes, all participants were given pseudonyms. Participant 0812F1 is now known by the name 'Julie'. Participant 0812T1 is now known by the name 'Susan'. Participant 0812T2 is now known by the name 'Helen'.

Initial coding was done line-by-line to identify any individual emergent themes for participants (Appendix U). The dissected data was explored for similarities or difference, compared and then placed in a category. Initial emerging themes from all three participants were reviewed and refined by reassembling the dissected data and clustering like-with-like, to form a new category. Where connections were

identified, data was given a new theme heading. An abridged example of this process is shown in Figure 3.

Figure 3: Abridged example of initial emergent theme refinement in the pilot study.



This process continued with all themes found within the data that had been extracted through the line-by-line coding process. All identified data was cross checked with each participant to identify connections or similarities and ensure commitment and rigour (Yardley, 2000). Refinement and reassembling of the initial data resulted in a total of thirty two themes being identified within the pilot data set (Table 5, page 79).

Table 5: Frequency chart of the thirty two emergent themes from the pilot study.

	PILOT STUDY THEMES	Julie	Susan	Helen
1	**Therapist experience**	X	X	X
2	**Preference**	X	X	X
3	**General comments on trauma work**	X	X	X
4	**Hearing narrative**	X	X	X
5	**CBT**	X	X	X
6	**EMDR**	X	X	X
7	**Emotional and physical changes**	X	X	X
8	**Permanent changes to self**			X
9	**Use of visual aids**		X	
10	**Intrusive thoughts**	X	X	X
11	**Intrusive images**	X	X	X
12	**Impact on professional life**	X	X	X
13	**Impact on personal life**	X	X	X
14	**Time management**	X	X	X
15	**Training**	X	X	X
16	**Supervision**	X	X	X
17	**Caseload management**	X	X	X
18	**Positives of trauma work**	X	X	X
19	**Protective factors**	X	X	X
20	**Ethical responsibilities**			X
21	**Personal triggers**	X		X
22	**Client disclosure**			X
23	**Confidence**	X	X	
24	**Role of imagination**	X		X
25	**Nature of trauma**	X		X
26	**Organisational pressure**	X		X
27	**Use of resources**		X	
28	**Session preparation**	X	X	
29	**Questioning/reflecting on practice**			X
30	**Self-awareness**	X		
31	**Treatment results**	X	X	
32	**Position to client**	X		X

The thirty two themes were examined for patterns or connections across the data set that would represent the most thought-provoking and important aspects of the participants account (Smith et al., 2009). Many themes seemed to lend themselves naturally for grouping together. Where connections were identified, such as negative effects reported, or what participants did to keep themselves protected from these, themes were clustered like-with-like. This resulted in a refined group of six super-ordinate themes which are summarised in Table 6.

Table 6: Summary of super-ordinate themes in the pilot study.

	SUMMARY OF SUPER-ORDINATE THEMES IN THE PILOT
1.	**CLINICAL EXPERIENCE**
2.	**PREFERENCE FOR MODEL**
3.	**PSYCHOLOGICAL/PHYSIOLOGICAL/BEHAVIOURAL THERAPIST CHANGES:** • Personal • Professional
4.	**ORGANISATIONAL RESPONSIBILITIES:** • Training • Supervision • Managing caseloads
5.	**BENEFITS OF TRAUMA WORK**
6.	**PROTECTIVE PRACTICE AND MANAGING RISK**

For research to be authentic, trustworthy (Lincoln & Guba, 1985; Denzin & Lincoln, 1994) and seen as credible, it must be a true account of the phenomenon being researched and reported, and closely resemble the reality that is being described by the participants within it (Plowright, 2011). To help evidence authenticity and trustworthiness, data was analysed further for specific examples of participant accounts. Master themes identified from the super-ordinate themes evidenced the participants' true accounts and represented them in their own terms. An abridged example (Table 7, page 82) is representative of participant responses within the themes of psychological/physiological/behavioural therapist changes, benefits of trauma work and protective practice and managing risk.

4.5. Summary of Pilot Study Findings

Whilst recognising its limitation with regard to its small size, the pilot highlighted both negative and positive experiences of working with trauma clients. It supported findings in previous studies by acknowledging the importance of therapist self-care, training, supervision and organisational support (McCann & Pearlman 1990; Pearlman & Saakvitne, 1995a; Maclean et al., 2003; Bell et al., 2003; Harrison & Westwood, 2009). However, the pilot also highlighted the difficulties therapists engaged in trauma work may face when using the two recommended treatment modalities for PTSD within NICE guidelines (NICE, 2005). Early indications were that EMDR may be a protective factor for ameliorating therapist vicarious trauma. This could have significant implications for clinical practice and warranted further exploration within the proposed main study.

Table 7: Abridged example of master themes in the pilot study.

ABRIDGED EXAMPLE OF MASTER THEMES IN PILOT STUDY	LINE
Psychological/physiological/behavioural changes	
Laura: ...I woke up thinking about it and it affected me for a long time...	57-58
David: … I have found myself, y'know, you become a little upset...	39-40
Julie: ... having some sort of air in the room because sometimes, y'know, I can get not panicky but I can feel some symptoms of anxiety, so my heart might race, or I get a bit hot…	230-231
Jenny: … on my way home from work, I'll take the scenic route home, have the radio on, get in and have a bath and then I'm changed into my home clothes...	232-233
Benefits of Trauma Work	
Julie: … what they feedback to you is also… I guess it boosts your ego or boosts your sort of confidence as a therapist…	316-317
Claire: … it is extremely gratifying...	228
Helen: … being able to show someone… that they can come out the other side of this … is very rewarding…	294-296
Protective Practice and Managing Risk	
Justin: … I'll make sure that I'm up to date on my theory, particularly if it's something that's not that familiar…	344-345
Julie: … I would have a gap between patients. So I have started to take steps to protect myself…	55-56
Angelia: 243-4 ... I'll very often erm, plan processing sessions for my last session of the day if you like so that I, so that there isn't a time pressure…	243-244
Helen: … good supervision, both peer and my clinical supervision, knowing that's available is helpful…	246-247

4.6. How Did The Pilot Inform The Main Study?

IPA was chosen for the pilot to evaluate its appropriateness for the main study and get a sense of the kind of data IPA might reveal. Due to the success of the pilot, IPA was again adopted for the main study. The process of undertaking the pilot and main study was fluid. There were times when the process was smooth and times of reflection when difficulties arose.

Interviewing skills are something used daily by therapists in an attempt to extract and explore important information about client experiences. The technique of interviewing within IPA was viewed by the researcher as having potential to uncover unique, important and valuable data from participants. One clear difference which the researcher was not prepared for at the start of the process was the difference between face-to-face and telephone interaction.

Participants in this study were offered their preference of either face-to-face or telephone interviews. All but one opted for a telephone interview which at times, made the task of transcribing audio recordings done over the telephone difficult due to various noise interference. Mindful of this, as experience grew in the process, so did the clarity of interview audio. Whilst telephone interviews helped retain a sense of participant anonymity, a disadvantage over face-to-face interviews was the loss of access to participant non-verbal cues and the opportunity for visible evaluation during analysis of the data (Sullivan, 2012).

Constraints with time, geography, mobility and finances can present difficulties for conventional face-to-face interviewing (Cater, 2011). Voice over Internet Protocol (VoIP) is a system which provides online users to send and receive voice and video across the internet via a real-time connection (Lo Iacono, Symonds & Brown, 2016). Although using VoIP, such as Skype or FaceTime may have enhanced this study, the necessity of access to high-speed internet, familiarity with online communication and any technical difficulties, such as a lost connection during an emotional conversation, could have also affected the quality of the interview (Deakin & Wakefield, 2013; Seitz 2015). Whilst VoIP was not considered for this study, with millions of users enjoying the system as a form of free communication (Skype, 2017; Apple, 2017), it could have afforded

the researcher the benefit of an infinite geographical recruitment criteria with minimal or no cost; and participants the opportunity should they take it, to share their experiences face-to-face via video call.

Another problem encountered on a couple of occasions, stemmed from being drawn into the discussion during the interview process. This was the trap of asking participants to expand on an interesting subject that was not going to yield appropriate data for the study. However, by remaining open to possibilities it might have yielded unexpected data, this ensured participants could discuss what was important to them, a critical aspect within IPA.

Reflecting on the different phases of analysis for the pilot study was probably where an important part of learning took place. Although each step of analysis was followed in the initial phase of data analysis, on reflection this was probably done far less methodically. Having engaged in further analysis for the main study, it became apparent that perhaps the analysis process had been less meticulous, through lack of experience. Whilst reflecting on an earlier assignment in which initial results of the pilot were discussed, there was a distinct lack of interpretation but volumes of description. This discovery led the researcher back to initial findings of the pilot and comments around the data. Whilst there was certainly some interpretive comments made at the time, these were not included in the assignment as they did not explicitly come from the participant. This could be seen as a serious flaw and more a descriptive, thematic approach rather than IPA. With confidence growing in the analysis method during the main study and the realisation that pilot data could have been analysed more comprehensively, the pilot data was re-analysed. This was to ensure the analysis process was completed as thoroughly as within the main study and to ensure quality assurance and rigour (Yardley, 2000).

The technique of analysis developed continuously throughout the process as the researcher was immersed in the data. Drawing on personal experience enabled the researcher to reflect and question any preference, assumption or belief she had around the subject area. Further analytic tools such as the ‘flip-flop technique’ and ‘So What?’ question (Corbin & Strauss, 2008), also allowed

for a more thorough probing of the data and helped give alternative perspectives. During the pilot data re-analysis, a further twenty two emergent themes were identified. These were combined with the thirty two emergent themes previously identified in the first phase of analysis, giving a total of fifty four (Appendix V). The fifty four themes were reviewed as a whole to identify connections or patterns across the data set, in readiness for comparison and inclusion with those emergent themes found within the main study.

4.7. Summary of the Main Study Findings

The analysis of the main study data was again coded line-by-line and followed the steps of analysis as described in Chapter 3 (page 67). As within the re-analysis of pilot data, the analysis technique developed and expanded with the use of various analytic tools to aid rigour. When compared and contrasted with the re-analysed pilot data, it was evident all but one of the themes in the pilot ('Use of visual aids') were replicated in both studies. In view of all the data being invaluable a decision was taken to combine the findings of the pilot and main studies, prior to refinement and restructure, to offer a more comprehensive picture of the overall seventy nine themes (Appendix W).

4.8. Summary of the Combined Study Findings

All individual themes arising from the data analysis were written out on a flipchart to enable easier identification and aid the researcher's mind mapping process. Hard copies of emergent themes for each participant were printed in coloured text, specific to individuals, to enable easy recognition of data and ensure the capture of the idiography versus group experience. These were then cut up and laid out on the floor. With so many emergent themes, the process could have been overwhelming. However, using a cut and paste method and stepping back with a de-centred view to reassemble, refine and restructure the fractured data, data felt more ordered, manageable and sound.

Initially, forty seven super-ordinate themes and four stand-alone themes were identified from the combined study data. Whilst the stand-alone themes remained the same after refinement and restructure, the forty seven super-ordinate themes were reduced to a total of sixteen. Continuing with the

protracted refinement process, patterns and connections across the whole data set identified seven super-ordinate themes together with seven stand-alone themes (Appendix X). From these, four stand-alone themes of: Comparison to other working practices; Use of medication; Use of repetition and Use of laughter, were initially excluded from the write-up. This was because they did not answer the research question and in some cases, were more around the process of the interview.

To ensure sensitivity to context, commitment and rigour, transparency and coherence and impact and importance (Yardley, 2000), the remaining ten themes were again reviewed, refined and restructured where necessary. The theme of laughter, previously excluded, was later revisited and included in the final thesis under the super-ordinate theme 'Protecting and sustaining the participant sense of self'. Finally, four overarching master themes were identified that addressed the aims of the study (Table 8, page 87) and answered the research question:

> *'How do CBT and EMDR therapists working with the recommended treatment modalities for PTSD, make sense of their experiences and protect themselves from any negative effects of the work?* Is there a distinction between the two modalities?'

Using the line-by-line coding, participant data was analysed further to identify direct quotes which best represented each master theme in the write-up of the study, evidence its authenticity, validity and give participants a voice. These are represented within the analysis section that follows and are discussed thereafter.

Table 8: Summary of master themes for the thesis write-up.

	SUMMARY OF MASTER THEMES FOR THE THESIS WRITE-UP
1.	**NATURE OF TRAUMA:** • Types of trauma presentations • High profile cases
2.	**PARTICIPANT SENSE OF SELF AND MANAGING THE PROCESS OF HEARING TRAUMA NARRATIVE:** • Listening to the client's story • When imagination takes over • Influence of multimedia in the therapy room and beyond • Personal triggers and significant life events • Negative psychological, physiological and behavioural change to the sense of self • Witnessing post-traumatic growth
3.	**PARTICIPANT EXPERIENCE OF DELIVERING THE TRAUMA MODELS:** • Participant experience of trauma-focused CBT • Participant experience of EMDR • Barriers to treatment
4.	**PROTECTING AND SUSTAINING THE PARTICIPANT SENSE OF SELF:** • Protecting the participant sense of self • Training • Supervision • Using laughter as a coping strategy

4.9. Summary of Study Development and Presentation of Findings Chapter

The suitability of IPA for this study was evaluated by testing and developing techniques on sampling, interviewing and analysis coding. Pilot findings both reflected and built upon findings of previous studies reviewed in the literature review. More importantly, the pilot produced rich and unique data in relation to one of the recommended treatment modalities for PTSD, being a potential protective factor against therapist vicarious trauma. This was a significant finding that may have the potential to reduce the negative impact of trauma work upon therapists and aid their wellbeing.

Due to the success of the techniques used in the pilot, IPA was found to be feasible for the main study. To enhance the chances of a successful study, the main study mirrored the pilot, except for the fact it was larger in size and consisted of eight, rather than three participants. Its aim was to build upon the pilot's findings with a view to informing practice and contributing to the existing knowledge base in the area of vicarious trauma.

Throughout the whole analysis process Yardley's (2000) four principles for quality research were observed to ensure a thorough and honest representation of findings. As findings from both studies were reflective of each other, to offer a comprehensive illustration of findings, the studies were combined before undergoing a protracted refinement process (Table 9, page 89). Finally, four overarching master themes emerged from the data which addressed the aims of the study and answered the research question.

Table 9: Summary of data analysis within the pilot, main and combined studies.

Study Data	No. of emergent themes	No. of Super-ordinate themes	No. of stand-alone themes	No. of master themes
Pilot Study	32	6	0	6
Pilot Study (re-analysed)	54	N/A	N/A	N/A
Main Study	78	N/A	N/A	N/A
Combined Study	79	47	4	N/A
Combined Study (after refinement)	79	16	4	N/A
Combined Study (after refinement)	79	7	7	N/A
Combined Study (after refinement)	79	7	3	10
Combined Study (final refinement)	79	7	4	4

The analysis findings are presented in the following chapter. Although traditionally academic articles are written in the third person, IPA's epistemological position encourages researchers to own their own perspectives and become closely involved with the lived experiences of the participant (Smith et al., 2009). Therefore moving away from tradition and in line with my epistemological position, the following chapters will be written in the first person to allow for self-reflexivity.

Chapter 5: Analysis of Findings

5.0. Overview

This chapter presents the analysis of findings as a whole for the eleven participants that took part in the study. These are made up of three participants within the pilot (first stage) and eight participants within the main study (second stage). For clarification, participants from both stages are clearly identified within Chapter 3 (Table 4, page 63).

For ease of reading and to save any potential embarrassment of participants, utterances such as “erm” and “um”, repeated words and sounds made whilst thinking during interview, have been omitted unless relevant to interpretation. In addition, any minor interjection made by the researcher during the interview to acknowledge what the participant was saying, such as “mhmm”, “right”, “okay” have also been excluded. A series of dots within square brackets [………] has been inserted into participant quotations, when respecting the anonymity of the participant and/or clients, where comments have been made that do not relate to the subject under discussion, or in places of repetition. Where relevant, square brackets will include explanatory comments such as, [company name] or [location].

5.1. Analysis

Four master themes were chosen to answer the research question and best represent participant experiences. These are:

1. Nature of trauma.
2. Participant sense of self and managing the process of hearing trauma narrative.
3. Participants experience of delivering the trauma models.
4. Protecting and sustaining the participant sense of self.

5.1.1. Nature of Trauma

During the course of participant interviews, references were made to the nature of trauma presentation that a client may present with (Figure 4) and the subsequent impact on the participant sense of self. Whilst these are not mutually exclusive, it provides the reader with a clear idea of the type of trauma therapists work with on a day to day basis.

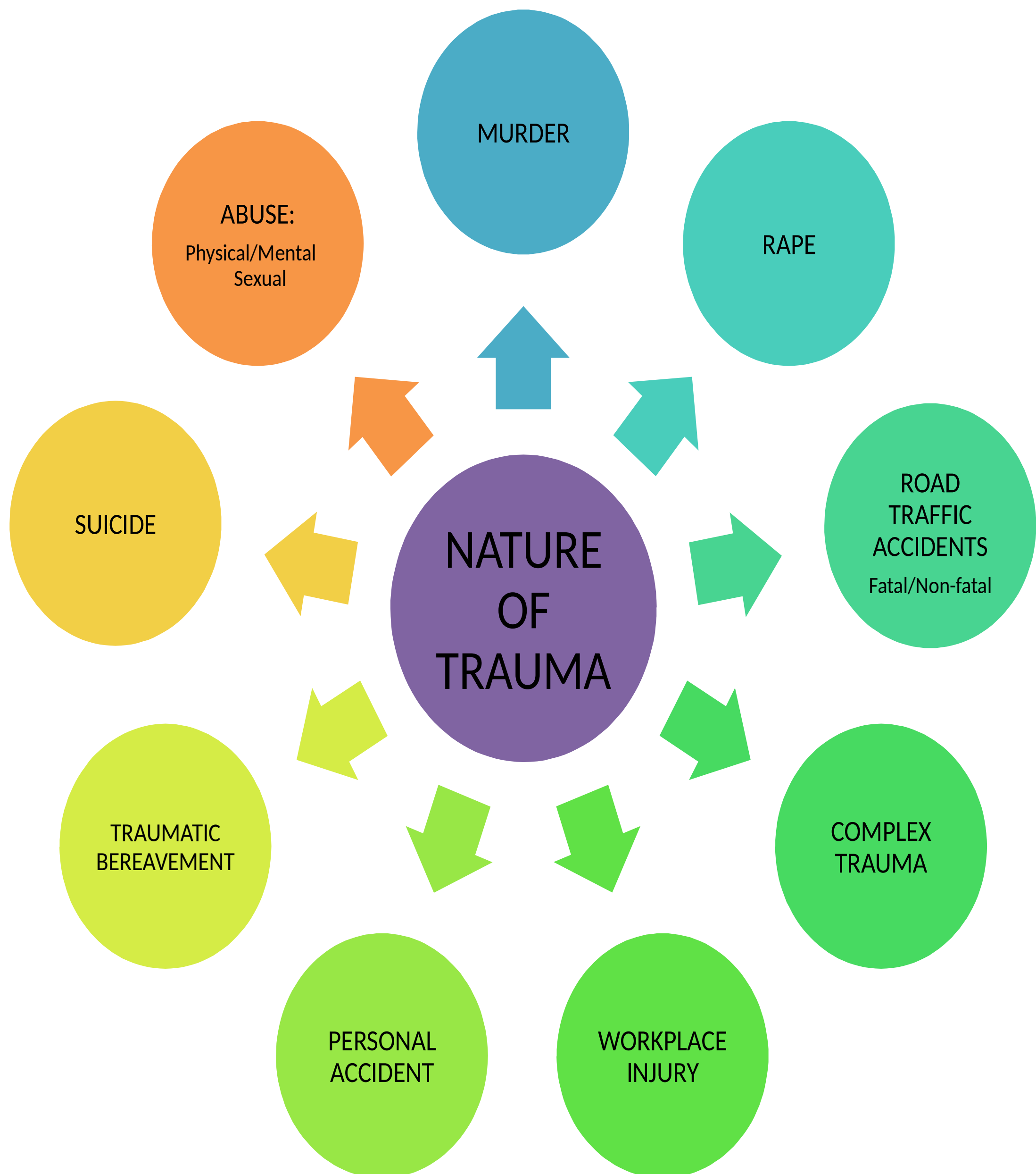


Figure 4: Nature of trauma presentations.

Julie highlighted just how emotive some of these trauma presentations can be for the professionals working with them. She touched upon one trauma presentation that had had a detrimential effect on all her client work, which involved the brutal murder of a young man.

> **(Julie)** 37-40... *I was affected professionally because I would be left with that image, so my attention was taken away from other clients that I saw. Then there is the personal aspect that I would wake up at night with it and I would almost get the images that she was getting, like flashbacks really…*

In this particular case, the resulting image for Julie that was recreated, embedded and replayed in her mind, was perhaps symbolic of her client's harrowing trauma image of the sole of a trainer imprinted on the head of her murdered son.

All participants in this study reported a new understanding of the psychological, physiological and behavioural impact to their sense of self since working with trauma clients. Although various changes to the participant sense of self arising from the nature of trauma work is discussed throughout this chapter, Adrian believes the psychological changes to his brain over a period of time, have helped him adapt to the difficulties associated with trauma work.

> **(Adrian)** 145-9 *… I think maybe in a [laughs] I was going to say in a subconscious way, in a preconscious way I think my brain prepares itself for particularly horrific and unpleasant things now […….] I think it's just the awareness that one can be caught…*

His use of the word "one", perhaps results from his clinical experience as a therapist and supervisor and his awareness that disruptions to the memory systems from the impact of working with trauma has no gender boundaries. His awareness of being 'caught' signifies his appreciation and understanding of the potential for a negative impact upon his sense of self and his conscious efforts of actively working to prevent this.

5.1.1.2. High profile cases. As well as the specific nature of trauma presentation, two participants touched on the subject of working with high profile cases. Whilst the high profile cases themselves cannot be discussed in any detail in order to protect client anonymity, the effect of these cases on participants, are discussed within the findings under the theme of 'Participant experience of self: 'Influence of multimedia in the therapy room and beyond' and 'Protecting and sustaining the participant's sense of self'.

5.1.2. Participant Experience of Self and Managing the Process of Hearing Trauma Narrative

One of the main overarching themes within the study was the negative and positive impact of trauma work upon participants. All participants taking part in the study spoke about the negative impact of working with trauma clients and the various levels of distress caused within their professional and personal life. On closer examination, some of their distress appeared to be related to the treatment modality they were delivering at the time, as well as to the nature of the trauma they were dealing with. Although it is acknowledged that any participant distress appears to have been generally well managed and not necessarily increased the risk of vicarious trauma, some of the difficulties discussed do have ethical implications.

For clarity, each sub-theme is presented under a separate heading:

1. Listening to the client's story
2. When imagination takes over
3. Using multimedia in the therapy room
4. Personal triggers and significant life events
5. Negative psychological, physiological and behavioural changes
6. Witnessing post-traumatic growth

5.1.2.1. Listening to the client's story

As previously discussed (page 16), central to resolving the impact of trauma is being able to remember and reprocess it, so the brain can update its memory networks. Using the recommended treatment modalities for PTSD, all participants spoke about their levels of distress when hearing trauma narrative. Participants were unanimous in their belief that hearing the client's trauma narrative had a detrimental effect on their emotional wellbeing. This was particularly evident in those participants working with full trauma narratives using trauma-focused CBT.

The harrowing details. Like Helen, the majority of participants recounted times when they had experienced replaying traumatic details or images etched on their minds as a result of the minutiae of the incident given by the client.

> **(Helen)** 139-40 *… it's kind of like a video when you've heard the narrative, a video in your head..*

Paul described one particular client presentation that was extremely harrowing. Due to its nature and to protect the client's anonymity, suitable extracts from the interview transcript were difficult to find, however it has been included within the analysis write-up as it is a particularly powerful example of the impact of hearing trauma narrative on the therapist's sense of self. His client had arrived at the scene of a road traffic accident to find a close family member had suffered the most horrific, fatal injuries. The client had gone to the aid of the deceased but due to the severity of their injuries, this action had resulted in further traumatisation.

> **(Paul)** 138-40 *… and I'm thinking, "Oh my God, that y'know, how, how easily that could be any of us". So it's those kinds of things that [pause] that send a 'eerggh', shiver down my spine…*

Within his extract, Paul is literally lost for words when he reflects on the enormity of the presentation and substitutes the noise "eerggh", and later in his interview, "aagghh", to reinforce his horror. Hearing his client's trauma narrative was not only disturbing for Paul on a professional level, leading to concerns for his client's safety but it also struck a chord on a personal level. Characteristic of other participant experiences, Paul's extract gives a sense of

the cognitive, physical and emotional changes to his sense of self as he places himself in the position of his client and reflects on his own family and the fragility of life.

Justin makes reference to the effect of hearing detailed descriptions given by one of his client's, related to the suicide of a member of her family.

> **(Justin)** 175-6 *… it's partly bereavement, it's partly the nature of the suicide and how she describes it. It's really quite graphic and horrible…*

Justin appears to have compartmentalised the elements of trauma work he finds challenging, which may help him make sense of his experiences. Again, his use of language points to the intense nature of his work and gives an indication that Justin does not always find hearing harrowing trauma details comfortable. This is supported at various times throughout his interview, when he implies his most emotive trauma cases are emotionally exhausting, a huge responsibility to bear and the ones that impact more heavily upon his sense of self (pages 99,103 & 111).

Disbelief in humankind. Five participants were negatively affected by client work that involved detailed descriptions of traumatic incidents of human brutality. Perhaps mindful of this, Laura only disclosed part of her client's presentation out of concern that I as a researcher may be affected too. Laura's client had witnessed what Laura described as a "*horrific incident*" in a foreign country. The incident had been encouraged by a crowd of spectators and resulted in the death of two people.

> **(Laura)** 53-60 *… that affected me in a big way because I didn't think that other human beings could treat other human beings like this. So it really did affect me [………]. I woke up thinking about it and it affected me for a long time and when I saw that particular race of person as well, it made me think back to the incident as well…*
>
> 97-9 *... when I saw certain people it made me think back to what [the client] had said and what these people could be capable or what other human beings y'know, could be capable of...*

From Laura's extracts it is clear her shock, horror and disbelief at the brutality displayed within her client's trauma presentation resulted in changes to her sense of self and disruptions to her cognitive schemas, dependency, safety, esteem and imagery systems. Furthermore, the knock-on impact of her client's presentation which Laura likened to "*a horror film*", also resulted in a clear cultural prejudice over some time.

Adrian also reflected on a past client that had presented with a single event trauma involving brutality. The client, although not involved in the trauma himself, had witnessed a traumatic incident via the media over the internet and described this during his CBT treatment.

> **(Adrian)** *83-5* *… He just witnessed something really, really horrible and well, the treatment in a way needed him, it was appropriate for him to tell me about it in treatment and it was such a horrible image [pause] that it stuck for a while…*
>
> 106-10 *… he described it quite vividly, that was part of it. He got quite upset describing it. Erm, [exhale of breath] and it involved one brutal human being doing it to a victim, y'know deliberately and I think that might be partly why it got me…*

Adrian touches on three points as he reflects on his client's presentation, hearing trauma narrative, client distress and brutality. The client's vivid description and Adrian's shock at the deliberate act of human brutality against another, impacted heavily and resulted in him replaying haunting images in his mind for some months. Within his extracts, Adrian's use of repetition is a good indicator to the severity of his client's presentation whilst his hesitation, change in breathing and harrowing imagery, indicate the extent to which his sense of self has been disturbed. Although on some levels Adrian may question whether he actually needs to hear all the trauma details, he makes sense of this and justifies it as appropriate for his sense of identity as a CBT therapist. Not the only participant to use similar language (page 105), Adrian's description of "…*it got me…*" gives a sense of him being trapped, falling prey to 'Trauma' and gives some indication as to his feelings of horror, disbelief and helplessness at the time.

Starting the journey towards recovery. Similar to Laura (page 95) and Adrian (page 96), Helen also reported psychological and physiological changes impacting on her sense of self when assessing a client with an extremely violent historical background.

> **(Helen)** 63-8 *... it was the nature of the trauma, y'know, what I'd already heard at that point. Although there were no familiar people involved, no family members involved, because of the horror of what I already knew about the methods, that was pretty hard to hear as well; and that kind of brought about disgust as well as some anxiety of what I might hear if the trauma treatment were to go on…*

Helen's reference to family denotes she usually finds client presentations involving family members more emotionally difficult than those which include strangers. However, due to information already gathered during her assessment, Helen found the methods of violence used by her client both horrific and repulsive and this may explain why her ability to cope with hearing further trauma narrative was tested and her sense of identity as a trauma therapist challenged. Furthermore, Helen's disruptions to trust, safety, power, esteem and imagery may also have heightened her own awareness of her personal vulnerability when lone working, fuelling her anxiety. She continued to discuss the issue of the legal and ethical dilemmas therapists may face during their work, which may have added to her anxiety if the client's treatment had gone ahead.

> **(Helen)** 73-80 *… It did need an awful lot of discussion because it was outside of our remit in the end and there was the sort of legal issues to be considered as well; legal and ethical issues to be considered. So in the end the treatment didn't go ahead but I'd already had a certain amount of information that gives way too much information frankly [laughing]. It's just about thinking about it in terms of work, acknowledging that y'know, everything does go into memory so it probably will always be there but if I think about it as work, then I can manage it…*

Helen's unease at listening to her client's trauma narrative is apparent from her acknowledgement that she had already heard more details that she had wanted to and is supported by her uncomfortable laughter. Although Helen tries to reassure herself and make sense of her experience by thinking of it in terms of her identity as a trauma therapist, her concerns of permanent changes to her memory system are evident.

Angela also talked about hearing trauma narrative whilst undertaking psychological assessments for medico legal work. As is often the case with legal work, one professional may undertake an initial assessment and recommend a specific therapeutic intervention. A second independent professional will be sought to implement the recommended treatment. Within her interview, Angela described being left at "an *uncomfortable point*", having completed client assessments only.

> ***(Angela)*** *52-5 … one of the things difficult in that sort of situation is that you hear the distress and the discomfort and the experiences of the distress and discomfort on the part of the patient but you're not then engaged with them through the therapeutic process. [………] it does leave at that uncomfortable point you are not actually there working through the therapeutic process together so I think that for some individuals and for some therapists, or certainly for me, it's left at an uncomfortable point. And I think that if you are dealing with the same kind of difficulty over and over again, it can heighten your awareness, your hypervigilance and your anxiety about certain situations….*

Angela makes reference to "*working through the therapeutic process together*" indicating a natural, knock-on-benefit for her to process her own association to the trauma memories alongside that of her client. From her extract, there is a sense that undertaking repeated assessments inhibited Angela processing her own associations to her clients' traumas, which left her struggling with unknown outcomes and a lack of closure. Over time, this led to disruptions to her safety and changes in behaviour impacting on her sense of self.

> **(Angela)** 66-70 *… I became very anxious as a passenger. When I was driving I was much more hypervigilant but on the other hand perhaps that wasn't a bad thing because y'know, it just ensured that I was much more cautious and aware as a driver, so y'know, perhaps there is [laughs] a kind of survival benefit…*

Angela has made sense of her behavioural changes by perceiving them as a benefit, rather than as a hindrance. As she is talking in the past tense, it could be assumed that her behavioural changes were only evident during her previous role as a psychological assessor. However, on closer analysis, she talks about "*perhaps there **is** a kind of survival benefit*", implying this practice continues. It is clear Angela has been influenced by her trauma work in her daily activities and has constructed a new reality on the dangers of driving to help her accept, manage and make sense of the changes to her sense of self.

A child's vulnerability. Two participants talked about hearing trauma narrative involving child abuse. From Claire's extract there is a sense of sadness created by the disturbing images of abuse clear in her mind during her work and replayed in her interview as she spoke.

> **(Claire)** 37-9 *... It was hearing stuff and the pictures it gave me of a child's vulnerability and that's the picture I have brought to mind now, not horrific, just vulnerable…*

Justin's reaction was very different.

> **(Justin)** 294-6 *… a road accident or something like that wouldn't really bother me, whereas if somebody was talking about early physical or sexual abuse really early in the child, I'm screwing up my face as I'm talking about that. That's pretty unpleasant to hear about and as I'm talking about it I can feel a familiar feeling of feeling quite negatively towards the perpetrators of that and even wanting to stop them or harm them. Or y'know, "How dare you!" Horrible people taking out their own disgust on small children. Despicable behaviour…*

Justin's anger and disgust directed towards perpetrators of child abuse is clear. Although Justin's extract starts with suggesting he would not be affected by something like a road accident, similar to the earlier theme of 'Disbelief in humankind' (page 95), this may be due to the fact he finds it easier to accept trauma presentations resulting from accidental rather than deliberate acts. Although he recognises "*feeling quite negatively*" towards them, Justin's use of language, physical reaction and fantasies of stopping or harming perpetrators, show his underlying feelings are much stronger. This is supported by him purposefully describing his physical reaction over the telephone to document and ensure there could be no doubt of just how he is affected by child abuse presentations. Within his extract, Justin, a father, clearly sees himself as a powerful protector as he literally steps into the scenario he is describing and confronts the perpetrator on behalf of the helpless child.

Seven participants talked about the negative effects of hearing trauma narrative involving the death of a child or children. This was particularly relevant if the presenting client was the parent of the deceased, however it was not necessarily age related. Paul and Angela alluded to experiencing changes to their sense of self.

> **(Paul)** 275-7 *… her [child] was killed and [he/she] was only like [pause], under five and [pause], that was hard [pause], especially when she described the, y'know, the gory bits [pause]. That's hard to deal with…*

Within Paul's extract it is clear his client's trauma presentation affected him in two ways. Firstly, by the young age of the child involved in the fatality and secondly, hearing the graphic details of the horrific injuries sustained. As a father to children of the same sex as the deceased, Paul's emotional response and identification with his client was heightened. As Paul reflects on the enormity of loss, his hesitation in speech indicates the extent to which he has been impacted emotionally as he tries to make sense of his client's harrowing presentation.

> **(Angela)** 80-106 *… somebody who was describing an incredibly distressing and unpleasant image relating to her son's death. The image was something that was not only incredibly powerful for her but it also became, quite intrusive for me [……..] I mean there was a massive amount of emotion in the room which was quite difficult [……..] and I think from an emotional perspect… [tails off] in that instance it was actually quite a struggle at times to kind of not feel the emotions as well, very powerfully…*

The nature of trauma and severity of impact on self when working with the loss of a child in Angela's case is clear from her extract. After hearing her client's graphic trauma narrative, Angela's trauma reaction mirrored that of her client and resulted in her experiencing haunting trauma images and a sense of overwhelming emotions. Furthermore, her sense of identity and perception of how a trauma therapist 'should be' appeared challenged as she struggled to balance her own strong emotions with those of her client's, whilst trying to remain emotionally detached and professional.

Managing hearing trauma narrative. Four participants questioned their sense of self when talking about managing hearing trauma narrative. Three participants felt they had become desensitised to hearing trauma to some degree through repeated exposure to it and clinical experience.

> **(Paul)** 296-9 '*Cause at the end of the day, we must habituate to it and I think, I almost think that there is that element of doing so and I think sometimes, y'know, if you hear trauma over and over and over again, it's like, okay. Do we, is there a part of us that, do we just inure to it..?*

Paul seeks to develop a meaningful frame of reference and both questions and answers why he may have become accustomed to hearing trauma details. His questioning and change of use in first and second person pronouns denote disruptions in intimacy, a sense of separateness from his professional colleagues and signifies his need to belong. This is further evidenced by his hesitancy to commit to his statement that therapists habituate to trauma work. Paul's use of repetition around repeatedly hearing trauma may help him make sense and justify his ability to remain *okay* and unaffected.

Although slightly different, Helen, who earlier alluded to the fact she believes the changes to her memory system are permanent and merely managed (page 97), returned to the theme later during her interview.

> **(Helen)** 113-5 *... it can be very hard going home at the end of the day with some of that material that you have heard still stuck in your head, 'cause it doesn't go does it? It stays there...*

The suggestion of traumatic material being stuck in Helen's head at the end of the day, indicates some cognitive and imagery disruptions and the blurring of boundaries between her professional and personal life. Again, Helen questions the possibility of permanent damage to her sense of self.

5.1.2.2. When imagination takes over

Another theme linked with hearing trauma narrative, was the consequence of the role of imagination. Six participants indicated the role of imagination within their trauma work had a bearing upon their professional or personal life resulting in disruptions to their imagery, safety, power, control or behaviour.

> **(Adrian)** 152-5 *… I would kind of see it as part of my task to understand what the guy had seen and why it was distressing and he was distressed. It was almost as if I was watching what he was watching…*

Adrian's extract gives a sense of how much importance he places on his professional identity and responsibilities as a trauma therapist. Not the only participant to talk about replaying trauma narrative almost as if watching a film (Helen, page 94 & Laura, page 96), Adrian uses his imagination to step into his client's experience and 'witness firsthand' their harrowing story in his mind.

Susan gave a particularly eloquent example of how her imagination took over when working with a client who had witnessed a traumatic incident in which two people were trapped by fire.

> **(Susan)** 116-120 *… the reason they have stuck in my mind so much, was like the fear of these two people, these two potential people that were basically, could have been burnt alive and they were trapped and there was no way that they could escape*. *So it was imagining that they knew or that they could potentially see and hear and smell what was coming. As I say, this roar of this fire, this fireball that was happening around them and yet they were both physically, physically trapped and it was just imagining that these people were potentially going to be burnt alive. It was that...*

By putting herself in the position of the people trapped in the fire, Susan's catastrophic thinking errors snowballed. It is clear from her extract and statement of "*they have stuck in my mind",* Susan has found this particular client's trauma narrative difficult to process and on some level, continues to struggle with haunting recollections of their traumatic case material. The tone and pace of Susan's voice in interview together with her vivid description gives a sense of her feelings of helplessness and panic and no doubt reflects that of her client and the trauma victims themselves at the time of the incident. Although Susan's rational mind knew the people trapped in the fire escaped, by placing herself in their desperate situation and imagining their horror and anticipation of certain death as the intense heat and noise of the fire surrounded them, her irrational mind took over.

> 127-32 *… It then went a step further. It was like, my God, what is their quality of life like now? How were they affected after the incident y'know? So it was imagining them not only at the moment in time during the actual incident but then kind of, me imagining them later like, how is it affecting them now, y'know? Have their marriages failed? Have they lost their job? What physical injuries did they sustain whilst they were in this position..?*

In Susan's second extract, her concern and compassion for the trauma victims shines through. However, her questioning around the resilence of the people involved may also reveal her own personal fears as to whether she would be able to cope in similar circumstances. It can be safe to assume from Susan's continual self-questioning and need to develop a meaningful frame of reference, she experienced disruptions to her imagery, power and safety. Further evident

is Susan’s need for closure, which is inhibited through unknown physical, psychological and social outcomes and maintained by her inability to remove the unprocessed trauma memories etched on her mind.

In opposition to those participants discussing the effects of hearing trauma narrative, Helen was plagued by disruptions to her imagery, safety and trust when she didn’t hear the full trauma narrative and was left to fill in the blanks herself.

> **(Helen)** 130 *… but that’s where your imagination can [laughing] run riot …*

Although on some level Helen now finds her irrational responses amusing, her metaphor of her imagination ‘running riot’ gives a sense of the lack of control she felt she had over the psychological and physiological impact of her client’s presentation on herself at that time.

Justin also reflected on how he has been affected at times during his work, through the use of his imagination.

> **(Justin)** 183-90 … *I’m not particularly distressed by blood and gore and those kind of things, I mean to an appropriate level of course [both laugh], but I’m not. I don’t feel squeamish and it’s just wow imagine, imagine my own child killing themselves. Maybe that’s part of it to me as well. I have a [child] and when I imagine myself in a parallel situation, that’s unthinkable. I guess thinking about it now superficially, if something terrible happened to my [child] I just don’t think I’d want to live anymore…*

From his extract, it appears Justin is less affected by hearing graphic content regarding physical injuries. However, when imagining himself being in the position of a parent who is dealing with a trauma related to their child, the impact for Justin is immense and almost too difficult to contemplate. The suggestion that Justin may take his own life when he thinks the “*unthinkable*”, points towards disruptions to his safety, feelings of vulnerability and perceived inability to cope with the enormity of losing his child.

5.1.2.3. Influence of multimedia in the therapy room and beyond

Whilst only one participant talked about her experiences of using visual aids during her work, it had a significant bearing upon her psychological and physiological symptoms impacting on her sense of self. Susan disclosed her client had been involved in a high profile traumatic incident and she was working with him using trauma-focused CBT to address his resulting PTSD. Due to the case's high profile, Susan and her client were able to look at footage of the incident on the internet, as well as on her client's phone. It is not clear through Susan's interview whether this action was client or therapist led and at what stage during the treatment this happened. She also does not specifically state whether the intention of this action was for general information gathering or exposure work. However, she didn't believe she would have looked at the footage during an EMDR session as she didn't consider it part of the treatment, which is suggestive that viewing the footage in Susan's mind was part of her CBT exposure work.

> **(Susan)** *65-71 … I think because we'd looked at the images on the internet and then also looked at the footage that had been shot on his phone, it made it all more seem like as if I was there and also as well, with his kind of like, narrative, his dialogue about his experience of what the [pause]. When we were working through hot spots and updating hot spots, he was, there was two particular hot spots in particular within that, that were extremely distressing, extremely distressing. Those were the two hot spots that just kept kind of like popping back into my mind…*

Susan's extract clearly shows the action of viewing her client's trauma footage personalised the trauma for her, as she literally placed herself in the position of the client. Susan talks about updating client hotspots (specific, emotionally distressing trauma memories, frozen in time). From her extract and use of repetition, these were not only distressing for the client to relive, but with the resulting disruptions to Susan's imagery and memory systems crossing the boundaries of her professional and personal life and impacting upon her sense of self, it is clear Susan's feelings echoed those of her client.

> **(Susan)** 89-94 *… I knew that it was kind of, really getting under my skin if you like. Do you know what I mean? That's the only phrase I can use. It's like getting under my skin because as I said, I was thinking about it at home and as I said, I was waking up in*

> *the morning sometimes thinking about it, and it was like, I was waking up, it was more than once that I was waking up thinking about it, so I knew that it was kind of, as I say, kind of like, gotten under my skin...*

Susan's metaphor of "*getting under my skin",* clearly illustrates the effects of working with her client's trauma as the haunting trauma images repeatedly played in her mind, permeating her outer layer through to her core and resulting in her emotional and cognitive changes.

5.1.2.4. Personal triggers and significant life events

Ten out of eleven participants discussed occasions where they have been personally triggered by client material. Seven found personal triggers or significant life events had impacted on their trauma work. These included becoming a parent, illness, family events, bereavement and moving locations.

Particularly relevant to the theme of personal triggers upon those participants who disclosed they were parents themselves, was the impact to their sense of self when working with trauma narrative involving children.

> **(Paul)** 106-9 *… as a parent myself it's like my worst nightmare thinking anything happening to my kids and so y'know, when you're being empathic and you're thinking [pause] "for fucks sake how mad must that be, to experience that". Y'know? It's then that it gets me…*

From Paul's extract, it is easy to deduce the strong emotional bond with his children in his role as a father. Described as his worst nightmare and reflective of Justin's earlier feelings (page 103), the thought of anything happening to his children is inconceivable to Paul and painful and frightening to comprehend. However, when using empathy and walking alongside his client placing himself in their shoes, Paul's vulnerability comes to the surface and he is touched on an emotional level. It is then that Paul, like Adrian (page 96), is caught in the clutches of 'Trauma' and rendered helpless to fend off the emotional impact as it '*gets*' him.

Two participants identified changes within themselves as therapists since becoming parents. Justin and David were in agreement that although they both enjoy trauma work, they recognised their feelings of vulnerability have increased since becoming parents during their therapeutic career.

> **(David)** *71-82 …I think I'm probably a bit more alert to danger than I would normally be [………] I think it initially started with that* [road traffic accidents] *but I think it's generalised actually and I think it's increased since I've had children as well. I never used to have a problem y'know, but now with children I think it makes you more vulnerable [………]. I think in my experience of working with post-traumatic injuries, the irrational fear that people often have relate to those closest to them, okay? And my child, children would be one of the first things that comes into my mind, so it does play itself out like that…*

Although David denied making any changes to his working practice resulting from any negative effects of his work, when asked about his personal life his extract points to a disparity between his identification with his former self and his current self since starting trauma work. David's current self may be difficult for him to accept as he distances himself from his vulnerability by slipping into the second person. David's identification with his lost self who "*never used to have a problem*" leaks out when talking about being more alert to danger than he "*would normally be*". However, contradicting his statement, he goes on to describe his current experience as a generalised awareness of danger which has been heightened since becoming a parent, suggestive of a new 'normal' and changes to his meaning making. This is supported further by the disruptions to his sense of safety and irrational fears for himself and his children.

Justin also acknowledged the significant impact that becoming a father has had on his identity as a practicing therapist.

> **(Justin)** *317-25…It makes a big difference and this is something that I have been talking about in my own supervision. The difference of I guess experience. I don't know if you have children yourself but to me for the first time experiencing that intense connection and just overwhelming love that you can only experience with a child of your own. I don't know, maybe I'm wrong, but that's my experience. Quite surprising really, something I knew but didn't really feel or didn't know what it was like to feel. [………] and yes, I've never had that before…*

Justin's use of supervision to support this change denotes an increase in his professional and personal vulnerability, heightened through his capacity as a father, from identifying on a much deeper level with clients he was previously unable to. He continued to talk about the influence of his own child on his trauma work when working with rape or abuse clients.

> 337-40 *… it does really impact on my work so I think my passion has probably deepened when I'm working with people that have been through these things* [rape/abuse]*. So I'm more impassioned to give the best service I can for people with those kinds of presentations…*

Justin has made sense of his changes since becoming a father and balanced his vulnerability by working harder for rape or abuse clients. Whether his passion has deepened due to the fact he is the father of a daughter or just because he is a father, is unclear. However, Justin's drive and willingness to work harder to support victims of such crimes, fuels his passion for trauma work and supports his sense of self.

Jenny's work with one client was interrupted for a brief period when her husband was admitted to hospital for planned surgery. Due to the nature of the client's PTSD presentation resulting from surgical clinical negligence, Jenny felt unable to see her.

> **(Jenny)** 102-3 *… There was an awful lot of storytelling involved and blow-by-blow narrative of how badly it had all gone wrong and that's when I realised I can't, I just can't do this at this precise moment…*

Although the effects were relatively short-term and Jenny was able to resume her work with her client as soon as her husband was discharged from hospital, her extract highlights the effect that personal triggers or significant life events have upon therapists during their work. Whilst this may have been a worrying time for Jenny in normal circumstances, her description and use of the metaphor "*blow-by-blow*" reinforces how hard-hitting listening to the details of her client's trauma narrative was on her sense of self. Furthermore, Jenny's use of language and repetition also signifies the level to which she found this particular presentation both frightening and unbearable to hear.

5.1.2.5. Negative psychological, physiological and behavioural changes to the sense of self

All participants discussed various negative changes to cognitive schemas and imagery systems, experienced at times during the duration of their trauma work. Whilst the changes do not necessarily fit exclusively in one category or another, these have been broken down into four categories to aid the reader and best represent the changes discussed. The categories of change are cognitive, emotional, physical and behavioural.

Cognitive change. Many examples of participant cognitive changes connected directly with hearing trauma narrative during clinical work have previously been discussed throughout this chapter (eg: pages 92, 95, 101). Other cognitive changes identified were connected to matters of practical application of the recommended treatment models and participant expectations or feelings of responsibility for others.

Claire feels helpless when working with clients who becomes stuck in the therapeutic process.

> **(Claire)** 79-85 *… they need to believe in getting better in order to stay engaged. So if things are difficult, if they are still getting nightmares, if they are still very avoidant, if they are still jumpy, then sometimes they have to hang on through all of that to stay engaged in order to get the benefits they want. So that's difficult for them. Difficult for myself as a therapist because sometimes we think it's not going anywhere and then you begin to wonder what else you can do…*

Claire acknowledges the precarious position trauma clients find themselves in when they doubt the therapeutic process, question their capability of recovery and find it difficult to move forward. From her extract, there is a clear sense of Claire's experience as a therapist, sometimes mirroring that of her stuck clients.

Not only had Paul a clear expectation on himself as a therapist borne out of his strive for perfection and his difficulty in dealing with failure, he also has an unconscious expectation on his clients to recover within his expected timeframe.

> **(Paul)** 164-5 *… I do have a massive perfectionist schema and I don’t like it if people don’t get better…*
>
> 175-8 *… I almost have an expectation that people will walk into my clinic and within eight, twelve, sixteen sessions they will be walking out feeling better…*

Similar to Paul, Julie’s expectation was also placed on her client.

> **(Julie)** 116-9 *… I mean I’m seeing a lady at the moment [………] who was abused as a child and [……….] she’d never cried in the session. I’ve seen her now twenty something times and she’s never actually cried…*

David has a clear expectation on himself as a therapist.

> **(David)** 135-7 *… I think my focus is solely on the patient and their affect and I, sometimes it’s easier than other times but I think as a clinician you have to mirror something that’s really cool, calm and composed whilst conveying compassion…*

Whilst David’s perception of what a therapist ‘should be’ is perhaps ideal and something which he strives for, his extract highlights occasions when his sense of identity as a trauma therapist has been challenged as he struggles to live up to his own expectations.

Expectations of others on the whole related to other professionals, employers or clients. When Jenny spoke about making a difficult decision to delay treatment with one of her client’s because of personal triggers, her difficulty arose from her sense of guilt in putting her own needs before the needs of others and the heavy responsibility she felt in letting down her employers and clients awaiting treatment.

> **(Jenny)** 177-9 *… it would have been a lot easier to make that decision based on the way I was feeling, rather than the repercussions of what making that decision would mean to the company and to other people on the waiting list…*

Adrian and Helen both reported changes to the way they think about their trauma work, which has been influenced by the expectations of others.

> **(Adrian)** 64-9 *... I think I could do it, I think my colleagues could do it but we can’t because of the restraints. Let’s say that happens once a fortnight but then that would trigger, I don’t know 24hrs to three days, particularly if it falls over a weekend if it’s*

> *come up on a Friday say, just very frustrated [laughs] and fed up with it and erm, [exhale of breath] having to redirect my thoughts to the benefits of working…*

Without doubt, Adrian feels constrained and disillusioned by the restraints placed upon himself, his colleagues and his identity as a trauma therapist. Using a coping strategy of laughter, Adrian's disruptions to power are evident and clearly shown with his frustration and frequent feeling of disillusionment impacting on his personal life away from work when he has the time to reflect. Furthermore, Adrian's sigh and purposeful effort in questioning of the advantages of working, gives a sense of his feeling of despair.

> **(Helen)** 221-3 *... well am I not doing the job effectively enough in the time that I'm told I should be able to do it in? So it's made me sort of think about my practice and think can I sort of speed it up a little bit..?*

Helen has felt inadequate by the expectations placed on her and questioned her competency, effectiveness and sense of self as a skilled trauma therapist. Furthermore she now feels compelled to work at a faster pace with trauma clients to compensate for her perceived ineffectiveness and her employers reduced therapeutic session times.

Emotional change. All participants reported experiencing a range of negative and positive emotional changes. However, within this section of the thesis, only an example of the impact of negative emotional changes will be presented.

Without doubt the therapeutic relationship is extremely important (Lambert & Barley, 2001; Paul & Charura, 2015) but even more so when working with trauma clients. In order to engage in trauma work, clients have to completely trust their therapist to be able to offer a safe, supportive and compassionate working environment whilst they relive their traumatic experiences. All participants talked about the therapeutic relationship they have with their clients and the importance they place upon it and all gave examples where they have been emotionally touched by their client's story.

Helen's sadness resulted from her identification and empathy for her emotionally overwhelmed clients dealing with family trauma.

> **(Helen)** 32-41 ... *it's when they actually got to the hot spots, to the sort of key areas that brought about strong emotional responses in the client and they tended to be because there were family members involved [………] their emotional responses were really strong and hearing what had happened it brought out the emotional response in me being also a mother and a sister and a daughter, so that I think came out stronger in the CBT than the EMDR…*

From her extract, there is a sense that when Helen accurately senses the feelings and personal meanings for her clients after hearing the full trauma narrative, the impact on her sense of self is profound.

Like Helen, Julie has literally felt engulfed by her overwhelming sadness.

> **(Julie)** 119-22 *... I just felt this enormous wave coming over me [bracelets jingle] of what I can only describe as sadness and it sort of almost came over us both and it almost, and we both, I mean, I started crying but she just lost it...*

From Justin and David's extracts, there is a sense of the resilience needed to work with trauma clients and the emotional changes that can bring. Justin's client had very complex historical trauma presentation which felt different to other cases he had worked with. Justin's client had PTSD and in his opinion was "*neurologically shut off to some degree*", when a further traumatic incident took place. Because of this, Justin believed the client only started to comprehend the enormity of the additional trauma during their therapeutic work. His extract gives a sense of the prolonged mental effort it took for him to sit alongside his client and support her through a rollercoaster of emotions, whilst dealing with his own.

> **(Justin)** 139-43 *… that's quite hard to deal with. So it's just, it takes quite a lot of, I find quite a lot of stamina for me to sit with her and hold her, psychologically hold her not physically, but be with her in a holding place as she goes through this, seemingly on some levels for the first time. That, that's very, very tough...*

We already know David believes his resilience for trauma work has declined since becoming a father (page 106). In this extract, he struggles to make meaning of this further.

> **(David)** 88-91 *... I'm less sort of resilient to y'know, car injury fatalities. I was going to say before children but x amount of years ago, so I don't know if it's a combination of more of them over many years or whether its y'know, something about having children as well or maybe it's a combination of both. So I would call it a cumulative effect really…*

David's self-questioning and recognition of the rise in trauma presentations he has worked with over the course of his career, may help give him a meaningful frame of reference and an alternative, justifiable explanation for his emotional change.

Another emotional change identified was when participants judged other professionals capabilities. Judgement was generally aimed at other professionals and based out of concern for client safety or in defence of a particular treatment model and the participant's sense of self. Paul and Justin felt aggrieved on behalf of their client's, who they perceived to have been formally misdiagnosed or received an inadequate service from other professionals.

> **(Paul)** 59-60 … *twelve sessions of CBT with another therapist and I mean it's been absolutely appalling. They had not done any proper psycho-education stuff with her...*

Jenny's frustration was aimed at the professionals who commission work within her primary care system, whom she believed had little or no understanding of it. From her extract her feelings of disgust, insignificance and injustice shine through.

> **(Jenny)** 290-1 *… but obviously we're governed by people who have no training in mental health or treatment in it and they seem to outrank us and it stinks at times I must admit…*

Claire felt passionate about the level of experience therapists should have before undertaking specific trauma training.

> **(Claire)** 283-88 … *So I feel quite strongly about people who take themselves off to something like EMDR training and have only been qualified a year or two as perhaps a counsellor or something; and they don't have that professional depth of experience that I think you need before you go into these cases; and I think that's*

dangerous because these techniques are very powerful and people are very vulnerable. So I suppose that would be my soapbox [laughing]…

Although laughing in recognition of her political statement, Claire's metaphor of her 'soapbox' clearly reinforces her strong belief that professionals with limited clinical experience from other therapeutic backgrounds to that of her own, do not have the capability to deliver EMDR safely and by doing so, put their clients at risk of re-traumatisation or themselves at risk from EMDR's formidable effects.

Paul, like Claire, also compares his clinical skills and experience to that of a counsellor.

(Paul) 64-7 *… I'm quite precious about CBT and I think if y'know, I've done all this training to be a cognitive behavioural psychotherapist but if anybody can, whose just got a bit of a background in counselling, can come along and do EMDR, then I almost feel it devalues my skills if I don't try CBT first…*

Paul remains loyal to his core therapeutic model before considering delivering EMDR. His use of language suggests how much value and importance he places on the CBT model and his professional identity as a cognitive behavioural psychotherapist. It is clear from his extract that Paul believes should he initially offer EMDR which he believes can be delivered by a professional less qualified or experienced than himself, his hard work in gaining his qualification may go unrecognised and thereby threaten his sense of self.

Physiological change. Many of the physiological changes reported by participants such as sleep disturbance, nausea, lack of concentration and hypervigilance resulting from increased arousal, were symptoms of participant anxiety and reflected those changes commonly experienced by trauma clients. Paul's extract reinforces this and clearly points towards his heightened anxiety and feelings of vulnerability on the road as a result of frequently working with repeated trauma presentations involving road traffic accidents.

(Paul) 92-4 *… when I'd been hearing so many people talk about being rear-ended in cars I became quite hypervigilant for threat myself when I was driving...*

Like David, another four participants reported feeling upset or tearful, either during or after a therapeutic session as a result of having heard a client's trauma narrative.

> **(David)** 38-9 *... going into detail with some of the intrusive situations I think afterwards, I have found myself, y'know, you become a little upset...*

Seven participants experienced replaying their clients haunting trauma images for up to several months. Like Julie, these powerful images impinged upon their professional and personal life, interrupted their concentration levels and normal daily functioning and for some, went on to disturb their patterns of sleep.

> **(Julie)** 19-22 ... *I used to be left with some of the images that they described. I'd keep those with me during my day, my working day and then in, from a personal prospective, sometimes at night I would have dreams about some of the things that were going on..*

Behavioural change. Seven participants reported changes in their behaviour. Angela gave two examples of when she has experienced disruptions to her safety, trust and power and felt violated by harrowing trauma details.

> **(Angela)** 136-9 *… there have been a couple of people that I've worked with where they've experienced sexual trauma and the kind of circumstances around that has kinda affected my own [pause] my own sex-life for a short period of time…*
>
> 144-8 *… I remember going home and feeling so grubby and kind of polluted by some of the things that I'd heard, that I'd get in the door and I'd just take off my clothes and put them straight into the washing machine and then get into the shower; and y'know it was like cleansing away the nastiness of the things I'd been exposed to…*

Angela's change in behaviour gives a powerful insight as to the impact of hearing trauma narrative during forensic work and provides clear evidence of the disruptions to her sense of self. Her feelings of contamination synonymous with sexual trauma clients, give a sense of her clients trauma seeping through her clothes and tainting her skin like some sort of insidious bacteria.

The shock and disbelief experienced by Laura after hearing one client's trauma narrative, led to short-term prejudice and fear towards those members of the public she appraised as having a particular cultural background.

> **(Laura)** 130-1 *... it did alter my behaviour only like I say, I had a different image for a while of the people involved…*

Like Paul, another two participants reported changes to their driving habits after becoming fearful and hypervigilant as a result of trauma work with victims of road traffic accidents.

> **(Paul)** 228-9 *… I go past that motorway most days [pause] but I make sure I drive carefully past there! ...*

5.1.2.6. Witnessing post-traumatic growth. Although all participants spoke about the difficulties encountered, they were unanimous in their positive comments about trauma work. Participants experienced trauma work as extremely rewarding and something which gave them a sense of job satisfaction. The work was also recognised for its benefits of financial rewards for those therapists in private practice and its clear cut positive treatment outcomes when compared to client work with other mental health presentations, such as depression. The biggest positive for all participants was undoubtedly feeling they were making a significant difference in helping trauma clients and the joy of seeing their recovery.

Client recovery. All participants talked with enthusiasm about the positives of being able to help their clients with their recovery process and watching their post-traumatic growth. Two participants described their trauma work as "*a buzz*".

> **(Justin)** 410-19 *… it's a buzz. I mean it's such an incredible privilege and pleasure for a stranger to come along and trust, with all this very delicate, very often frightening material and trust in me and trust in the process and trust in, y'know the theory and everything else that I bring along. And to spend however long it takes, whether it's y'know, a few sessions or two or three months or a year or even longer not very often, but through that process gradually get to know that person as they really are; alongside them getting to know themselves and seeing that person get to a place where they're just functioning much better and just feel much better. Quite often euphoric through such rapid change. It's just such a pleasure and that's why I do it…*

The pleasure, excitement and personal gratification Justin gains from working with trauma clients is palpable within his extract. It is also clear he feels humbled by the trust afforded to him by his clients as he carefully builds the therapeutic relationship over time. Furthermore, the significant client changes as they move towards recovery and the reactions of euphoria witnessed by Justin, like all participants, fuel his passion for trauma work.

Paul's use of metaphor confirms he literally sees his clients as fallen. Like Justin, his pleasure and personal gratification at watching his clients' post-traumatic growth is unmistakeable within his extract and is strengthened by his use of repetition.

> **(Paul)** 318-9 *… the satisfaction that when you see people get back in the saddle, I just love that. I really, really do, that's a real buzz for me…*

Helen's fulfilment in her role as therapist is clear when she talks collectively about her belief that the clinical skills therapists deliver, make a significant difference to vulnerable clients struggling with symptoms of PTSD.

> **(Helen)** 258-61*... to how as therapists they can pick people up in the darkest places where they feel their relationships are affected, their lives are impacted greatly, y'know. They're angry, they're hurting, so much is not good in their lives and we get to move them through to a better place, so I think that's the positives of it for me…*

Similar to Paul, it is clear Helen initially sees her clients as fallen. There is a sense she views herself as someone who is able to offer her clients support, guidance and a beacon of light (hope) as they walk through the dark tunnel together towards post-traumatic recovery.

Two participants describe their clients' post-traumatic growth as magical. Angela's preference for EMDR comes from her experience of watching the rapid change in her clients as they go through treatment.

> ***(Angela)*** *114-22 … I love working with EMDR particularly and my experience with EMDR is very often, I don't know, something about the rapidity and spontaneity of that change and how sometimes it just seems to happen, even when you're not expecting it and erm, it's quite a magical process; and the joy of seeing people change from somebody who really, really struggles say to hold an image or representation to get to the end of an*

EMDR session and y'know, maybe they spontaneously burst out with laughter or something like that because it has changed so much for them and I just find that so joyous…

Even though Angela is fully aware of how quickly trauma memories can transform for a client when using EMDR, her description of it being a magical process gives a sense of her surprise and delight at its unexpected results. The pleasure she gets from watching EMDR's results is unmistakeable within her extract and can be in no doubt. However, another part of the magic for Angela and something which may support her professional sense of self, is the resulting professional satisfaction and pride she experiences as she witnesses her clients astonishing changes within the therapy room.

Paul also talks about post-traumatic recovery in the terms magical and God-like.

(Paul) 321-5 *… almost feels [laughs] I can't believe I'm going to say this, almost feels God-like. It does in a way. You know when you've got these people who, whose lives have just shrunk and a few choice words and y'know, I kinda almost call it myself, y'know, 'sprinkling a little bit of magic' and hey, you're sorted...*

Paul's discomfort at describing his work as 'God-like' is clear. His terminology suggests he sees the process and consequently himself, as a powerful agent of change. Paul's description of working with clients "*whose lives have shrunk*" bring to mind an image of him being much larger than them and is also suggestive of an unconscious power difference perhaps borne out of his experience at the start of therapy when working with clients who feel vulnerable and helpless to help themselves. Although Paul minimises his clinical skills by simply using *"a few choice words"* and *"sprinkling a little bit of magic and hey you're sorted*," his language and metaphor conjure up another God-like analogy and the image of a priest (Paul) splashing holy water or waving incense to purify, protect and repel evil (trauma). When asked to confirm what the 'magic' was for Paul, he struggled to give an answer.

327 *… Oh it's the CBT, or it's the way, or [pause], I've no idea. Ooh, I've no idea [laughs]. I think it is taking chances...*

Even though not able to give a definitive answer, Paul's 'sprinkling of magic' allows him to offer his clients a flexible, spontaneous treatment approach that he can adapt to their specific needs.

Client feedback. Julie and David talked about the feeling of professional satisfaction trauma work gives them and the significance of positive client feedback.

> **(David)** 205-8 *… I just can't quantify the feeling of reward you get when you see somebody with a dreadful post-traumatic injury and at the end they are clear of all symptoms. In fact it resonates so much when I am teaching, like I did last week, I actually quote somebody who I saw twelve years ago and what they said after treatment...*

To be quoting client feedback twelve years after discharge, is testimony to how much it meant to David and the extent to which he continues to feel a sense of professional pride and satisfaction when his clinical skills are validated and appreciated by his clients.

5.1.3. Participant Experience of Delivering the Trauma Models

Although only seven out of eleven participants were trained in both modalities, there was an overwhelming consensus from all participants that the current recommended treatment modalities for PTSD are effective. Although generally participants acknowledged their preference to their favoured treatments, they did not suggest one modality was better at treating trauma than the other and were led, where possible, by their client's preference of treatment model. Whilst perhaps this finding is not surprising, differences did arise when participants talked about their personal experiences of delivering treatment and the impact of this upon their sense of self.

5.1.3.1. Participant experience of trauma-focused CBT. Participants found trauma-focused CBT to be very effective for treating PTSD and were enthusiastic about the results they have seen. However, compared to its counterpart, participant interviews lacked the same passion and were more negative in their comments when it came to delivering reliving during treatment.

David's description of how he views trauma-focused CBT mirrors his feelings about working right in the heart of trauma.

> **(David)** 54-6 … *I probably for myself would be more affected by the preferred choice of the trauma-focused [CBT] because well, as I say you are in the eye of the storm with that…*

His use of metaphor brings to mind an image of him battening down the hatches during a brief calmness, knowing the worst is yet to come and this may be indicative of how he feels. Although more negatively affected by his core model, he felt its results were clearly visible which supported his sense of identity as a CBT therapist.

> ***(David)*** *45-7... [CBT] is the one I started doing originally and although it's the one where I might become more affected by on occasion, it's where I can actually see people going through intrusive exposure and obviously 12-14 sessions down the line we can do that in the room without being affected. I think it's more, it feels quite tangible, y'know..?*

David talked about 'seeing' people go through intrusive exposure through the reliving process. This was one area that fuelled his passion for his core model and gave him confidence in its effectiveness. Although David's statement of, "*we can do that in the room without being affected,*" suggests a personal negative impact arising from his client's trauma, like Angela (page 98), it also highlights the mutual benefit and personal post-traumatic growth for David as the therapeutic process continues.

We know Helen's experiences of trauma-focused CBT have been less favourable than EMDR (pages 94 & 101), but she was still positive about its benefits.

> **(Helen)** 145-6 *... it can be more contained because you're dealing with just the one incident...*

The control that Helen perceives she has with trauma-focused CBT, being more defined and easier to manage that its EMDR counterpart, may give her a sense of confidence for those times she feels compelled to work at a faster pace (page 110) or when faced with a complex trauma presentation that feels overwhelming.

Interestingly, Paul likens CBT to Star Trek's Borg who, like himself, is in pursuit of perfection.

> (**Paul**) 212-4 … *The Borg [laughing], the Borg was a thing that used to assimilate everything in its path and CBT is a bit like that…*

Whilst initially seen as the enemy and a recurring antagonist, according to their spokesman in the form of an assimilated Captain Jean-Luc Picard, the Borg only want to "raise the quality of life" of the species they "assimilate" (Star Trek, 2014). From his metaphor, Paul views CBT as a superior treatment method which absorbs knowledge from other models has the ability to improve and adapt, and has more recently led the field in mental health treatment approaches.

> **(Susan)** 30-1 *... I've found with the CBT side of things, I become more involved in the story, in the kind of, in the person's narrative of their experience…*

As highlighted by Susan, three participants felt a stronger emotional connection to a client's trauma story when working with trauma-focused CBT which led to negative psychological, physiological and behavioural changes impacting on their sense of self.

5.1.3.2. Participant experience of EMDR. Although there were some reported drawbacks to the model, on the whole when talking about EMDR participants were more passionate about the results they have seen compared to when delivering trauma-focused CBT. All participants trained in EMDR found it to be a very effective, trustworthy model for treating PTSD, with Paul's enthusiasm, use of language and repetition summing up their strength of feeling.

> **(Paul)** 70-2 *... because I think it's really effective. I really believe it. I think it's, I've seen really incredible things as the results of EMDR. Y'know, really, really believe it to be a very effective form of treatment for trauma…*

Part of participant passion for EMDR came from recognising the strength of the method and watching their clients' swift post-traumatic recovery. For one participant, left anonymous to protect their identity further within the findings,

this feeling was heightened by their own personal experience of receiving EMDR after suffering historical post-traumatic stress disorder.

> **(Anonymised)** 25-7 *… after seven years of talking therapy, I didn't feel that much better and after two or three sessions of EMDR, it was amazing and yeah, the outcome was just quite incredible and I've been very impressed with EMDR ever since...*

Claire's experience of EMDR is an extremely effective treatment and one that is adaptive and respectful of her clients' privacy in its entirety.

> **(Claire)** 152-4 … *So it's not saying, "Look come to me and tell me all about it all over again and feel embarrassed and shy and shameful and all that stuff". They don't have to do that and I really value that aspect of EMDR*…

Claire uses EMDR to treat clients who have felt unable to disclose certain information, such as intimate details of rape and abuse, or those who have signed The Official Secrets Act (1989) under which it is a criminal offence to disclose official information without lawful authority. The importance Claire places upon privacy is based upon her clinical experience of the extreme difficulties some clients face when engaging in trauma treatment and like many other participants, her sense of responsibility and feelings of protection towards them as demonstrated in her extract. By affording those clients presenting with disruptions to dependency, safety, power, independence or esteem the opportunity of complete privacy, Claire's sense of self may be supported whilst helping to build client trust and forge a strong therapeutic relationship early on in treatment.

> **(Paul)** 50-2 *… I suppose EMDR for me is always the big gun I use when all the others don't [pause] don't work I guess…*

Although Paul seemed somewhat reflective as to why he uses EMDR, like Claire, he views it as an extremely effective, powerful therapeutic tool that targets and discharges trauma memories left untouched by other treatment models. However, to remain faithful to his core model and to protect his sense of self as a CBT psychotherapist and his expectations on client recovery (page 109), it appears Paul only uses EMDR, his 'weapon of choice', as a last resort for those clients stuck in their recovery process.

Compared to its counterpart, delivering EMDR helped some participants feel less emotionally involved with their clients trauma experience, whilst still producing excellent treatment results. Both Susan and Helen spoke about feeling more emotionally distanced from their clients' trauma responses rather than becoming immersed in their experience as when delivering trauma-focused CBT.

> **(Susan)** 31-2 ...*I think with the EMDR I've been more detached from it, more removed, if that makes sense? ...*

Whilst feeling emotionally distanced from client emotions could be argued to be a negative for the therapeutic relationship, Helen clarified what it meant to her.

> **(Helen)** 153-5 *... I say detached, I mean I'm sitting in front of people or very close to them and facilitating their processing so they have the video in their head rather than mine, so that's what I mean by detached so I'm just reading the body signs and looking for signs of processing and facilitating further...*

It is very clear from the extract, that Helen is engaged in the therapeutic process and working hard to support her clients in their trauma processing. However, by using EMDR, she is able to distance herself from her clients' trauma stories and doesn't replay the haunting trauma images she experiences within her trauma-focused CBT work.

David's experience of EMDR when comparing it to trauma-focused CBT was it being a gentler form of treatment for both the client and therapist.

> **(David)** 56-62 *... EMDR I guess, there is a parallel process going on. It's less invasive and intrusive for the patient and conversely I think it is less intrusive and invasive for the therapist [………] because I think you are, it's almost like, of course it's not semi-hypnotic but it's almost, you're making an almost unconscious reference to the traumatic information, so I think it is easier to process on some levels…*

David appears to believe the effort of actively engaging in trauma treatment is easier with EMDR than trauma-focused CBT. However, his use of language and switch between first, second and third person pronouns in his extract is suggestive his voiced experience may be different to that of his personal experience. Interestingly, when discussing EMDR being less intrusive and

invasive, David talks about "*the therapist*" rather than 'me', and distances himself from his statement.

David's familiarity and comfort in the trauma-focused CBT model gives him a sense of confidence and protects his sense of identity as a trauma therapist. When revisiting his experience of delivering EMDR later in his interview, he questioned his competence in the model.

> **(David)** 228 *... trauma-focused I can rely on seeing the change. EMDR because y'know, it's maybe more subtle? Maybe I'm not as convinced that I have done the work and that somebody has just avoided it? Gone through the motions and then off they go…*

Within his extract, there appears to be some underlying anxiety for David when delivering EMDR. He not only questions his experience of the EMDR model when comparing it to trauma-focused CBT but also his clinical skills and the therapeutic relationship. David's doubt is based on him being unable to "*rely on seeing the change.*" As David feels less competent in EMDR and not convinced he has done the work, this fuels his doubt and leads him to question whether the client has gained any therapeutic benefit from his intervention or avoided addressing the trauma altogether. When asked how he might be convinced that the EMDR is working, David continued:

> 234-35 *… EMDR processing should account for that you know, but if I got affect in the descriptions very early on then I need to trust that. Just trust in it…*

The use of repetition around trust in the extract further highlights David's anxiety around his competence in EMDR or his belief in the method. Repetition in this example may serve David twofold. Firstly, to act as a form of self-reassurance and secondly, to help boost his confidence in his EMDR skills. As the interview continued, David went on to identify how he could gain the trust he lacks.

> 237 *… By doing it a lot more…*

Throughout David's interview, there is a sense of the high standards he puts upon himself to be a perfect therapist and this is illuminated by his drive to be supremely competent.

> *240-41 … Could be using excuses and it could be I don't have the time to focus energies on being supremely competent in that, as I am competent in trauma-focused [CBT]…*

However, the underlying conflict in his sense of self and disruptions to his trust, power and safety when delivering EMDR, may test this and lead to further avoidance of the model. This is supported by his admission that due to the time and mental effort it would take for him to become "*supremely competent*" in the model, he has no plans to deliver more EMDR to gain the trust he currently lacks

Although participants that used EMDR found it very effective, there were drawbacks when using the model. Julie suffers more negative effects when working with EMDR compared to trauma-focused CBT.

> **(Julie)** 102-33 *… the other difference I guess though, is that in terms of traumatisation to me, I probably do get more traumatised in a different way when I do EMDR…*

It is clear from Julie's extract she finds her trauma work distressing regardless of the treatment model she is delivering. Her use of the words traumatisation and traumatised, give a sense of the level to which she has been disturbed. However, the negative impact she experiences during EMDR when no narrative is taking place, stems from the somatic symptoms she experiences which mirror those of her trauma clients during their EMDR processing.

> 126-31 *… I'm seeing a guy at the moment who [details of accident] he was crushed by this machine and anyway, he obviously survived because I am seeing him but I was working with him yesterday and he was remembering the accident [………] and feeling this sort of pressure on him and again, I had this wave of this sort of pressure [pointing to torso], so that sort of happens quite regularly…*

Julie's wave metaphor suggests she experiences a surge of physiological symtoms when delivering EMDR. As Julie talks in terms of 'traumatisation', it gives an indication to the level she has been disturbed. There is a sense that the unexpected, intense, physiological responses have left her feeling anxious and vulnerable and perhaps even questioning her ability to cope. This is supported later in her interview where she confirms the impact from EMDR has left her tentative about the process of undertaking trauma work. Julie's 'traumatisation' also points towards disruptions to her frame of reference and

safety, which is supported within her second extract where she reminds herself that her client is alive and well. Although contradicting her actual lived experience, she has made sense of her experiences by viewing her symptoms as a sign of her strong emotional connection with her clients. This meaning making may support Julie's sense of self as an EMDR therapist and thereby assist in reducing her residual anxiety and feelings of vulnerability.

Another negative experience of delivering EMDR was the uncertainty participants felt with regard to where the EMDR process may lead. Unlike trauma-focused CBT, the therapist does not take the client through an account of the trauma in a chronological way. Therefore, because EMDR is a very natural way for the client's brain to make any necessary links to the trauma memories itself, it cannot be contained or structured in the same way. Consequently, unconscious material may come up for the client during trauma processing.

> **(Claire)** 138-9 ... *that I think it is more effective, more practically effective and I think it is a really deep process, so it gets underneath everything which can be a double edged sword obviously…*

Claire's use of the metaphor "*double edged sword"* sums up the difficulty therapists can experience when delivering what they see as an effective treatment, whilst balancing the uncertainty faced when supporting clients with any expression and emotional discharge of unconscious material, known as abreactions.

> **(Claire)** 301-9 … *They can be very, very scary and I think particularly when you first start. They are so scary for first the client and the therapist. If the client picks up the therapist's fear that's usually counter-productive I think, because the client doesn't feel safe and held and therefore will feel more frightened. The therapist I think can feel very frightened as well and in that situation I think there is always the likelihood of collusion between the two who will say, "Oh well, that's probably enough for today. Let's stop and relax and get back to normal", and of course all that does is just open all the stuff, make it really painful and horrible and then pull back and you haven't achieved anything. So, I think that is really dangerous…*

Claire's experience of severe abreactions being frightening for both herself and her clients is clear in her extract with the repetition of the words *very* and *scary*. Like David (page 122), Claire talks about fear in the third person and distances

herself from her personal experience, protecting her professional identity. Her extract confirms Claire's awareness of the likelihood of collusion and its consequences has evolved with time and supports the fact she is an experienced EMDR practitioner. Furthermore, it gives a clear sense of the difficulties faced by EMDR therapists and in particular, those who are less experienced and highlights the importance of good supervision.

5.1.3.3. Barriers to treatment

Throughout participant interviews, various themes came up regarding the factors that hinder delivering trauma treatment. Although some participants worked solely within organisations or private practice whilst others worked in both, the barriers to treatment sometimes overlapped. The majority of participants working within organisations indicated the restraints imposed upon them, had the greatest impact on their sense of self as professionals.

Time restraints and service provision. NICE Guidelines (2005) recommends between eight and twelve treatment sessions for PTSD, depending upon complexity and ninety minute treatment sessions for any session in which reliving takes place. For the majority of participants, the lack of autonomy or control, linked to restraints on their time and service provision, led to disruptions to their sense of self and independence and power.

Jenny gave a very clear picture about the pressures of waiting lists within the organisation she worked for that operates a payment by results contract and due to funding, offer just six one hour sessions before an enforced discharge period of three months.

> **(Jenny)** 149-52 *... there is still that undercurrent of we must earn, we must get people through, we must make sure that there is no empty spots, no empty spaces, all cancellations are filled and if we have a cancellation then we are expected to do a telephone assessment. Y'know, there is no breathing space…*

Jenny's metaphor of "*no breathing space*" is replicated in her lack of breath and her flowing description in her response. It is clear from her extract she feels suffocated by the amount of pressure within her clinical practice and her lack of self-rule.

Adrian's experience is similar to that of Jenny's and illuminates his feelings of powerlessness, frustration and constraint which has led him to question the ethical position he and his colleagues are in and whether he wants to continue working in the profession at all.

> **(Adrian)** 40-4 *… it really brings the spotlight to bear on it and y'know, it brings up, y'know, critical issues really and that is not being able to do clients a decent job because of the constraints on our time. Not being able to use if you like the power of the method [EMDR] and such experience and knowledge I have of it. Not being able to use it, that's the trouble…*
>
> 51-6 *… I feel quite frustrated with what we are discussing, quite a bit of the time. Like, I wouldn't say quite the majority but a significant minority of the time and occasionally when something comes up it can really get me quite frustrated, sad, fed up. Wondering whether I want to keep doing it? Whether we, we meaning me and my colleagues should be doing it..?*

To help their feelings of diminished personal autonomy, three participants gave examples of timing their trauma sessions before lunch or at the end of the day. This practice not only reduced any pressures on their session time, it gave participants confidence that their ethical practice and management of any negative impact of the work on their clients or themselves remained steadfast.

Like Adrian, Helen has obviously questioned the ethical position of working within a restricted timeframe and has chosen to extend her working day to ensure her professional sense of self remains intact.

> **(Helen)** 109-*112* *… if I don't give myself more time for the trauma clients and for myself afterwards in my day, which usually means working a longer day, then I wouldn't be able to do clinically what I feel is good practice really for both myself and the client…*

Paul feels frustrated when his professional judgement is questioned and his autonomy is shackled by insurance providers who impose restrictions on the treatment he can offer clients.

> **(Paul)** 190-2 *… Sometimes I do find myself a bit hamstrung where I'm seeing somebody at the moment who I recommended EMDR and they [the insurers] said no. The insurers were only going to pay for CBT and that is a bit of a pain because I think, y'know, this person needs EMDR…*

In complete contrast to other participants, Claire feels grateful for the protection afforded to her and her clients within her organisation.

> **(Claire)** 103-4 *... And the luxury of the work that I do, which I know my colleagues out in the big wide world don't have, is I'm not limited to a number of sessions...*

It is clear when comparing herself to many of her colleagues working elsewhere in the field of mental health, Claire recognises, enjoys and places high value on the lack of restraints upon her automony and treatment recommendations.

> **(Susan)** 18-21 *... I've favoured the CBT side of things more, purely because I didn't want to, kind of like, split my focus on the CBT course and I've favoured that I think but that's purely my decision to not offer EMDR during the IAPT course and that was just purely my choice ...*

When undertaking simultaneous training organised by her employer, Susan recognised she did not have the mental capacity to develop her clinical practice in both areas. In order to successfully manage this and retain her autonomy, she withdrew one trauma treatment option to concentrate on the other.

Clients who don't engage. Four participants touched upon the subject of lack of client engagement. One acknowledged his frustration with clients who did not appear to place much value on their treatment (and consequently himself) and prioritised other commitments over their treatment sessions. All four participants expressed feelings of compassion for clients who found it difficult to engage in trauma treatment through fear.

Angela's sadness at her client's damaged resilience, helplessness and feelings of anxiety over the client's decision for dropping out of treatment reflected those of other participants. Just as her client found it unbearable to engage in treatment, Angela found it almost unbearable to think of her 'wounded' client being left untreated.

> **(Angela)** 157-73 *… I have felt it quite difficult and challenging where somebody has felt unable to move from that and engage in a therapeutic process and y'know it feels like somebody's left with this absolutely enormous wound and yet can't bear for that to be dealt with in any way [……..]. I think it's the sort of situation where you do your best to ensure people are fully understanding of what is on offer, how it might work, how they might be supported, but [………] if they choose not to engage, yeah, that's a*

> *bit uncomfortable. I think that's about therapist anxiety for me y'know, questioning whether have I helped the person feel safe enough? Have I helped them understand the model effectively? Have I explained the treatment process well enough? Is there something I have not done well enough to enable them to feel that they actually want to go through that?*

From her extract, it is evident Angela felt an overwhelming sense of helplessness and responsibility for her client's decision not to engage in the therapeutic process and address the trauma memories haunting and restricting her life. We already know Angela struggles with unknown endings (page 98) and from her style of self-questioning there is a sense that she feels she missed an opportunity to engage her fragile client in treatment and on some level, perhaps feels she let her down.

> **(Angela)** 186-8 *… All I was able to do was help her understand as best I could and leave the door open for her so that should she change her mind at any point, she knew that she would be able to connect to a professional in her area…*

Although Angela's second extract conveys her sadness at being unable to help her client, there is also a glimmer of recognition of the effort she was able put in. Her use of the third person when talking about her client returning to treatment in the future, could point towards Angela herself no longer being available. However it could also point towards her doubts that her client did not engage as she felt unable to 'connect' with her and thereby fuel and maintain any internal challenge to her sense of professional self.

5.1.4. Protecting and Sustaining the Participant Sense of Self

Whilst participants seemed to accept the potential for being negatively affected by their work as part of their job, they were able to balance this by implementing certain practices to protect and sustain their sense of self. These included general self-care such as regular exercise, hobbies, mindfulness; autonomy in managing caseloads, training and supervision.

Therapist self-awareness of risk was highlighted by participants when talking about the negative effects of their trauma work. Many examples of awareness of risk resulted from prior experience of negative effects of the work and

subsequent changes made to their practice. The most important protective factor for participants was the timeframe in which they prepare, implement and debrief trauma work. Very aware of the potential risks and their ethical responsibility for client wellbeing during treatment, over half of participants were particularly cautious when delivering trauma treatment.

David's acute awareness of the intensity and potential risk of a negative impact on himself or his client during trauma work, ensures he plans his sessions carefully and allows additional time should emotions spill over.

> **(David)** 161-3 *... I'll make sure y'know, given a particular case, that I have got enough time before and after the session in case it's going to get complicated, to mop things up or y'know, compose yourself a bit…*

Two participants were hesitant before introducing the concept of EMDR to clients. Whilst Paul finds EMDR very effective, he delays introducing it to his clients.

> **(Paul)** 41-6 *… I tend to do CBT first rather than EMDR and I think partly that's because I [pause], whilst I find the EMDR very effective I always have a problem describing it to clients cause it sounds, it sounds so much like new age hippy bollocks [R. Laughing] and I always think if I come straight out with, y'know, I'm going to do this treatment that's evidence based and really effective and I'm going to wave my fingers at them [both laugh] they are going to go running…*

Although Paul is committed to his core model of CBT and uses this before EMDR, within his extract he acknowledges this is partly due to a difficulty in describing the EMDR model to clients. From his use of language, Paul believes that because the treatment is difficult to define and sounds like holistic nonsense, clients may be distrustful at the treatment and in turn, more importantly, Paul's professional credibility and sense of identity. Paul's belief is that the distrust may result in clients either not engaging in treatment or dropping out early. We already know from Paul's own admission (page 109), he has a perfectionist schema and finds it difficult if clients don't get better. Therefore, structuring in time for clients to build confidence in his capabilities and develop their trust within the therapeutic relationship before introducing EMDR, helps him protect his sense of self.

Not the only participant to have learnt through experience, Susan has a greater understanding of the potential for a negative psychological and physiological impact upon her sense of self when engaging in trauma work.

> **(Susan)** 155-6 *... I think it's reminded me that I need to work hard to keep myself safe…*

Helen has made sense of her treatment preference of EMDR by viewing the model as one that has the ability to shield and offer her protection from the effects of listening to distressing or harrowing trauma stories, experienced with trauma-focused CBT.

> **(Helen)** 264-8 *… I think really perhaps touching a little bit more on the EMDR and the difference in why I might prefer that; I think it is because there is a chance, that you possibly wouldn't hear the more unpleasant things necessarily, if that makes sense? The client is experiencing it so it will still be upsetting for them maybe but you do seem to hear less of the traumatic material...*

Jenny uses the skills learnt through a former career to help her cope with her work as a CBT therapist.

> **(Jenny)** 247-8 *… I do seem to have built up a fair amount of armoury whilst I was nursing that y'know, I still use today and still rely very heavily on...*

Jenny's use of metaphor gives a clear image of the internal battles she faces, when working with trauma and again gives a sense of the level of protection she needs to engage in the work and support her wellbeing.

Paul and Claire's reference as to why they have become seemingly unaffected by their work over a period of time, whilst aiming negative connotations towards themselves, also give a sense of protection.

> **(Paul)** 285 *… I don't know if this, it's just me becoming a hardened bastard but that just didn't resonate at all with me…*
>
> **(Claire)** 58 … *Maybe I've just been around too long and got a thick skin…*

Paul in particular, refers to himself somewhat harshly as, "a *hardened bastard"* because he was not emotionally affected when working with a high profile case in which children had died*.* Their use of words '*hardened'* and '*thick skin',*

suggests both participants consider the tough outer shell they have built up over a number of years to help them manage the negatives effects of their work, could be seen as socially unacceptable.

5.1.4.1. Training. Training and competence was viewed as another area that helped all participants feel safe and confident to practice in the area of trauma. All participants valued their training and enhanced this by keeping up-to-date with literature around treatment protocols, using supervision to aid their learning, or attending continuing professional development workshops.

Whilst training was seen as a protective factor for participants and a very positive part of continuing professional development, the importance of comprehensive, good quality trauma training prior to engaging in trauma work was highlighted by Julie, Susan and Laura, to help reduce the risk of a potential negative impact from those cases in particular that are especially harrowing. Each spoke about the damaging effects of receiving what they considered in hindsight and experience, inadequate trauma specific training which had a direct result on their sense of identity as a trauma therapist and lead to a lack of confidence in delivering the trauma-focused treatment protocol for PTSD.

> **(Laura)** 262-7 *... I don't think it was actually sort of explained to me about how, y'know, it could have such an effect on me. I don't think I was fully aware of the impact that it can have [………] it's the nature of some of the cases you know. The nature of the trauma of some of the people that you see. I don't think I fully realised how that could affect me actually…*

Laura felt unprepared for the disruptions to her sense of self and surprised when affected by the unexpected negative impact resulting from some particularly harrowing trauma presentations. For Susan, her lack of confidence continues to leak out.

> **(Susan)** 240-1 ... *y'know that diagram of the PTSD model. That complicated model...* [Ehlers & Clark, 2000]

5.1.4.2. Supervision. Another protective factor for participants was the use of clinical supervision. All spoke of the importance that supervision has played within their work and the value that they place on this.

> **(Paul)** 112-3 … *that's when I feel my supervisor earns their crust, when there's a trauma, y'know? When there's nasty, nasty trauma…*

Paul spoke about his appreciation of supervision. Although his extract gives a sense that Paul may not always see every supervision session as value for money, his use of metaphor and language suggest this is balanced with the times that he does. It is plain during exceptionally harrowing or disturbing trauma presentations, the interactions and responses offered to Paul by his supervisor are invaluable to both emotionally hold him and offer support with any feelings of isolation that can arise undertaking confidential therapeutic work.

Whether individual or group, participants used supervision to process their trauma work and work through any negative effects resulting from it.

> **(Susan)** 96-100 *…as soon as I started talking about it in supervision, I just burst into tears straight away, so I knew. I could feel that build-up although I hadn't anticipated that I was actually going to shed tears about it. It was something that had obviously built for a couple of weeks and then got to the supervision stage and it just all came kinda of tumbling out...*

Although Susan indicates some awareness of her emotional build-up related to hearing trauma narrative in the weeks leading up to her supervision, she was taken by surprise when she became upset. Her description of her distress "*tumbling out*" gives a sense of the emotional and physiological strain Susan was under when suppressing her feelings. It also denotes her relief when she finally felt safe enough to release them due to the warmth, compassion and trust offered by her supervisor and supported by their supervisory relationship. Although Susan does not clarify why she did not seek supervision earlier rather than waiting for her appointment, her extract highlights the sometimes unexpected, emotional responses therapists can experience and the importance of accessing supervision as soon as these changes occur.

Findings also highlighted the importance of peer supervision to complement and support supervision with individual supervisors. David placed great importance on peer supervision with experienced colleagues.

> **(David)** 175-81 *... I find actually discussing it with someone I value clinically the most beneficial thing. That might not always*

> *be a supervisor because you know, I guess logistically you could be allocated a supervisor whose skills are very good and competent but you know, you might have a work colleague who is far more experienced in treating post-traumatic injuries. Somebody who personally and professionally you value more, and you know, you feel comfortable and safer perhaps…*

For David's sense of identity to remain intact, it is clear he needs confidence in his supervisor's trauma-specific competencies to enable him to discuss case material and support and develop his clinical skills. Where he perceives this as lacking or weak, David's sense of safety is clearly threatened and there is a risk of non-disclosure. By accessing additional supervision with a colleague whom David believes has a greater depth of clinical experience in trauma specific presentations, he is able to support any feelings of vulnerability or doubt and maintain his levels of confidence.

5.1.4.3. Use of laughter as a coping strategy. Laughter or humour was evident within the majority of participant interviews. The laughter or humorous responses of participants are shown throughout various extracts within this chapter (eg: pages 110, 113 & 117) but were generally used as a coping strategy when talking about their experiences of trauma to signify embarrassment, anxiety, irony or relief.

When Paul was asked what helped him do his trauma work, although perhaps tongue-in-cheek, his answer gave a sense of just how intense his work can be.

> **(Paul)** 218-20 *… Drink copious amounts of red wine, that tends to help [laughs] not during the session of course, although I have been tempted…*

Throughout his interview, Paul acknowledged he strives for perfection (page 109). His use of laughter suggests his slight unease at voicing one of his chosen coping strategies which could be construed as less than perfect. The stress Paul's work places him under, perhaps fuelled by his need for perfect outcomes, is apparent within his extract and his honest reference to the occasions when has been tempted to use alcohol during his working day. Paul's laughter may also serve to help him make light of any difficulties and thereby reduce the impact of the work on his sense of self.

Justin, talking about self-awareness and how he makes a point of putting anything that may be nagging him to one side so it doesn't affect his client work, became distracted during his interview.

> **(Justin)** 382-86 *… making sure that's to one side so I am fully available to the client, that my own stuff isn't going to contaminate the process, so I'm receiving as clear as I can. Sorry, [laughs] my cat just caught a mouse [both laugh]. I'm looking out the window in the garden; poor mouse is going to be very traumatized…*

Justin's laughter may make light of the event unfolding before his eyes. Although only a mouse in this example, the irony used is perhaps representative of the many professionals who use humour as a coping strategy when working dealing with traumatic situations. Even more ironic, was the fact that Justin's distraction whilst talking about being fully available to processes, rendered him momentarily 'unavailable' to the researcher and effectively allowed his cat and the mouse to 'contaminate' the interview process and illustrates the ease to which therapist drift may occur.

5.1.5. Summary of Analysis Section

Four master themes (Figure 5, page 136) emerged from the data and were analysed to best represent participant experiences and answer the research question. All themes raised by participants within the study highlighted both the negative and positive experiences reported when working with trauma clients using the recommended treatment modalities of trauma-focused CBT and EMDR.

The following chapter moves on to discuss the results of the study and considers its findings in relation to existing research. Furthermore, it will evaluate the research design and consider the implications of the findings, recommendations for future research, the limitations to the study and the proposed dissemination strategy.

1. Nature of Trauma

Type of trauma presentations
High profile cases

2. Participant experience of self and managing the process of hearing about trauma

Listening to the client's story
When imagination takes over
Influence of multimedia within the therapy room and beyond
Personal triggers and significant life events
Negative psychological, physiological and behavioural changes to the sense of self
Witnessing post-traumatic growth

3. Participant experience of delivering the trauma models

Participant experience of trauma-focused CBT
Participant experience of EMDR
Barriers to treatment

4. Protecting and sustaining the participant sense of self

Protecting the participant sense of self
Training
Supervision
Use of laughter as a coping strategy

Figure 5: Diagram of the four master themes identified within the combined study findings.

Chapter 6: Discussion

6.0. Overview

The aim of this study was to explore how trauma-focused CBT and EMDR therapists working with the recommended treatment modalities for PTSD, made sense of their experiences and protected themselves from any negative effects of the work. Furthermore, it considered whether there was a distinction in therapist experience between the two modalities. This aim has been achieved within this thesis and important findings that can be used to assist therapists to cope with vicarious traumatisation have been identified. The thesis starting point was identifying whether vicarious trauma exists and the evidence that underpins it; and once this was established, how it is defined in the literature, with a consideration of the adequacy of these definitions. The literature review also established just how complex and multi-faceted vicarious trauma can be. This will be discussed further together with its implications later in this chapter.

Importantly, the research has identified the direct impact on psychological therapists working with trauma clients. Also identified are pre-disposing, thus risk, factors and protective factors, the implications of which are discussed. The discussion chapter for ease of reading will be discussed under the following main headings:

1. The findings from the study analysis
2. The researcher's reflexivity and personal learning
3. An evaluation of the research design and research question posed
4. Implications of the findings and recommendations for future research
5. Limitations to the study
6. Recommendations for future research
7. The dissemination strategy

To aid the reader, unless specifically stated, the numbers of participants represented within the findings will be described in the terms set out in Table 10 (page 138). To allow for reflexivity, the researcher will be referred to as 'I'.

Table10: Participant representation within the data findings.

Number Of Participants	Also Referred To As…
2-3	Quarter
5-6	Half
8-10	Majority/most
11	All

6.1. Discussion

This study importantly identified specific factors and influences which may impact heavily upon trauma therapists and subsequently provoke a negative therapist emotional response. Additionally, the work has added to and helped clarify the important question of which therapists may be pre-disposed to vicarious trauma, as suggested by Pearlman and MacIan (1995); Schauben and Frazier (1995) and Way et al. (2004). This research has also extended the research evidence base through its identification of additional factors which can help therapists sustain their ability to work with trauma over the medium to long term.

The IPA methodology and its double hermeneutic interpretation process (Smith et al., 2009), directs that research results are written from the perspective and interpretation of the researcher trying to make sense of the participants experience of their trauma work. This process is shown in Figure 6 (page 139). The research findings can be understood within four overarching superordinate themes of; ‘Nature of trauma’, ‘Participant experience of self and managing the process of hearing trauma narrative’, ‘Participant experience of delivering the trauma models’ and ‘Protecting and sustaining the participant sense of self’.

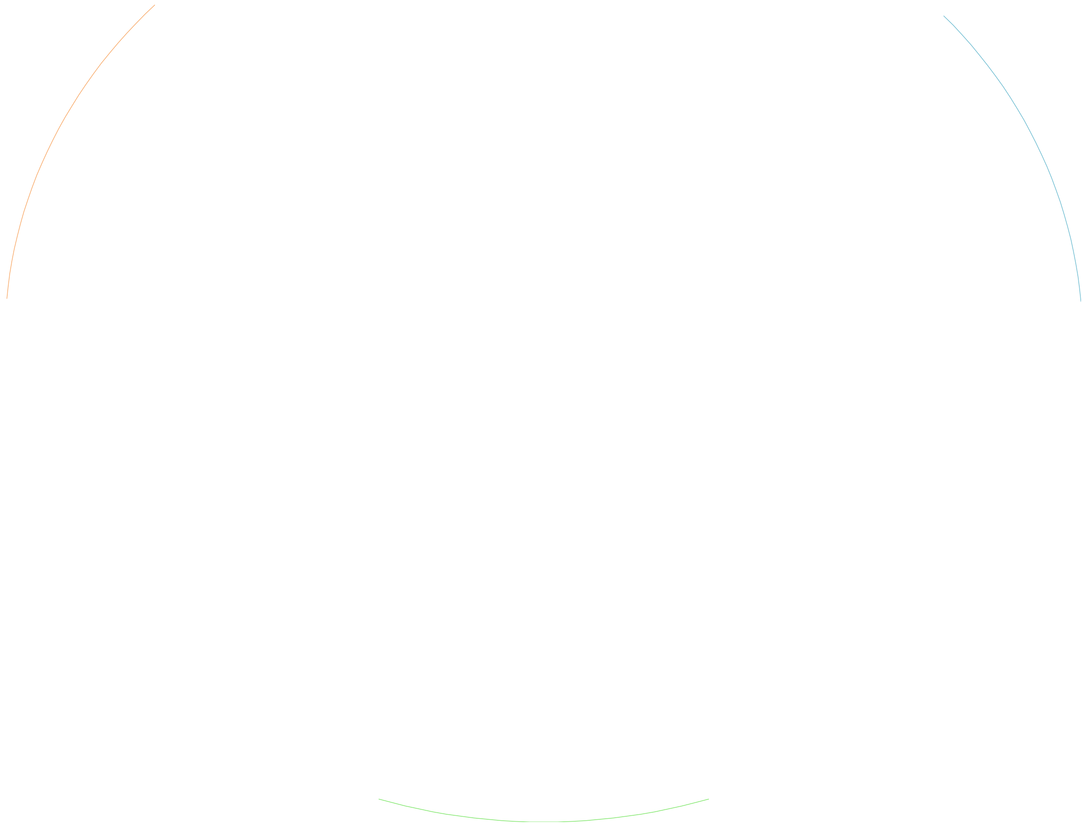


Figure 6: Double hermeneutic cycle of interpretation for the study.

6.1.1. Nature of Presentation

The research findings identified how the nature of the traumatic incident itself impacts negatively upon participants. All participants spoke about the type of trauma presentations they have worked with (Figure 4, page 91) and the impact of these on their sense of identity and personal and professional lives, with many reporting symptoms associated with vicarious trauma. This finding supports previous research that argues professionals working with trauma who are exposed to emotionally shocking material over time, may suffer symptoms of vicarious trauma (McCann & Pearlman, 1990), also referred to as secondary traumatic stress (Figley, 1985) or compassion fatigue (Figley, 1995). Specific to therapists working with trauma survivors, vicarious trauma can result in symptoms representative of PTSD (McCann & Pearlman, 1990). Although

there were varying degrees to which participants were affected in this study, the more severe or frequent a specific trauma presentation was, the greater the negative emotional impact. This again is important as it suggests that those therapists most at risk of vicarious traumatisation can be predicted to a certain degree and thus can be targeted for strategies that help them to manage this issue. This is perhaps not unexpected, as the same risk factors of severity and repeated exposure to trauma, both predict the development of PTSD (McCann & Pearlman, 1990; NICE, 2005).

6.1.2. Participant Experience of Self and Managing the Process of Hearing Trauma Narrative

The literature in respect of vicarious traumatisation indicates a number of psychological changes can occur in therapists or others exposed to the trauma narrative. Such changes can occur in their trust of others and within their sense of control in their own life. Furthermore, changes in intimacy with partners or others can occur, along with reductions in esteem with risk aversion or excessive safety concerns being triggered. It is also relatively common for the therapist to experience intrusive symptoms such as images (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995a; Steed & Downing, 1998; Iliffe & Steed, 2000; O'Halloran & Linton, 2000; Trippany et al., 2004; Jordan, 2010; Elwood et al., 2011).

Unlike previous studies, this study identified specific variables in the way that trauma narrative is presented, which influences the trauma impact on the therapist sense of self and which could be seen as predictors of anxiety, other strong emotions or vicarious trauma. The IPA process facilitated this new finding through the depth of analysis of the lived experience of research participants. All variables identified (imagination, multimedia, personal triggers and significant life events, negative cognitive, emotional, physiological and behavioural changes) in respect of how trauma narrative is presented, will be discussed in more detail under the following section 'A process of change'. Furthermore, a number of key positive aspects identified will also be discussed which reflect and build upon findings of others (eg: Arnold et al., 2005; Harrison & Westwood, 2009; Barrington & Shakespear-Finch, 2013). These are

particularly important as they supported the emotional wellbeing of participants and fuelled their passion for carrying out their trauma work.

6.1.2.1. ‘A process of change’

Following the analysis of the participants accounts, this study supports existing research evidence with the finding that hearing trauma narrative provokes disruptions to a therapist’s sense of identity and changes to their cognitive schemas and imagery systems (eg: McCann & Pearlman, 1990; Iliffe & Steed, 2000; Jordan, 2010). Furthermore, it makes a contribution to knowledge with the finding that hearing trauma narrative triggers a therapist ‘process of change’. Within the identified changes, the boundaries of the negative influences may become blurred. Whilst not all changes may be experienced for every trauma case a therapist is presented with (and acknowledgement is given to the different ways a cycle may operate dependent upon an individual’s trauma processing), Figure 7 demonstrates how these individual changes are linked and highlights a negative cycle that therapists may find themselves experiencing. Recognition and awareness of this cycle is therefore paramount to prevent a decline in therapist welfare and promote wellbeing.

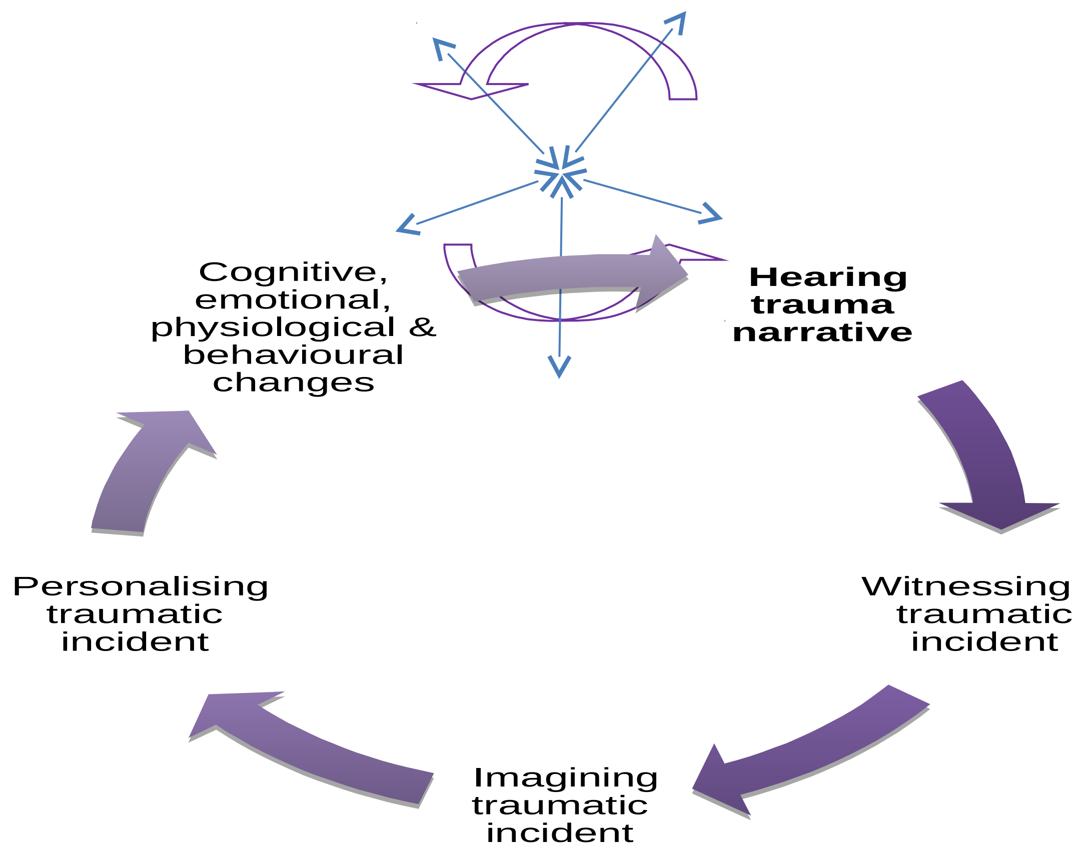


Figure 7: A process of negative change for therapists working with traumatised clients.

6.1.2.2. Hearing trauma narrative: 'Listening to the client's story'

One of the main themes within the study and the first 'process of change' was the phenomenon of hearing trauma narrative when listening to the client's story. Although a theme within its own right, it permeated throughout all four overarching master themes and encompassed all negative aspects of trauma work. Terms such as '*horrific', 'harrowing'* and '*gruesome'* were used throughout participant interviews to describe their clients' trauma presentations and denote the level of distressing narrative they were exposed to.

Findings show hearing trauma narrative was significant in four different areas, the boundaries of which often overlapped. These were graphic description, human brutality, assessments and trauma presentations involving children. Reflected in all areas were the difficulties associated with the degree of graphic trauma narrative given by clients, resulting in changes for participants, similar to those symptomatic of PTSD experienced by the client (WHO, 1994; APA, 2013). Importantly, this finding supports previous research where the significance of these areas was found detrimental to therapist wellbeing (McCann & Pearlman, 1990; Steed & Downing, 1998; Jonsson & Segesten, 2004).

A trauma therapist's role consists of many layers. First and foremost, it is about establishing a therapeutic relationship to help the client engage in trauma work (Paul & Charura, 2015). During the process of supporting the client, assessing risk and delivering an effective course of treatment, the therapist attempts to balance any negative effects of the work upon themselves. When presented with a particularly harrowing or graphic example of trauma, findings show the therapist response may reflect that of the client and at times, feel unimaginable or overwhelming (McCann & Pearlman, 1990; Steed & Downing, 1998; Chrestman, 1999). The most significant example of this came from Paul discussing a client presentation involving graphic details of horrific fatal injuries of a close family member (page 94).

Findings confirm hearing the graphic trauma narrative not only represented the extent of detailed narrative a therapist may face but more importantly, supported

previous research suggesting trauma work can have a significant effect on the therapist's psychological and physiological state which negatively impacts upon their sense of self (McCann & Pearlman, 1990). Unfortunately balancing the anonymity of participants and clients whilst eloquently presenting the horror of what a participant hears does not go hand-in-hand. Due to the unusual and potentially identifiable nature of the presentation, this harrowing example was difficult to represent within the findings and potentially does not do this theme, one of the most prominent reported, justice. However, this particular presentation is a good case example where in order to reduce risk and bolster the professional and personal wellbeing of therapists, appropriate and adequate support is vital.

Paul's use of language during his interview clearly conveys his horror at hearing his client's harrowing trauma narrative. His sense of safety appears disrupted through identification with his client's loss and the imagined loss of his own family members, in particular one who had just started driving. Furthermore, his level of disturbance was strengthened by concerns for his client's safety. This finding is particularly significant as client risk, disruptions to safety and identification with clients, have all been recognised as predictors for a traumatic stress reaction (Farber, 1979; Deutsch, 1984; McCann & Pearlman, 1990; Sharry, Darmody & Madden, 2002; Jonsson & Segesten, 2004).

Listening to trauma narrative involving human brutality left participants shocked and disturbed. Nearly half of participants experienced changes to their sense of self, worldview, dependency, safety and esteem, supporting findings of McCann and Pearlman (1990). Each were disturbed by the capabilities of humans and struggled with the negative consequences of hearing trauma narrative over a period of time. This finding is important as left unaddressed, this may cumulate in therapist vicarious trauma (McCann & Pearlman, 1990), burnout (Maslach, 1998), secondary traumatic stress (Figley, 1985) or compassion fatigue (Figley, 1995), already established a risk over time.

Furthermore, hearing harrowing trauma narratives resulted in nearly a quarter of participants being able to clearly visualise their client's traumatic event through their own interpretation. As a result of hearing harrowing details of an incident in a foreign country with different cultural influences, Laura experienced temporary cultural prejudice and changes indicative of those of vicarious trauma, to her safety, dependency and esteem impacting on her sense of self (McCann & Pearlman, 1990). This finding is concerning as in the current climate of religious and cultural differences, wars, acts of terrorism and an upsurge of daily news and media footage of their consequences, this is one area of trauma work where the risk of therapist vicarious trauma through changes in cognitive schema and imagery impacting on their sense of self, becomes more prevalent. To help prevent this and equip therapists recognise and deal with its effects, education about vicarious trauma is recommended.

Hearing disturbing details of the violence inflicted upon others by her own client challenged Helen's sense of self as she struggled with disruptions to trust, safety, power, esteem and imagery. Rather than feeling empathy towards her client, Helen felt disgust (page 97). This was based upon the level of brutality inflicted and "*the methods*" used, which gave the participant "*way too much information."* Appearing to be unable to bracket out or set aside thoughts and hypothesis about information that was already known (Husserl, 1970; Starks & Brown Trinidad, 2007), the work negatively impacted on Helen in two ways and provides further evidence of the difficulties therapists face.

Firstly, the lengthy discussions around the ethical implications and service remit should the treatment proceed, indicate a pre-existing level of disturbance for Helen. Risks for individuals working in the health and social care sector dealing with unpredictable client behaviour and situations have previously been documented by the Health and Safety Executive (HSE, 2013). Although Helen gave no indication that her client had acted in a violent or aggressive manner during the assessment, her awareness of his historical violence may have influenced how she felt about working with him in the future and signify her concerns over managing potential risk. This finding is important as training has previously been identified as a protective factor for trauma work (Williams &

Sommer, 1999; Harrison & Westwood, 2009). Mandatory training focused on managing exposure to such risk, could therefore help reduce the potential for a negative impact and support therapist wellbeing.

Secondly, Helen's anxiety was heightened through anticipation of hearing further distressing trauma narrative. Whilst not explicit, such disturbance may signify a saturation of resilience levels and denote some pre-existing disruptions to safety, esteem and dependency/trust, all of which have been linked to vicarious trauma (McCann & Pearlman, 1990). This finding is also important as there is some evidence to suggest that therapists who have previously suffered personal trauma may go on to experience vicarious trauma or secondary traumatic stress (Baird & Kracen, 2006), the onset of symptoms which may not be detectable at an early stage.

Assessments were also found to be an area associated with the difficulty of hearing trauma narratives. This was due to the repercussions of hearing narrative when undertaking repeated assessments or working with a high frequency of case presentations, similar in nature. Over time, vicarious trauma can develop from the volume and range of cases that a professional is exposed to (Tehrani, 2011). This study found the repetitive characteristic of assessments or frequency of similar cases, led to negative consequences for participant wellbeing with disruptions to safety, control, intimacy and imagery previously identified as vicarious trauma indicators. This finding is important as it supports and adds weight to existing research (McCann & Pearlman, 1990; Pearlman & MacIan, 1993; Chrestman, 1999; McLean et al., 2003; Pross, 2006). Furthermore, it adds a new contribution to knowledge with the finding that clients who don't have the resources to engage through the therapy process and ultimately drop out, may also unintentionally leave therapists in a similar position. Findings of this study support previous recommendations for promoting wellbeing by ensuring varied caseloads and a recognition that assessments should not be the sole responsibility of individual therapists (Chrestman, 1999; McLean et al., 2003; Pross, 2006.)

The final area associated with hearing trauma narrative was trauma presentations involving children. Although just over half of participants disclosed they were parents, client presentations involving children were experienced as one of the most difficult for the majority, with participants becoming a container for their clients' trauma responses. This finding supports previous research where traumas involving children were rated the most stressful and intrusive (Clohessey & Ehlers, 1999; Jonsson & Segesten, 2004).

This study also found child presentations were particularly difficult for participants in cases of historical abuse or bereavement. However, difficulties experienced in relation to the bereavement of a child were not found to be aged related. When working with a parent of *any* child involved in a traumatic incident, just over half of participants suffered negative changes to their cognitions, emotions, physiology, behaviour and imagery systems impacting on their sense of self. This figure relates to the percentage of participants who were parents themselves and indicates a link to personal triggers or identification with clients (Jonsson & Segesten, 2004). This finding is particularly noteworthy and another area where therapists who could be potentially at risk of vicarious trauma may be predicted and targeted for additional support or training.

Comparable to the negative effects of working with child bereavement cases, findings show nearly a quarter of participants suffered similar difficulties whilst working with adult survivors of historic child abuse. Difficulties indicate links to personal triggers, human brutality or empathic engagement with the client, all of which have previously been found to be predictors for a traumatic stress response (Steed & Downing, 1998; Jenkins & Baird, 2002; Jonsson & Segesten, 2004; Badger et al., 2008).

6.1.2.3. Witnessing traumatic incident: ‘The influence of multimedia in the therapy room and beyond’

A second ‘process of change’ and an unexpected finding connected to the nature of a trauma presentation, was high profile cases and the influence of media within the therapy room and beyond. These were found to elicit a strong emotional response for the therapist. Paul and Susan both touched upon the

subject of working with clients who had been involved in high profile cases. Although both were affected by the media influence, the effect for each was different. This is a particularly interesting and important finding as visual aids are increasingly becoming available as a tool for therapists to use with the availability of multimedia recorded at the time of the trauma on mobile phones, CCTV, in-vehicle recording or home personal security systems.

The availability of media footage led one participant to have increased exposure to their client's traumatic material whilst delivering trauma-focused CBT. This finding is significant as exposure through electronic media, television, movies or pictures in work-related settings, has been identified as important in the DSM-5 criteria for PTSD (APA, 2013:271). During treatment, media footage was incorporated as a visual aid, thus placing the participant first-hand in the position of a helpless witness to client suffering (Neumann & Gamble, 1995). While the purpose of this may have been a mechanism for client exposure (Foa & Rothbaum, 1998; Elhers & Clark, 2000) or to enhance participant understanding of the traumatic incident, is unclear. Furthermore, due to the cases high profile, trauma exposure continued within the participant's private life through various modes of multimedia within the public arena. Findings confirm witnessing media images alongside hearing the harrowing trauma narrative, compounded the negative impact of the work, heightened levels of disturbance and resulted in imagery, emotional and cognitive changes consistent with those found within vicarious trauma and PTSD (McCann and Pearlman, 1990; APA, 2013). Importantly, this finding indicates the use of multimedia as a therapy aid is a risk to be aware of and any impact on therapists should be carefully considered.

Another aspect when working with high profile cases is the consideration of any impact upon therapists providing client treatment. A serious or shocking case may bring about trauma in a professional very quickly (Phoenix, 2014). Often, these are the cases that receive a great deal of public attention like the deaths of James Bulger or Peter Connelly (Tehrani, 2011). In such cases, new pressures come into play as a result of the public's reaction and the increased media scrutiny that is placed on professionals (Clebourn-Jacobs, 2013;

Phoenix, 2014). Therapists working with survivors in the aftermath of trauma are likely to have a very different experience from professionals caught up in an investigation resulting from an unexpected traumatic incident. However, the impact of public scrutiny fuelled by negative, unbalanced media reports has been found to be distressing and all-consuming (Clebourn-Jacobs, 2013). The public scrutiny of a high profile case, or fear of it, could influence the way a therapist responds and treats high profile clients (Bergman-Levy, 2015). This is important as feelings of responsibility for client recovery, was clear throughout all participant interviews. When working with high profile cases, findings show those feelings and the expectations of self or others may be heightened and result in a decline in therapist wellbeing.

Paul grappled with the notion of being unable to resonate with a historical high profile case he had worked on, in which children had died and there was an outcry of public grief (page 131). Although appearing to remain emotionally detached in part, findings confirm with his sense of alienation from other people compounded by media reports, he questioned his response and change in intimacy, a component of vicarious trauma (McCann & Pearlman, 1990). Under different circumstances, the participant may not have questioned the changes as he continued treating his client. However, due to the public response to the case in the media, he questioned what it was about him that made him unable to resonate with the case. Rather than considering it a possible coping strategy for his trauma work and form of self-protection, his explanation and justification of his developing meaningful frame of reference, was that he was "*becoming a hardened bastard*". Not the only participant to aim negative connotations towards themselves for their emotional response, his example reflects further components of vicarious trauma with changes in dependency/trust and esteem (McCann & Pearlman, 1990).

Within society, constructionism focuses on how meaning is generated and communicated collectively (Crotty, 1998). It could be assumed from Paul's language in this particular case, he believed his reaction was not considered a normal reaction to an abnormal event. When 'bad things happen to bad people', it can be viewed as more socially acceptable not to experience a

negative emotional reaction as public attitudes often stem from a position of it being justified or deserved. However, for those in society considered ‘innocent’ or ‘vulnerable’ such as the children who lost their lives within Paul’s high profile case, the emotional responses and public attitudes often stem from a position of distress or anger (Phoenix, 2014). This finding is interesting as Paul’s explanation when questioning why the case did not resonate, may have been heightened and maintained by his comparison to the media and public response and what he believed was considered socially acceptable in the wider society (Crotty, 1998). Importantly, shame, guilt or fear of negative judgement may also be additional evidence for disruptions to esteem and perhaps a reflection of underlying changes to power or independence, yet further components of vicarious trauma (McCann & Pearlman, 1990) and an indication to the extent of negative impact on his sense of self.

Another reason certain presentations may not resonate, is because of the role of desensitisation (Wolfe, 2004). Nearly a quarter of participants felt they had become desensitised to hearing trauma narrative through undertaking repeated exposure work with clients, as well as a maturity in their clinical experience. This finding is important as desensitisation changes maladaptive thoughts and beliefs and reduces negative emotions (Clark, 2013). Contrary to this, was the finding that all participants were, at times, negatively affected by their trauma work. This finding clearly indicates that although the negative effects for some participants may have lessened over time, they are not completely desensitised to its effects and these still remain a risk to be aware of.

Findings show due to scrutiny or interest surrounding high profile cases, alongside the natural desire of the therapist involved to make sure the treatment has a successful outcome; the pressures of trauma work may be exaggerated, unexpected and lead to a decline in wellbeing, supporting and adding to previous findings (Clebourn-Jacobs, 2013; Phoenix, 2014). The potential for multimedia footage becoming available as a traumatic event unfolds is becoming more likely as the world’s technology improves. ‘As a society, we are constantly exposed to huge amounts of ‘raw’ information by written and electronic media which influences our perspective of our environment and as

professionals we face the consequences of this influence on our practice and our clients (Bergman-Levy, 2015:19). Whilst different for Paul and Susan, the consequence of media images and reporting, resulted in temporary disruptions to their schemas and imagery systems impacting on their sense of self and reflective of those found within vicarious trauma (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995a). As exposure to trauma through media has found to be an important consideration for a PTSD diagnosis (APA, 2013), findings confirm the nature of trauma presentation and any media influence pertaining to it, should be considered a risk factor when engaging in trauma work.

6.1.2.4. Imagining traumatic incident: 'When imagination takes over'

'Imagining trauma.' The third 'process of change' is when a therapist using empathy, attempts to understand the client experience and 'walk in their shoes' (Rogers, 1975). This is one area within the literature where it has been suggested empathic engagement can have a detrimental effect on therapists (Pearlman & MacIan, 1995; Figley, 1995; Pearlman & Saakvitne, 1995a; Jenkins & Baird, 2002, Badger et al., 2008). Findings of this study support earlier findings, with just over a quarter of participants struggling with empathic engagement due to the amount of disturbing trauma narrative and experiencing changes to their esteem, independence, trust or safety impacting on their sense of self (McCann & Pearlman, 1990).

Susan (page 102) gave an eloquent example of how through empathy, therapists may find their cognitions becoming distorted (Burns, 1980). Susan's imagination ran riot, whilst working with a client presentation in which people were trapped by fire. By using her imagination to place herself in the position of the casualties, her catastrophic thinking took over. Again this finding is important as catastrophic thinking has been found to be an irrational thought process which has a person believing a current or future event is or will be much worse than in reality (Grohol, 2007). For therapists, this could potentially exacerbate any negative trauma effects. Whilst in this example the outcome for the casualties could realistically have been catastrophic, Susan knew they had been rescued. However, within her interview the switch between rational and

irrational cognitions about the trauma under discussion is clear with statements such as, *"There was no way that they could escape. Have their marriages failed? Have they lost their job?"* Findings confirmed the consequence of such distortions resulted in intensified negative emotional and physiological changes to the Susan's sense of self which might otherwise have been avoided.

'Visualising trauma.' Another change connected to imagination, was the therapist's ability to visualise their client's trauma through their interpretation of the detailed trauma narrative. It has previously been found that a traumatising event experienced by one person, may become a traumatising event for another (APA, 2013). Findings confirm participants who could clearly visualise their client's trauma, experienced similar changes to their cognitive schemata and imagery systems to those described within vicarious trauma (McCann & Pearlman, 1990). As therapists with the ability to visualise client trauma through their own interpretation may be at higher risk of vicarious trauma, it is important to consider any similarities or difference in the level of meaning between the client and therapist experience.

The cognitive model of PTSD helps to identify a client's set of pre-requisite maintenance factors for PTSD (Elhers & Clark, 2000). These include; a client's beliefs and experiences before the trauma, cognitive processing during trauma (what their mind did to protect them), characteristics of the traumatic event (important details), negative appraisal of the trauma and its effects (what they believe about the trauma and its effects), nature of the traumatic memory (symptoms they are experiencing), the sense of current threat (what they feel now) and any current coping strategies which may prevent the updating of the negative appraisal and its effects or the nature of the traumatic memory. For those clients with a diagnosis of PTSD, successful recovery and post-traumatic growth is prevented without specific intervention (NICE, 2005).

Table 11 (page 152) highlights similarities between the client's trauma experience resulting in PTSD and the therapist's treatment experience. Whilst

Table 11: Illustration of similarities between the client and therapist experience.

PTSD formulation	Client Experience	Therapist Experience
Belief and experience prior to trauma	*Physical abuse during childhood. I'm vulnerable.*	*I'm responsible for client recovery. I must be perfect.*
Cognitive processing during trauma treatment	*Activation of threat system. Dissociation. Focus on weapon.*	*Possible activation of threat system whilst focus on client reactions to trauma e.g. hotspots, abreactions.*
Characteristics of traumatic event	*Feeling overwhelmed. Life threatening.*	*Feeling overwhelmed, horrified, shocked.*
Negative appraisal of trauma and effects	*I'm damaged. I have no future. I'm not safe.*	*I may be permanently damaged. I'm not safe. I'm polluted. Certain people cannot be trusted.*
Nature of traumatic memory	*Flashbacks. Nightmares. Heightened senses.*	*Intrusive thoughts/ Intrusive images of client trauma. Disturbed sleep.*
Sense of current threat	*Fear. Hypervigilance.*	*Increased anxiety. Hypervigilance. Cultural prejudice.*
Unhelpful coping strategies	*Avoidance of any reminders. Try not to think about it. Smoke cannabis to relax. Drink alcohol to sleep.*	*Avoidance of any reminders. Work longer hours. Use of alcohol to relax.*

fictional for the purpose of illustration, it is based upon a collection of factual responses from participant interviews which clearly evidences similarities between client and therapist responses, the trauma impact and the potential risk for a decline in therapist wellbeing. This study therefore supports previous research (Sexton, 1999; Tiegreen & Newman, 2009) which recommends any practice or intervention to protect therapists from the negative impact of trauma

work and which addresses difficulties, is crucial to prevent the deterioration of symptoms which may result in extended sick leave or potential resignation.

6.1.2.5. Personalising traumatic incident: Personal triggers and significant life events

The fourth 'process of change' and closely linked to the third, is when therapists personalise the trauma through personal triggers, significant life events and use of their imagination. This change served to negatively affect participants to a deeper degree. When dealing with clients affected by trauma, therapists may identify with their clients and unwittingly place themselves in their position. Such identification may lead to comparison of how they or their family members might be affected in the same situation, as they process their own feelings around the trauma beyond the counselling room. Although findings confirmed this can be beneficial in some cases and fuel therapist passion for trauma work, identification with clients was generally experienced in negative terms.

It has previously been found that parenthood can influence how an individual may be affected when dealing with trauma (Goldblatt, 2009; Janke-Stedronsky, Greenawalt, Stock, Tsan, MacCarthy, MacCarthy & Copeland, 2016). This study supports these findings with the finding that Justin and David, who started their therapeutic careers before becoming parents, experienced a significant difference in their sense of self after they had children. Both experienced their trauma work as being more difficult to deliver because of their increased emotional vulnerability. Furthermore, their vulnerability was compounded through their new identification with trauma presentations that involved children. With nearly 7.5 million families with dependent children and a further 11 million with non-dependent children living within the United Kingdom (Office for National Statistics, 2015), the potential for a negative impact on therapists who are parents is high. This is important as identification, previously viewed as a positive cognitive mechanism to reduce anxiety, has been found a potential risk factor and strong predictor in the development of a traumatic stress reaction, particularly in relation to trauma presentations involving children (Clohessey & Elhers, 1999; Jonsson & Segesten 2004). Findings confirm raising the awareness of vicarious trauma could help support parents and prepare those

new to parenting, to plan, recognise and thereby minimise the risks of difficulties occurring.

6.1.2.6. Cognitive, emotional, physiological and behavioural changes to the sense of self

The fifth 'process of change' is the personal cognitive, emotional, physiological and behavioural changes the therapist experiences. All participants experienced similar changes, reflecting those found in previous studies (Neumann & Gamble, 1995; Steed & Downing, 1998; Iliffe & Steed, 2000; Eidelson et al., 2003). Many participant extracts gave powerful examples of how trauma work has affected their professional or personal life and impacted on their sense of self, with changes amongst others in mood, imagery, concentration, sleep and sex-life. Whilst all participants experienced elements of disruption to their basic sense of identity, world-view, spirituality and cognitive frame of reference supporting previous research (Pearlman & Saakvitne,1995a); only Helen intimated concerns of the permanent change considered a possibility within vicarious trauma (McCann & Pearlman, 1990) .

Upon closer analysis of the data, findings revealed several other areas of change that might be considered permanent and a result of adverse effects of trauma work. As previously discussed, Justin and David experienced a decline in resilience levels when working with trauma cases since becoming parents. Whilst this change could be intensified by the additional responsibilities that parenthood brings, findings show their decline in resilience was linked to their disruptions in safety and heightened awareness of danger, empathy and identification with their clients when imagining themselves or their children in a similar position.

A quarter of participants have made sense of the associated risks of trauma work and the impact upon their sense of self, by incorporating the use of reassuring 'safety behaviours' (Thwaites & Freeston, 2005) within their clinical practice, such as booking trauma cases before lunch or at the end of the day, to reduce their professional anxiety. The use of safety behaviours to reduce anxiety, have also crossed the boundaries of their professional practice and is

evident in their personal lives with behaviours such as becoming a more cautious driver or changing clothes and showering to remove any 'trauma contamination'. Whilst in some respects this could be viewed as supporting their wellbeing, this finding is concerning as the use of safety behaviours have been described as the major cause of persisting anxiety and the reason why people don't experience relief during further exposure (Wells, Clark, Salkovskis, Ludgate, Hackmann & Gelder, 1995).

Individual predictors are important for how well humans respond to stressful events (Jonsson & Segesten, 2004). One thing that may help lessen the negative effects of working with trauma is being able to separate those aspects of work that make it particularly difficult. It has been established within the findings that hearing trauma narrative and hearing trauma narrative alongside witnessing harrowing or disturbing images, can be detrimental to the therapist's sense of self and result in a decline in wellbeing. Another consideration adding to therapist distress may inevitably result from the therapeutic relationship itself and the close emotional connection with the client.

The strength of emergency service personnel when dealing with traumatic incidents is their ability to deal with the practicalities of the situation facing them by offering medical or practical interventions. Due to these initial, often crucial priorities, their work may be carried out on 'autopilot' with very limited or no emotional connection with the person/s involved. Having worked with various emergency service personnel throughout my police and therapeutic career, a theme that often arises is their coping strategy of actively seeking to remain emotionally detached whilst dealing with the practicalities of the situation that confronts them. The practical assistance emergency service personnel demonstrate at traumatic incidents may help in various ways.

Firstly, those individuals confident they can control a situation have been found to handle traumatic events better than those who believe that they are controlled by external influences (Solomon, Mikulincer & Flum, 1988). Individuals with a strong internal locus of control (Rotter, 1966) believe life events primarily derive from their own actions (Carlson, Buskist, Heth &

Schmaltz, 2007). For example; when receiving exam results, individuals with an *internal* locus of control tend to praise or blame themselves and their abilities, in contrast to those with a strong *external* locus of control, which tend to praise or blame external factors such as the teacher or exam (Carlson et al., 2007). As locus of control has been identified as important for individuals to stay healthy (Jonsson & Segesten, 2004), the practical assistance given when dealing with the horror facing them may act as a survival tool in their recovery process (Garrick, 2006).

Secondly, linked to control and common though not unique to emergency service personnel, is the use of humour as a coping strategy. Gallows humour is a light or satirical response to hopeless, serious, frightening or painful situations and can be integral to a sense of hope, well-being and humanness (Garrick, 2006). Based on Freud's theory, that joking relieves anxiety or repressed impulses and laughter converts unpleasant feelings into pleasant ones (Freud, 1960), it is common amongst emergency service personnel and hospital workers who face dealing with death or dying everyday (Garrick, 2006). Whilst clients and non-professionals should be shielded from this type of humour so it is not misinterpreted as cruel or uncaring (Mandell, 1988; Rosenberg, 1991), sharing humour within professional circles can be an important outlet to relieve the build-up of stress (Freud, 1960). Furthermore, when dealing with the aftermath of trauma, it may help create an emotional or psychological distance and support an individual's locus of control (Rotter, 1966; Garrick, 2006).

Thirdly, whilst completed under controlled research conditions, it has been found that intrusions to directly perceived trauma or verbal traumatic information can be modulated during or after a stressful event by completing a task (Holmes, Brewin & Hennessy, 2004; Holmes & Bourne, 2008; Krans et al., 2010; James, Bonsall, Hoppitt, Tunbridge, Geddes, Milton & Holmes, 2015). In relation to emergency service personnel, the physical practicalities of carrying out the tasks required within their professional role, for some, may play a part in interrupting their trauma processing and thus reduce the negative trauma effects. The tasks completion, may serve to divert their focus from any person/s

involved and thereby allow them to remain emotionally distanced. Whilst this could lead to difficulties later, similar to those experienced by therapists undertaking multiple assessments without closure on recovery, it may also act as a buffer to any traumatic responses and help depersonalise the trauma.

Whilst the therapeutic relationship and a strong emotional connection is vital for clients to feel emotionally held and safe enough to commence trauma work, of equal importance is the working practices of therapists. Any practice that is not detrimental to the client but that may benefit therapists engaged in recurrent trauma cases should be considered. Making a further contribution to the research knowledge base on vicarious trauma, this study found emotional distance; tasks and humour may be extremely significant for therapists engaged in trauma work and play an important role in reducing the negative impact to the therapist sense of self.

The psychological strategy of ‘self-distancing’ has been found to help control thoughts, feelings and behaviour (Kageyama, 2016). As humans, we are motivated to understand our feelings (Wilson & Gilbert, 2008). Whilst in the majority of cases this meaning making process works well and we are able to experience and explain events before moving on, this can become inhibited when trying to make sense of negative emotions (Kross & Ozlem, 2011). Those who analyse their feelings from a self-distanced perspective have been found to report less distress than those who adopt a self-immersed perspective (Kross, Ayduk & Mischel, 2005; Kross & Ayduk, 2008, 2009). Throughout interviews, some participants had made sense of their experiences by emotionally distancing themselves and talking using second or third person pronouns. As self-distancing focuses less on recounting an experience and more on reconstructing it in a way that provides insight and closure (Kross & Ozlem, 2011), participants gave a sense of being unconsciously able to protect their professional identities.

When compared to its CBT counterpart, participants were more vocal and considered when talking about EMDR, with nearly half benefitting from feeling more distanced from the trauma narrative and less emotionally affected. This

finding is particularly noteworthy. Whilst being less emotionally affected could be argued to be a negative for a therapeutic relationship, findings confirmed EMDR was still based on the essential components of empathy and unconditional positive regard (Rogers, 1961; 1975) but viewed as a protective factor which supported participant emotional wellbeing and aided their sense of self.

Furthermore, it has previously been found that trauma images can be modulated when trauma processing is interrupted by completion of a task (Holmes & Bourne, 2008; Krans et al., 2010). Similar to hypnosis, during EMDR many therapists ask clients to track their fingers with their eyes whilst they wave their arm back and forth during a set of eye movements or use bi-lateral hand-taps (Shapiro, 2001). Although hearing less harrowing or disturbing trauma narrative than when delivering trauma-focused CBT may be a protective factor in itself, the procedure of arm-waving or hand-taps within EMDR may also naturally help therapists modulate trauma images by interrupting their trauma processing in the same way as has been found when completing a task. Alternatively, it may help them remain emotionally distanced and protect their sense of self in a similar way to when emergency service personnel perform an operational task when dealing with a traumatic incident. This is an important finding and one which also supports previous studies (Holmes et al., 2004; Holmes & Bourne, 2008, Krans et al., 2010; James et al., 2015).

As previously discussed (page 156), gallows humour is a humorous response to serious, frightening or painful situations, often used by individuals' within the helping professions (Freud, 1960; Garrick, 2006). Findings show participants used humour in different ways when talking about their trauma experiences. Humorous responses or laughter was used by five participants to mask embarrassment, four participants masked feelings of anxiety, one participant to signify relief, and as with the example of the traumatised mouse, four participants responded with irony. What was not evident from the findings was whether participants used humorous responses with colleagues or during supervision to help lessen the negative impact on their sense of self and this may be an area for future research.

The risk of working with traumatised clients has been well documented (eg; Pearlman & MacIan, 1995; Iliffe & Steed, 2000; Harrison & Westwood, 2009). Whilst not always permanent, all participants regularly experienced disruptions to schemas and imagery systems that impacted on their sense of self and resulted from their exposure to emotionally shocking trauma presentations, supporting findings of McCann and Pearlman (1990). However, some symptoms appeared more consistent with vicarious trauma's closely related concepts burnout (Maslach, 1982), secondary traumatic stress/compassion fatigue (Figley, 1985, 1995) or countertransference (Freud, 1910), the boundaries of which can overlap in the literature. Despite this, participant disruptions appeared well managed, with a quarter of participants viewing these as an inescapable part of the work.

6.1.2.7. Witnessing post-traumatic growth

Concepts like vicarious trauma remind us of the potential for therapists to be psychologically harmed by their work (Barrington & Shakespear-Finch, 2013). Although there are differences in the way trauma-focused CBT and EMDR are delivered, the numerous guidelines and protocols available to help therapists practice safely, was seen as a positive within study findings (Foa & Rothbaum, 1998, Shapiro, 2001; Westbrook et al., 2007; Elhers & Clark, 2000; Ehlers, Clark, Hackmann, Grey, Wild, Liness, Manley, Waddington & McManus, 2010).

Previous research acknowledges that trauma work can be viewed in a positive light (McCann & Pearlman, 1990; Steed & Downing, 1998; Harrison & Westwood, 2009; Iliffe & Steed, 2000; Eidelson et al., 2003; Ben-Porat & Itzhaky, 2009). This study supports earlier research with the finding that all participants enjoyed their trauma work, despite its difficulties.

The positive psychological change, known as post-traumatic growth, resulting from engaging in the struggle associated with traumatic or highly challenging circumstances (Calhoun & Tedeschi, 2001), was the principal positive for participants. This was particularly in the case of complex presentations where post-traumatic growth was most evident. However, participant passion for

trauma work was also fuelled by several other key areas which add and extend the existing knowledge base. These were the general admiration held for clients engaging in trauma treatment and the therapeutic relationship; successful treatment outcomes and receiving positive client feedback, which for David had left a lasting impression of over twelve years (page 118). Findings confirm all participants found trauma work rewarding and motivational and were united in their positive comments and the benefits of working with trauma clients. This finding is significant as compassion satisfaction has been found to play a critical role in reducing the negative effects of vicarious trauma and its concepts (Stamm, 2002) and may explain why many therapists are able to manage difficulties affectively.

6.1.3. Participant Experience of Delivering the Trauma Models

The majority of participants spoke about having a preference towards either trauma-focused CBT or EMDR when working with trauma clients. Since its introduction in 1920 by psychologist Edward Thorndike, the term 'halo effect' has been used to describe cognitive bias in psychological research (Cardello & Nielsen, 2013). Although preference to a particular model may arise through the 'halo effect', participants were in agreement that neither model was superior to the other, supporting findings of Chen et al. (2015). Of the eleven participants that took part in the study, three preferred trauma-focused CBT and six preferred EMDR. Discussed are the study's findings in relation to participants' experience of delivering the trauma models and the barriers which hindered participants work. These expand and concur with previous findings around the models treatment effectiveness for PTSD (Shapiro, 2001; Jaberghaderi et al., 2004; NICE, 2005; Bradley et al., 2005; Seidler & Wagner, 2006; Bisson & Andrew, 2007; Foa et al., 2009).

Findings confirmed core therapeutic training was incredibly valued by participants and something which gave them a sense of confidence and comfort in their chosen model and supported their sense of self. Also reflected, was the aspect of participant loyalty to a core model. Paul spoke about feeling "*precious"* about his core model of CBT and disclosed he would feel his skills were being devalued, if he didn't use the model prior to any other (page 113).

By using his core skills initially, this may help Paul feel more creditable for the hard work and time spent in gaining his CBT qualification and helps validate his clinical skills and sense of self as a CBT therapist. Such creditability may also lead to feelings of professional satisfaction which has been found to be an important aspect in reducing compassion fatigue and burnout (Stamm, 2002; Conrad & Kellar-Guenther, 2006).

Whilst participant experience of their preferred model was often spoken about in terms of general perception, one participant (left anonymous for confidentiality) disclosed having a personal trauma history for which they had experienced receiving treatment themselves. In contrast to earlier studies that considered therapists may be pre-disposed to vicarious trauma if they had a personal trauma history (Pearlman & MacIan, 1995; Schauben & Frazier, 1995; Way et al., 2004), findings in this study offer an alternative viewpoint.

Rather than being pre-disposed to the effects of vicarious trauma, the participant in question considered their trauma history to be a benefit for their trauma work. This was because they could identify with what their client may be experiencing through personal experience of PTSD and receiving treatment, a fact if appropriate, they may share with the client. Appropriate therapist self-disclosure has been found an important therapeutic intervention which can help a client feel more involved in the treatment process and encourage their own self-disclosure (Keijsers et al., 2000). Seen as a benefit rather than a negative, a personal trauma history may help twofold. For the client presenting with PTSD, apart from the benefits previously mentioned, the disclosure itself may instil a feeling of hope for post-traumatic recovery and clear evidence of treatment success. For the participant, having previously received successful treatment with EMDR, their belief in the model or any potential 'halo effect' may help inoculate them against symptoms of vicarious trauma.

Although all participants were passionate when talking about their clients' post-traumatic recovery, a disparity was identified in how participants felt about actually delivering the two trauma models. Examples of participant passion for delivering trauma-focused CBT were lacking despite being reported as an

effective model of treatment with good treatment results. Rather than appearing to enjoy working with the model, participant experience confirmed this wasn't always the case. This area was one in which data was re-checked to ensure my preference for EMDR had not unduly influenced the findings.

As previously stated (page 16), a key requirement of trauma-focused CBT is the therapist's ability to tolerate hearing a client's traumatic experience through the reliving stage of treatment (Foa & Rothbaum, 1998; Clark, 2013). As findings confirmed that listening to trauma narrative had resulted in a detrimental effect on all participants psychological wellbeing at times, this suggests that being able to tolerate hearing a client's traumatic experience, whilst remaining emotionally detached and unaffected, does not necessary go hand-in-hand.

Participants engaged in trauma-focused CBT were on the whole more negative about delivering the model. This was due to the model's intensity around the reliving part of the protocol and hearing the detailed trauma narrative which helped them identify with their client's trauma and led to changes in their cognitive schemas or imagery, similar to those first identified by McCann and Pearlman (1990) and impacted on their sense of self. Whilst over a quarter of participants reported trauma-focused CBT as feeling more manageable than its counterpart due to its structured approach, the resilience needed to engage in the model was palpable within their interviews. Participants using the CBT model repeatedly returned to the theme of the difficulty of hearing trauma narrative and becoming emotionally involved in client presentations. Again, this finding is important and supports previous research highlighting the risk of therapist vicarious trauma arising from trauma work and an area in need of support (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995a).

In comparison, participants talked passionately about delivering EMDR and thoroughly enjoyed working with the model. EMDR was found to be an extremely effective treatment and was deemed successful in cases where trauma-focused CBT was not. Of particular note, was the rapid change in client recovery compared to its counterpart. This finding could be very significant

when working with a restricted number of sessions due to a lack of funding or long waiting lists.

Another interesting and unexpected finding was the benefit of client privacy within the EMDR model. This was due to clients still being able to receive treatment without having to disclose full trauma details if they felt uncomfortable. For those clients who have signed The Official Secrets Act (1989) or those presenting with feelings of embarrassment or shame (Lee, 2009), this was found to be especially helpful.

Although participants found it difficult to explain just how EMDR worked, their comments about the model captured their wonderment. All participants trained in the model were extremely complimentary about its treatment results and talked about them in terms such as; "*profound", "incredible", "extremely effective"* and *"magical".* Whilst difficult to measure, EMDR was also viewed as a model that had the 'Heineken' effect and one which addressed difficulties on a much deeper psychological level, reaching parts that other therapies, including trauma-focused CBT, may not (Figgess, 2007).

Although Julie described feeling more traumatised whilst delivering EMDR compared to when delivering trauma-focused CBT (page 124), she was still passionate about the model. Unique to her EMDR sessions, her traumatisation resulted from experiencing negative somatic symptoms which impacted upon her sense of self. These mirrored those of her client during processing, when no narrative was taking place. Whilst in other models of therapy this could be explicated as a form of transference (Freud, 1910), it could also be evidence of mirror neurons in humans, which fire during both the execution and observation of a specific action (Keysers & Gazzola, 2010).

During the early 1990s, Neuroscientist Giacomo Rizzolatti and a team of researchers discovered individual neurons in the brains of macaque monkeys fired when monkeys grabbed an object themselves and when they observed another primate grab the same object (Winerman, 2005). The effects of EMDR on Julie may have resulted from watching her clients' abreactions (Shapiro,

2001). Through witnessing her clients psychologically relive and ‘act out’ their trauma responses, individual neurons in her brain could have been fired. Whilst research in the area of mirror neurons in humans is just beginning to emerge and is beyond the scope of this research, Rizzolatti believed it may help explain how and why as humans, we react instinctively to other people’s thoughts, feelings and intentions and why we feel empathy towards them (Winerman, 2005).

Findings show overwhelming support for EMDR and its effectiveness, with two thirds of participants who voiced a preference, favouring the model when working with trauma. Preference was based upon the models effectiveness and the speed of post-traumatic recovery. As previously discussed, nearly half of participants expressed the benefit of feeling more detached from trauma narrative and felt less emotionally affected which supported their sense of self. This finding is significant as whilst EMDR may not be the treatment choice for every client, with its rapid trauma processing, excellent treatment outcomes and ability to alleviate therapist distress levels, it may provide therapeutic benefits to therapists, clients and organisations alike.

Although the model evoked participant anxiety around abreactions, findings show anxiety was connected to the timeframe in which participants had to work with a client, rather than actually managing the abreactions themselves. Not just a problem related to EMDR sessions, timeframe was also found to provoke anxiety within trauma-focused CBT treatment sessions. Participants working within the primary care system experienced the most difficulties with effective time management due to restrictions within their clinical practice and feeling compelled to see clients just before their lunchbreak or at the end of the working day to allow flexibility should the treatment session run over. To address the negatives of hearing the full trauma narrative with the trauma-focused CBT model would be difficult without completely changing the treatment protocol. Yet, the anxiety evoked within EMDR sessions could substantially reduce if organisations supported therapists and allowed sufficient timeframes in which to work, experienced by participants in this study, as a barrier to treatment.

6.1.3.1. Barriers to treatment

Several barriers that hindered participants undertaking trauma work were identified in the findings. The most significant, time restraints and service provision are discussed further under 'Protecting and sustaining the participant sense of self: Supporting protective practice' (page 166). Further difficulties of client non-engagement/drop-out and the expectations that participants place upon themselves, are discussed herein.

Findings of this study identified just over a quarter of participants were negatively affected by unexpected premature endings impacting on their sense of self. This is important and supports previous findings where premature endings have been found to be one of the most stressful parts of trauma work for therapists (Farber, 1979; Deutsch, 1984). Some participants doubted their clinical skills or their part in the client's decision to drop out of treatment, whilst others felt a range of emotions from frustration to regret. This finding was also reflective of hearing trauma narrative during repeated assessments, due to participants being left with residual unprocessed trauma material, supporting findings of others (Chrestman, 1999; McLean et al., 2003; Pross, 2006). Furthermore, clients with heightened anxiety finding it difficult to engage in treatment due to exposure to their feared and avoided situation (Clark, 2013), were also found to unintentionally leave therapists in a similar position and vulnerable to the effects of vicarious trauma.

Whilst findings showed client non-engagement/drop-out were seen as barriers to treatment, also apparent whether explicit or implicit, was the high expectations participants place on themselves for their clients recovery. The burden of responsibility for client recovery may in some cases fuel therapist passion for trauma work. For others, it adds further pressure to an already pressured role. Paul spoke about his perfectionist schema and the expectation he places on himself and perhaps subconsciously his clients, that after a number of sessions they will walk out feeling better (page 109). David seemed to doubt his EMDR clinical skills and questioned the trust within the therapeutic relationship based on his expectation of seeing the client change (pages 123-124).

Findings show there may be an unconscious expectation in therapists to evaluate their competency or treatment effectiveness, in terms of what *they* believe to be successful. Therapists are only human and although skilled at identifying any dysfunctional beliefs of clients, they may be affected professionally or personally if they fail to recognise and reality test their own. To appraise competency based on self-perception, may not only unintentionally increase the risk of therapists experiencing a negative stress response but it could also give a false representation of individual client recovery rates. It is important therefore in order to sustain the professional and personal self (Skovholt & Trotter-Mathison, 2016), that self-awareness of therapist beliefs is encouraged, identified, gently challenged and supported through such things as supervision, training and self-reflection.

6.1.4. Protecting and Sustaining the Participant Sense of Self: Supporting Protective Practice.

This study sought to identify and highlight protective factors that may help ameliorate vicarious trauma previously identified as the reason for a high turnover of staff or loss of professional satisfaction (Sexton, 1999). Findings confirmed all participants implemented certain protective practices to help aid trauma work and thus prevent them becoming adversely affected.

Findings highlighted the importance of clear guidance with regard to service provision, appropriateness of referrals and accessing support. Whether working within an organisation or private practice, self-care techniques, self-awareness, caseload management, supervision and training were all considered an important part of helping participants professional and personal wellbeing. This is particularly important as individuals with an effective repertoire of coping strategies have been found to endure high levels of stress with minimal consequences for their mental health compared to those who rely on inadequate coping strategies (Solomon et al., 1988). Many protective practices put into place by participants in this study, reflect those found in other studies (Neumann & Gamble, 1995; Steed & Downing, 1998, Lonergan et al., 2004; Harrison & Westwood, 2009; Jordan, 2010). However, a major concern of this

study was the finding that for some therapists, these vital practices can be difficult to sustain.

On World Mental Health day in 2007, the UK government announced an NHS initiative for improving access to psychological therapies (IAPT) (DoH, 2007a; Clark, 2011). The initiative lead to thousands of therapists training to deliver a range of evidence based treatment protocols recommended by the National Institute for Health and Care Excellence (NICE, 2016). IAPT offers a stepped care approach within the primary and secondary care system, aimed at targeting clients presenting with depression and anxiety disorders. More specifically, it advocates following the PTSD treatment guidelines as set out by NICE (NICE, 2005). In 2013, Clinical Commissioning Groups took over from primary care trusts to commission the majority of NHS hospital and community services in their local area (NHS Choices, 2015). Cuts to funding within the NHS mental health service and social services have been well documented (Cooke, 2014; Cooper, 2014; Mind, 2014). With funding equivalent to £253 million being removed from budgets, fifty seven mental health trust services throughout the country have been affected, resulting in a strain on mental health services (Cooper, 2014). More recently, analysis suggests mental health trusts have suffered a real term cut of 8.25%, the equivalent of removing £598 million from their budgets (Buchanan, 2015).

Participants valued their autonomy and placed importance upon it when managing caseloads. Due to lack of funding within primary care, findings have identified in some areas restrictions are being imposed on the therapeutic timeframe to work with clients. As one of the most important protective practices that participants spoke about, was the timeframe in which they work and manage their trauma caseload, this finding is concerning. Allowing sufficient time to prepare, treat and debrief clients was seen as a high priority for all participants to sustain their sense of self. This finding echoes those of Culver et al. (2011), where trauma clients were considered the most challenging due to the additional time and resources needed for them to safely process their experiences.

Findings of this study show for some clients the complexity of their presentation can be overwhelming, especially if co-morbid with other psychological problems. Some clients may present with suppressed traumatic memories, others, with false memories due to cognitive distortion as unlike a video-recording, they are stored in the brain like a collection of jigsaw pieces which reform when a memory is recalled (British Psychological Society, 1995). Some clients may not have enough inner resources to relive their traumatic experiences and want to avoid the distress and associated PTSD symptoms; or in cases with survivors of interpersonal trauma, they may have difficulty in establishing a trusting therapeutic relationship (Westbrook et al., 2007).

To engage in trauma treatment, clients need to believe in and understand the treatment process, build resilience and have confidence in their therapist's clinical skills. This can take time to develop over a number of sessions prior to trauma work commencing. Therefore, organisations that offer just six sessions of therapy before clients are required to have an enforced therapy break, as disclosed within this study, are not only fostering a 'revolving door' policy for client treatment but also invite further problems with client trust, confidence and resilience, should the client return to treatment. Furthermore, this practice maintains and exacerbates client symptoms of PTSD by feeding into any avoidant behaviour of trauma reminders.

The standards of conduct, performance and ethics of the British Association of Behavioural and Cognitive Psychotherapies (BABCP) (Appendix Y) are similar to those within the British Association of Counselling and Psychotherapy (BACP) in respect of acting in the best interest of the client. The BACP ethical framework (Appendix Z), promotes justice and beneficence. The BACP state justice as:

> '…the fair and impartial treatment of all clients and the provision of adequate services…' whereby '…Practitioners have a duty to strive to ensure a fair provision of counselling and psychotherapy services, accessible and appropriate to the needs of potential clients...' (BACP, 2013:2)

They state beneficence as, ‘a commitment to promoting the client’s well-being’ which involves, ‘acting in the best interests of the client based upon a professional assessment’ (BACP, 2013:2).

Whether organisations are working within the IAPT model or not, imposing timeframe restrictions upon this vulnerable client group, against the recommendations of NICE guidelines and the ethical frameworks of the BABCP and BACP is unhelpful (NICE, 2005; DoH, 2007a; BACP, 2013; BABCP, 2015). One would hope the majority of therapists would not engage in trauma work if they considered the limited timeframe too restrictive or unethical. However, it is clear from this study’s findings that in some areas, due to the level of service pressures within the primary care system, there is an increasing burden on therapists to speed up the therapeutic process to adhere to ‘payment by results’ contracts and reduce waiting lists. Furthermore, in stark contrast to those participants with no time restrictions placed upon them, findings show there may be an increasing pressure on some therapists to work into their own time to ensure safe trauma processing of the client or themselves.

These findings are very concerning as time pressure serves to foster an environment in which mistakes are made and puts client and therapist welfare at risk. Limiting timeframes could promote unethical practice with therapists cutting corners or rushing treatment in an attempt to alleviate client suffering within the boundaries of their service provision. This practice, highlighted by some participants, may also be at the expense of therapist wellbeing with additional stress or loss of job satisfaction, resulting in compassion fatigue or burnout, the concepts of which are related to vicarious trauma (Figley, 1995; Maslach & Leiter, 1997; Stamm, 2002; Conrad & Kellar-Guenter, 2006; Pross, 2006).

Unethical practice could and should be brought into question where a client is put at risk (BACP, 2013; BABCP, 2015). Although findings do not specifically indicate this, adequate provision of mental health services is essential for their wellbeing and the wellbeing of therapists working with them. Findings show that the lack of funding within the primary care system has led to some participants

grappling with the effects of having to decline a service to clients who they are trained to work with and whom are willing to engage. Others have been obliged to place enforced therapy breaks on client treatment. Whilst this may be very dependent on how local commissioning groups fund individual services and may not be a countrywide problem, this feels both ethically and morally wrong and has been shown within the study's findings to impact negatively on the participants' sense of self. Furthermore, it was not the intention of the IAPT service at its inception, which aimed to improve access to psychological services (DoH, 2007a).

The question of beneficence was also highlighted within findings. When working with third parties, such as insurance companies involved in litigation cases, findings show therapists working in private practice may also find their clinical practice restricted following completion of an assessment, if their recommended treatment is declined.

Within this study, findings confirm that being unable to deliver recommended trauma treatments through restricted timeframes, funding or enforced therapy breaks, not only resulted in a decline in participant wellbeing but by default it placed them in the position of having to work in opposition to the framework of their governing bodies (BACP, 2013; BABCP, 2015). All of this only serves to increase the risk of a negative stress response impacting on the therapist's sense of self, absence through sickness and the potential for therapists to leave the profession.

6.1.4.1. Importance of supervision

Organisations and individuals offering trauma work need to ensure adequate resources are in place to help alleviate the build-up of any distress and allow for discussion of trauma responses in full (Trippany et al., 2004). Whilst this may not always be through supervision, findings confirm the importance of supervision and highlight the risks when not in place.

All participants had an awareness of the negative effects of trauma work to their sense of self through experience. Within the literature search, trauma

therapists commonly used colleagues to discuss effects of vicarious trauma rather than a supervision setting (Pearlman & MacIan, 1993; Van Minnen & Keijsers, 2000). In contrast, findings of this study suggest on the whole, participants used the supervision setting as their main outlet to discuss any issues arising from case material and support their sense of self. One exception to this was a workplace supervisor being allocated due to organisational logistics, rather than clinical experience or expertise (David, page 134). In the reported example, discussing case material with a clinically valued colleague was preferential to that of a workplace supervisor. This finding supports those of Webb and Wheeler (1998), who argued supervisees are more likely to disclose, when they have chosen their own supervisor and are supervised independently of the work setting.

Supervision was found to be an important protective factor within trauma work, supporting previous studies (eg: Bell et al., 2003; Adams & Riggs, 2008). Some therapists may feel the need to protect colleagues from the horror of graphic trauma narrative (McCann & Pearlman, 1990). However, reluctance to disclose when presenting client material could have negative implications for therapist wellbeing and the supervisory relationship (Catherall, 1995; Westbrook et al., 2007). Within this study, Justin and Laura reported they did not wish to disclose graphic detailed information relating to trauma presentations they were discussing during their interview. Whilst acknowledging the difference between clinical supervision and participant interview, their reluctance to disclose may intimate their awareness as to the level to which another individual may be affected. It could also denote a personal benefit of self-protection from further exposure to trauma material. For participant protection with regard to risk and the awareness that harrowing trauma narrative may have been something they felt uncomfortable discussing under interview conditions, their decision was respected. However, their reluctance was borne out of concern they may 'pass on' the trauma during the interview and perhaps uncertainty as to how I may be affected. This finding, whilst tentative, could be important for supervision and therapist welfare.

The percentage of non-disclosure during supervision can be high for many different reasons. A positive association has been identified between the quality of the supervisory working alliance as perceived by the supervisee and the extent of their disclosure (Webb & Wheeler, 1998). Results from a study by Mehr, Ladany and Caskie (2010) found that just over 84% of trainees withheld information from their supervisors during a single supervision session. In comparison, Falender and Shafranske (2004) found 90% of therapists failed to disclose negative reactions to supervisors, with 60% failing to disclose personal issues. Some therapists may have difficulty accessing supervision when not coping due to a sense of guilt or shame (Van Minnen & Keijsers, 2000; Jonsson & Segesten, 2004). As conscious and unconscious aspects of therapeutic relationships can help process trauma responses (Pearlman & Saakvitne, 1995a), it is important to consider the effects of this on therapists and the clinical supervision process itself. Findings of this study reflected those found within other studies (Webb & Wheeler, 1998; Van Minnen & Keijsers, 2000; Jonsson & Segesten, 2004; Falender & Shafranske, 2004).

Findings confirm, whilst not explicit, that the action of delaying supervision until a pre-arranged appointment to discuss the effects of trauma work which had built-up over several weeks, may have been due to feelings of guilt or discomfort at ‘inconveniencing’ a busy supervisor (Susan, page 133). This finding is concerning as delaying seeking supervision is something that could exacerbate any negative effects of trauma work. It also supports the argument for supervisors to foster an environment that is accepting and readily available to support any work-related stress as it arises (Catherall, 1995).

It has previously been established that guilt or shame may place therapists in a difficult position when accessing supervision (Van Minnen & Keijsers, 2000; Jonsson & Segesten, 2004). This study found that certain safety behaviours offered temporary relief to feelings of discomfort, embarrassment, anxiety and unprofessionalism arising from listening to harrowing trauma narratives. This finding is important as it has previously been found that safety behaviours only serve to maintain anxiety (Wells, et al. 1995). Also important though perhaps unsurprising, was the finding that the ‘financial burden’ and constant pressure of

payment by results contracts and the repercussions of missed targets on employers and consequently employees future employment prospects, increased feelings of anxiety and guilt, thereby adding to therapist distress.

Supervisors cannot be expected to be specialists in all fields and the availability and cost of competent, appropriate, external supervision may be constrained (Sexton, 1999). However, to ensure safe practice and safeguard therapist wellbeing, this study's findings supports earlier research in the view that effective supervision requires recognition of the seriousness of vicarious trauma and trauma-specific supervisors chosen by the supervisee and who ideally are external to the workplace setting (Figley, 1995; Pearlman & Saakvitne, 1998; Webb & Wheeler, 1998; Lonergan et al., 2004).

My supervision experience spanning the eighteen years of working within the mental health field, has unsurprisingly been varied and it has also fulfilled different needs at different times. I have been fortunate to be able to manage this through working with the expertise of multiple supervisors. The value I place on supervision is immense and for those times I have felt dissatisfied, it has been when it is rushed, interrupted, only client focused or like David (page 134), when I have perceived the supervisor to be inexperienced in the subject matter I am bringing. It is only through reflection within the doctoral process that I have come to realise those times of dissatisfaction, all equate to supervision with allocated supervisors chosen by employers within employment. As a therapist within private practice, my freedom of choice in private practice supervisors has been invaluable and something which has helped strengthen the supervisory relationship, my clinical skills, confidence and supplemented the supervision provided by my employer. Whilst only my experience, I believe that if the same right of 'client choice' was extended to supervisees working within organisations, the clinical supervision experience would be improved, therapist confidence in clinical skills and depth of knowledge increased and any increased costs or time spent on supplementary supervision reduced.

6.1.4.2. Importance of trauma training

Findings confirm comprehensive, good quality training was essential to participants prior to engaging in trauma work as it formed a solid foundation for the work, built confidence and aided wellbeing. Furthermore, difficulties in confidence, competence and awareness of risk were evident where this was lacking.

Findings confirm participants who were less experienced or relatively new to trauma work suffered more negative effects than those more experienced. This finding supports others who argued a lack of clinical experience may be a pre-disposing factor to vicarious trauma (Neumann & Gamble, 1995; McLean et al., 2003; Adams & Riggs, 2008). This finding is important as whilst much therapeutic training is client-focused, findings confirm psycho-education of vicarious trauma alongside post-traumatic stress disorder would help therapists entering trauma work recognise and address any potential negative effects on their sense of self. Although the negative changes impacting on participants' sense of self within this study could be seen as indicators for vicarious trauma, findings did not identify any participant in which the changes at the time of interview, had led to them becoming vicariously traumatised.

Also evident from findings was the importance participants placed on good quality training, practice and clear guidance for delivering the model they were working with, to help prevent the risk of a heightened susceptibility to stress responses, or ineffectual client treatment (Rosenbloom et al., 1999). Furthermore, skills from training or experience in former careers were frequently found to complement participants therapeutic work, helping them cope with its demands and often leading to greater understanding or compassion for clients.

Participants who started trauma work before receiving adequate trauma training were found more vulnerable to experiencing negative psychological, physiological and behavioural changes impacting on their sense of self (page 132), concurring findings of others (Danieli, 1994; Williams & Sommer, 1999; Iliffe & Steed, 2000). In comparison, where participants perceived they had received an adequate level of trauma training, they felt more confident to deliver

the treatment protocols from the outset. This finding supports those of Williams and Sommer (1998), who argued therapists working in the trauma field are vulnerable to its negative effects if they lack a strong foundation of trauma theory. Whilst there is no evidence to substantiate clients received a subordinate level of treatment due to lack of training, findings confirm for therapist wellbeing and more importantly, vulnerable clients, it is essential that therapists do not start working with trauma clients prior to undertaking sufficient, specific, trauma training.

Findings also raised the question of organisations offering further training opportunities to therapists, before they have completed a current one. Susan talked about starting CBT training before completing EMDR training (page 128). While the significance of this may be altered in circumstances where the focus of the training was unrelated, this was particularly relevant as both models of training were structured around working with trauma presentations. Findings confirmed that undertaking dual training gave rise to Susan being put in a position of having to make a conscious choice to set aside her EMDR skills practice, to concentrate on her CBT competencies as she did not have the capacity to focus on both. EMDR training comprises three sequential parts which allows for on-going skills practice and specific case examples or difficulties encountered to be incorporated into the subsequent training. Whilst awaiting the final part of EMDR training, aimed at complex cases and blocks that hinder trauma processing, Susan was undertaking the IAPT, CBT training course (DoH, 2007a). To retain focus and increase her regularly assessed CBT competencies, her EMDR skills practice ceased. This finding is particularly important and resulted in the treatment options offered in clinical practice, stemming from a place of participant ‘training need’ rather than ‘client need’ and led to the treatment choice of the client being eradicated.

In today’s world of mental health, there appears a high expectation on therapists to be trained in a variety of therapeutic treatment models. It is clear from this studies findings, that the potential impact of this may leave therapists at times questioning their fidelity to a therapeutic modality (Paul, page 113) or their clinical effectiveness (Helen, page 110; David, page 123). Whilst this

impact should be explored and supported through supervision, the practice of simultaneous training could lead or encourage therapists to spread their skill-set too thinly. Although a difficult area to manage, especially when therapists are eager to learn new skills and organisations want to up-skill their workforce, such practice could result in overwhelmed therapists and/or ineffectual client treatment (French & Harris, 1998; Rosenbloom et al., 1999; Gentry, 2002). Whilst continuing professional development should be encouraged, I believe this should not be at the expense of other training or client care. By limiting training opportunities to allow new skills to be embedded and honed before embarking on further training, findings suggest additional pressure on therapists could be minimised and so aid their wellbeing and support their sense of professional identity.

6.2. Reflexivity and Personal Learning

Evidence suggests that professionals working with trauma who are exposed to emotionally shocking material over time, may suffer symptoms of vicarious trauma (McCann & Pearlman, 1990), secondary traumatic stress (Figley, 1985) or compassion fatigue (Figley, 1995). Specific to therapists working with trauma survivors, vicarious trauma can result in symptoms representative of PTSD. To help understand the negative changes therapists experience to their trust, control, intimacy, esteem, safety and intrusive symptoms, McCann and Pearlman (1990) provided a theoretical framework. Although considered a normal reaction to an abnormal event, I undertook further research in this area to increase current understanding of the phenomenon, find strategies to help reduce its negative effects and add to the body of existing literature (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995a, Steed & Downing, 1998; Iliffe & Steed, 2000; O'Halloran & Linton, 2000; Trippany et al., 2004; Jordan, 2010; Elwood et al., 2011).

This study adds weight to previous research focused on the vicarious trauma phenomenon (McCann & Pearlman, 1990). It makes a valuable contribution to the research evidence base by exploring the subjective experience and coping strategies of trauma-focused CBT and EMDR therapists working with trauma caseloads. It expands previous findings by considering the impact of treatment

modalities, identifies a process of therapist change and distinguishes what supports and hinders protective practice.

My learning during the literature search deepened as the review process continued. The database used as a starting point for a broad literature search (Google Scholar) produced overwhelming data not narrow enough to offer any depth to the area of my study, so was used to generate ideas for key search terms. By using medical and psychological databases and learning to search in a more systematic manner applying a funnelling strategy, I was able to drill down and identity literature appropriate to address the search objectives.

Whilst reflecting on the research process, I felt particularly grateful to all the participants that freely gave their time and willingly took part in the study. Analysis and interpretation was as a result of a unique interaction with the data through my lens as researcher, trying to make sense of my participants' experience. IPA strives for 'experience close' rather than 'experience far' (Smith, 2011) and I hope I have been able to successfully represent my participants' experiences and allow their views to be heard.

My initial interpretation of the data was stunted by an overwhelming sense of not wishing to misrepresent or cause offence to any participant who willingly gave their time to help with my research. New to the IPA methodology, my hesitation in bold interpretation led to me producing a more thematic analysis at times which although important, simply described participants' experiences. Although this allowed me to represent their whole experience and allayed fears of me interpreting the data in a different way than my participants may have expected, by default I fell into the trap of misrepresenting the rich data produced by not presenting the underlying participant messages leaking out. At the eleventh hour, data was again re-analysed to try to ensure where possible an even more comprehensive interpretative account of participant experiences. This resulted in some participant extracts being extended or removed where found to be particularly descriptive.

The influence of parenthood was one theme raised during participant interviews. As a parent myself, I could identify with those participants who found client presentations involving children difficult. However, as a parent prior to my therapeutic career, I am unaware as to how the change of becoming a mother might have impacted upon my work. I have reflected on whether as a parent, a therapist may be more susceptible to being negatively affected by trauma cases involving children and questioned whether it is simply a case of being able to identify with a client through our own experience. Future studies could help identify further changes and build upon important findings of this study.

Within the theme of hearing trauma narrative, one participant discussed a particularly harrowing client presentation. This was the one presentation that led to personal negative, emotional, imagery and cognitive changes for me as a researcher. Although changes were relatively short-lived and on the whole only impacted during the process of analysing and writing up findings, I noticed a 'process of change' similar to that reported by participants. This was down to me considering not only the impact of the trauma work for the participant but more importantly, the impact of this particular trauma upon the client. Similar to my participants, I found myself visualising the trauma scene as I imagined what it must have been like for the client to experience. I too, momentarily, could identify with the client as I placed myself in their position and could understand the participant's concerns for their client's safety before they moved towards post-traumatic recovery. What surprised me most, was how on a few occasions during the data analysis, I felt tearful as I reflected on the inevitable distress of the client as my imagination took over. Whether my response was intensified through being immersed in trauma data for months during the research process, I'm not sure. However, it was another reminder of the magnitude of trauma work, the significance of effective treatment and varied caseloads, and the importance of supervision and self-care to protect the sense of self.

During the process of undertaking this research, I have considered my personal experience of delivering the two trauma models and my preference for EMDR. Like some of my participants, I find that when working with EMDR, it helps me

process trauma material much quicker and in effect acts as a protective 'buffer' against all the detailed traumatic information I receive with trauma-focused CBT clients. I too, have found the process of delivering EMDR incredible. I cannot say the same with trauma-focused CBT and can empathise with the participants who have struggled with its intensity. Although there has been controversy around EMDR (Devilly & Spence, 1999; Herbert et al., 2001; Davidson & Parker, 2001), I found myself smiling at the participants that described the process as 'magical' because I could relate to exactly what they meant. With magic, the observer can see it working but cannot explain how it is done and to me, EMDR is similar in that regard. Whilst EMDR is certainly no illusion, there is something about the instantaneous client changes during processing, that make it a very exciting model to work with. To witness a client in distress change their memory to the trauma, laugh and look at you often amazed and confused as to what just happened is without doubt, for me, the best part of trauma work.

Prior to the research described in this thesis, I had never considered using EMDR without hearing the client, (who may be struggling with shame, embarrassment or guilt), vocalise some details of a traumatic image or thought. I have reflected on this and recognised that within my CBT training and clinical supervision, non-verbalisation has always been considered an avoidant client behaviour which should be gently challenged. However, through listening to one participant's EMDR experience, who in some cases has respected the client's privacy in its entirety, I have returned to my person-centred core values, been led by the client and successfully offered and implemented this into my practice as appropriate.

My learning throughout the doctoral process has been continuous. From the outset, it has led to a new understanding of the phenomena under discussion, a command of relevant research methodologies and developed my writing and presentation skills. I believe my growth as a researcher is reflective of my clients' post-traumatic growth. Pre-existing beliefs have been challenged and adapted and fear and avoidance has transformed into resilience and a determination to succeed. Within my professional practice, my learning has

contributed towards establishing new ways of working, new professional networks and a dissemination of knowledge gained in the process of undertaking the professional doctorate.

6.3. Evaluation of Research Design and Research Question Posed

IPA, the qualitative research design for this study, was chosen for its commitment to the examination of the lived experience of my participants. Semi-structured interviews facilitated an open discussion between me as researcher and my participants. Built on a framework of initial questions aimed at answering the research question, this allowed them to discuss which aspects of trauma work were important to them. The research question considered how CBT and EMDR therapists working with the recommended treatment modalities for PTSD, made sense of their experiences and protected themselves from any negative effects of the work.

Consideration was given to recruiting participants from the company that I worked for on a part-time basis before snowballing, together with the possible implications of this (Asselin, 2003; Costley, 2010). Through supervision, potential problems such as participant disclosure of personal difficulties to a colleague, or disclosure of unethical practice were explored. The effect upon existing or future working relationships, should action need to be taken arising out of such disclosure was contemplated. However, as less than 7% of employees opted to take part in the study, I accepted these possible implications.

The final sample size for the study felt appropriate and provided enough rich data to compare participant experiences and answer the research question. The decision not to bring new emergent themes into participant interviews as they progressed was considered and discussed through doctoral supervision. Whilst this may have been valuable in hindsight to build upon themes as they arose, I did not want to influence participants and wanted them to discuss their own experience, rather than expanding upon the experience of others.

6.4. Implications of the Findings and Recommendations

Sense of self was a key finding running throughout all the themes identified within the study and as such, it is what the recommendations are clustered around. One of the largest themes within the findings and the most difficult aspect of trauma work for participants, was hearing clients trauma stories and the resulting impact upon their sense of self. Findings indicate certain strategies such as; time management, trauma-specific supervision, comprehensive trauma training and EMDR may reduce the negative effects of hearing trauma narrative upon the therapist sense of self.

Findings confirm the supervision process is an important factor in protecting therapists from the negative effects of trauma work although difficulties may arise if the therapist lacks confidence in their supervisor. To reduce the risk of therapist vicarious trauma, it is fundamental that supervisors who offer trauma supervision should be competent in the field of trauma so they can identify, recognise and support any therapist difficulties which may arise during the work. To help foster an effective, open supervisory relationship, recommendations are for supervisors to be qualified to post-graduate level in delivering trauma-specific supervision and up-to-date in their continuing professional development specific to the trauma field. Furthermore, supervisors should ideally be external to the workplace environment and chosen by the therapist. Where the availability or cost of appropriate, competent and external supervision is constrained by organisational issues, supervision should be monitored and regularly appraised to ensure it is fit for purpose.

Findings show that certain types of trauma presentations may also be better addressed and supported within a specialist trauma team. In particular, those presentations considered more severe or frequent in nature and previously identified as a predictors for a traumatic stress response (APA, 2013); and those identified within the findings as impacting heavily on the therapist sense of self (eg: trauma involving children). Recommendations are for organisations to consider introducing specialist trauma teams that can offer additional support to trauma therapists alongside their supervision and where recognition, support

and management of vicarious trauma can be more personally enhanced within the comfort and safety of specific team environment.

Training was found to be a protective practice that helped participants feel more competent and confident when engaging in trauma work. Findings confirmed participants who lacked comprehensive training, were less experienced or relatively new to trauma work, suffered more negative effects. As training was an important protective factor, it is essential therapists do not start trauma work until they receive adequate, specific and comprehensive trauma training. Whilst acknowledgement is given to the developing skill set of trainee trauma therapists, recommendations are for clinical practice to be delayed until successful completion of a course of advanced trauma training (eg: diploma level). This should include psycho-education of vicarious trauma, potential risks to the therapist's sense of self and most importantly, have an emphasis on self-care. Advanced training would not only offer a more ethically sound and appropriate level of care for clients but would also afford a duty of care to therapists by providing an opportunity should it arise, for early recognition and appropriate support with any vicarious trauma symptoms (NICE, 2005; Kingdon, McGuire, Stalmeisters & Townend, 2017).

Furthermore, findings show organisations have a duty of care to curb additional training opportunities for those therapists who are already undertaking training in a new area. This action may help reduce any additional stress and allow new clinical skills to become established and developed prior to setting them aside to develop further new skills. Furthermore, the risk of ineffectual or poor quality client treatment as a result of reduced competency levels can be avoided. It of course remains the responsibility of individuals and organisations working within the trauma field to ensure safe practice. Where an inadequate level or provision of training is perceived as unethical and negatively impacting upon client or therapist welfare, this matter should be addressed immediately and delivery of trauma treatment should cease until such time that competency levels increase. Failure to address such difficulties should be reported to the appropriate professional standards body.

Whilst the study's sample size was small, another interesting finding that warrants further investigation was that EMDR may also provide therapists with some form of protection against the negative effects of hearing trauma narrative. As therapists we have a duty of care to clients and therefore it is essential that they have a choice in their treatment and access to the therapies that work for them. However, we as individuals and the organisations we work within, also have a duty of care to ourselves. If, as findings show, EMDR has the ability to reduce the possibility of therapist vicarious traumatisation, whilst still providing a rapid, effective treatment for clients, it is important to investigate further. This finding is one where recommendation could be weighted in favour of the therapist choosing to deliver EMDR over trauma-focused CBT if they are working with certain trauma presentations which they recognise may impact heavily upon their sense of self.

There are several concerning findings within this study resulting from a lack of mental health funding. Therapists working within organisations that do not have adequate funding to provide specialist trauma services, may be being placed under increasing stress to work against the ethical framework of their governing bodies, by attempting to provide 'a quick fix' for clients in inappropriate, restricted treatment lengths. For organisations that operate a payment by results service, there may be an increasing burden on staff to work harder and faster for their employers as they try to meet contractual targets, creating a fear culture around job loss. Professor Sir Simon Wessely, president of the Royal College of Psychiatrists recently said:

> "…We are being asked to do more with less. We are campaigning and saying that people need to be more open about mental health problems and come forward earlier but when they do, we find ourselves with less resources to treat them and they are getting short-changed..." (Buchanan, 2015)

This position is particularly concerning for the mental health profession and clients presenting for treatment. Pending mental health services receiving further government funding, the current position remains the same. In stark contrast to those who might argue some treatment is better than none for those people desperately seeking help; until funding starts to trickle through, there is

the ethical and moral argument of whether organisations that do not have adequate funding to provide adequate services, should be offering them at all.

Restrictions on service and a failure to provide an appropriate standard and duty of care for clients is unethical and not a position I support (NICE, 2005; BACP, 2013; BABCP, 2015). There are existing guidelines for working with PTSD and it is incumbent upon services to ensure therapists are in a position to be able to deliver therapy to fidelity (NICE, 2005). Findings confirm where this position is threatened due to restricted or inappropriate treatment lengths, organisations are also failing in their duty of care of therapists (Kingdon, McGuire, Stalmeisters & Townend, 2017).

It is clear from the findings of this study and others (eg. Steed & Downing, 1998; Harrison & Westwood, 2009; Ben-Porat & Itzhaky, 2009), therapists are energised by their trauma work and find it personally rewarding. However, if the therapist sense of self is to be sustained, it is important that trauma work remains fulfilling, stimulating, dynamic and fresh whilst providing the opportunity to witness a real and measured improvement in client recovery. Recommendations are for those components which help promote the therapist sense of self, to be supported. This support can be safeguarded by organisations and individuals following the existing guidelines for the treatment of PTSD (NICE, 2005). Furthermore, it can be enhanced by amongst other things, having regular access to appropriate support systems, continuing professional development, up-to-date research and networking with like-minded professionals.

6.5. Limitations to the Study

There are several limitations to the study. The first being not all participants were trained in both trauma-focused CBT and EMDR. Part of the criteria for the study was the requirement for participants to be qualified in either model. This criterion was set to encourage as many participants as possible to opt-in to the study. The study may have been improved if all participants who opted in were qualified in both modalities. However, mindful of this and to reduce any preference, active recruitment of potential participants who could provide

sufficient data for a successful study only stopped when the number of participants using only trauma-focused CBT, equalled the number of participants using only EMDR. Acknowledgement is also given to the limitations of such study data collected with regards to any negative effects of trauma work, due to the exclusion criteria implemented to safeguard and protect the mental wellbeing or recovery of potential participants. Potential participants, such as those who have left the profession or changed roles due to becoming negatively affected, could provide further insight and valuable data for any future studies, if located.

Much social research is founded on the use of a single research method and as such, may suffer from limitations associated with that method or application of it (Bryman, 2003). Qualitative researchers using phenomenological or constructivist paradigms are not in pursuit of a definitive truth about individual experiences and do not seek to validate any claim or meanings of them, other than to explore how understanding of them can be enhanced (Frost, 2008). Constructivism values the multiple realities that people have in their minds (Golafshani, 2003). Using triangulation and engaging in multiple data collection methods to bring various ways of understanding the data and to highlight complementary, contradictory or absent findings within it, would have offered this study a diverse construction of realities and the prospect of enhanced credibility and richness (Bryman, 2003; Golafshani, 2003; Frost, 2008).

A further limitation was the sample size itself. Similar to some of the studies identified within the literature review (e.g. Steed & Downing, 1998; Iliffe & Steed, 2000; Lonergan et al., 2004), this study had a relatively small sample size of self-selected participants. Whilst a small sample size is accepted within IPA as the focus is on the detail and depth of analysis, the findings cannot be generalised unless supported by other warrantable research (Plowright, 2011).

The majority of participants taking part in the study did not indicate any significance of witnessing client distress, thus potentially limiting results on the full impact of trauma work. Whilst in hindsight, this may have been useful to

explore, as the IPA methodology encourages facilitation of a participant's lived experience, discussion centred around what was central to them.

Being a researcher with an 'insider' perspective, could also play a conscious or unconscious role in participant/researcher responses (Asselin, 2003; Gale, 2004; Costley, 2010). This may result in some participants changing their behaviour for fear of judgement (Gale, 2004). As a researcher, similar to any client presentation in my work as a therapist, I am reliant upon the responses my participants give me being open and honest. From their responses, I have no reason to doubt they engaged openly and honestly and therefore trust these unreservedly.

Finally, only one participant within the study preferred a face-to-face interview whilst all other interviews took place by telephone. As the only face-to-face interview was the very first to take place, my hope is this would not have had any significant implications for the study data obtained. Whilst the method of interview for the study could be criticised for its inconsistency (Gale, 2004), this was led by the participants. The choice of interview method was offered to aid the interview process and help participants feel more at ease. Therefore, the participant's preferred interview option was respected.

6.6. Recommendations for Future Research

Any research that helps identify risks or benefits to professionals working with trauma clients is valuable. As well as adding to the existing body of knowledge, further studies in this area are recommended to build upon important findings of this study, increase understanding of the phenomenon of vicarious trauma and inform clinical practice. Throughout this study, several areas were identified where future research is recommended.

It has been found that EMDR may act as a protective factor for therapists, by enabling them to emotionally distance themselves from trauma narrative. Further studies researching EMDR's potential to reduce the negative effects of

hearing trauma narrative and modulate trauma images, is recommended to build upon important findings within this study.

Findings suggest trauma therapists who are parents, may be affected differently to those who are not. This is particularly the case when a therapist is a new parent and working with a child-related trauma. A study researching the influence of parenthood upon trauma therapists from early pregnancy is recommended to build upon the findings within this study and raise awareness of parenthood and its influence within the therapy room.

Findings suggest the availability of media in high profile cases may compound difficulties associated with client trauma for some therapists. High profile cases may be harder than others to switch off from, due to the constant reminders within the public arena. Future studies are recommended to develop this study's findings and help build a picture of how high profile cases influence trauma work. Such data would allow any negative influences to be addressed more comprehensively and identify additional support or training needs that may arise.

The question of moral, legal and ethical dilemmas connected to historical disclosures of human brutality inflicted by the client, was raised during one participant's interview. Although possibly a rare occurrence, future studies are recommended that consider whether therapists working with clients traumatised by their own actions, are affected differently to those working with clients traumatised by the actions of others. As with other study recommendations, this would inform clinical practice, identify areas of risk and help support therapist wellbeing.

Gallows humour has been found to be an effective coping strategy to help lessen the negative effects of serious, frightening or painful trauma work (Freud, 1960; Garrick, 2006). Within this study, laughter often masked underlying feelings of discomfort. To build on findings and increase understanding of

vicarious trauma, further research is recommended which considers when and why trauma therapists may use humour.

The intense nature of trauma work and its associated negative impact, may lead some therapists to leave the profession (Chrestman, 1999). Whilst locating therapists who have already left the profession would be problematic, future research is recommended to help identify those perhaps considering this and to pinpoint their exact reasons for change.

Findings of this study did not address the effects of witnessing client reactions to trauma. However, as mirror neurons could be an important factor in therapist responses, it may be an area suggesting further research. This could distinguish any relevance of witnessing client distress and provide additional data to those studies addressing the significance of hearing trauma narrative.

Furthermore, although not related specifically to individuals working with trauma clients, future studies are recommended that consider the affect and implication of enforced treatment breaks due to restrictions in funding, from the viewpoint of the client.

6.7. Dissemination Strategy

One of the broad aims of the professional doctorate with the University of Derby included making, ‘an original contribution or application of knowledge to a specialist field of study’ (Townend, 2013). Having embarked on the professional doctorate and achieved this aim, it is important to disseminate my research findings.

‘When disseminated, well-executed qualitative research helps expand research horizons’ (Fawcett, Waller, Miller, Schweiterman, Hazen and Overstreet 2014:6). Dissemination is defined as ‘the targeted distribution of information and intervention materials to a specific public health or clinical practice audience’ (Neta, Glasgow, Carpenter, Grimshaw, Rabin, Fernandez and Brownson, 2015:49). Its intention is to distribute knowledge and associated evidence-

based interventions, change practice patterns and contribute to the body of existing knowledge (Kerner, Rimer & Emmons, 2005; Neta et al., 2015).

This study's findings add to the existing body of knowledge focused upon the subject of vicarious trauma which occurs only amongst those working specifically with trauma clients. To help reduce or ameliorate its symptoms, organisations and individuals working with a trauma caseload must have an awareness of how it manifests itself. By disseminating findings of this study, existing patterns of practice can be reviewed, considered and changed as necessary, to help reduce any negative effects and support therapist wellbeing. Dissemination of findings has already started at local level through discussions with professional colleagues and supervision of supervisees. This has provoked a positive response and an interest in reading my study.

By establishing links with other organisations, further local level dissemination will be through oral presentations and trauma workshops. Initially, these will be aimed at professionals currently working as therapists within the field of mental health and local colleges offering training to therapists of the future. Once established, consideration will be given to offering presentations and trauma workshops to different populations.

National dissemination will be through poster presentations at the annual conferences of EMDR UK and Ireland Association, BABCP and BACP, as well as submission to publish in appropriate peer-reviewed journals. Those journals particularly aimed at targeting the CBT and EMDR audience such as, 'The Cognitive Behaviour Therapist' and 'EMDR Now' will be approached initially. Expansion to journals aimed at a more generic audience such as, 'Counselling and Psychotherapy Research' and 'BPS Journals' will follow. Whilst not limited to the United Kingdom and Ireland, scope for dissemination internationally will start through established links with colleagues currently working abroad.

6.8. Summary of Discussion Chapter

This chapter has presented and discussed the four master themes found within the study's findings. It has explored how participants interpret and experience trauma work, highlighted both negative and positive responses, and identified barriers to treatment and ways to support clinical practice. It has considered the design of the study, the research question, implications of findings, limitations to the study, future research recommendations and dissemination. The following chapter summarises the researcher's conclusions relating to the theoretical and methodological aims of the study.

Chapter 7: Conclusion

7.0. Overview

The aim of this study was to explore how trauma-focused CBT and EMDR therapists engaged in trauma work interpreted and made sense of their experiences and which practices helped them cope with the demands of the work. This study has considered whether vicarious trauma exists, the evidence that underpins it, how it is defined in the literature and its implications. Furthermore, adding and extending the existing evidence base, study findings have been presented and discussed.

7.1. Study Conclusion

IPA was chosen for the study as within the qualitative tradition of enquiry, it was considered the most appropriate methodology to fulfill the research aims and answer the research question. Eleven participants took part in the study, made up of three in the pilot and a further eight in the duplicated larger study. IPA allowed each participant to give a rich, detailed description of their own, unique experience and discuss any elements important to them. All participants were qualified and experienced in delivering trauma-focused CBT or EMDR.

Recorded semi-structured interviews were conducted with participants by telephone or face-to-face, dependent on participant preference, with all but one requesting a telephone interview. Prior to analysis, interview transcripts were transcribed verbatim and sent to participants for validation of their true account. Following initial analysis, a decision was taken to combine the pilot and main study data to present a more comprehensive view of the results. After a protracted process of data analysis and refinement, four master themes were chosen for the write-up which best addressed the aims of the study and answered the research question. These were: 'Nature of trauma', 'Participant sense of self and managing the process of hearing trauma narrative', 'Participant experience of delivering the trauma models' and 'Protecting and sustaining the participant sense of self'. Importantly, findings of the study both concur and challenge previous studies findings and add depth by introducing new concepts in relation to the vicarious trauma phenomenon.

Whilst there are limitations associated with making generalisations from IPA studies, findings indicate hearing detailed trauma narrative had a significant impact on participants sense of self and triggered a ‘process of change’ that influence how therapists undertaking trauma work are affected.

Neither trauma-focused CBT nor EMDR was found superior to the other and both had reported successful treatment outcomes for the client. However, making an original contribution to knowledge, findings indicate EMDR was found to have the potential to protect therapists from the distressing effects of hearing the full trauma narrative in trauma-focused CBT. This finding is important as all participants taking part in this study reported negative changes to cognitive schemas and imagery systems resulting from hearing trauma narrative, supporting findings of McCann and Pearlman (1990) and symptoms consistent with burnout (Maslach, 1998), secondary traumatic stress and compassion fatigue (Figley, 2002).

Although hearing trauma narrative was found the most significant aspect of trauma work leading to a decline in therapist wellbeing, specific factors compounded therapist distress and supported findings of others Chrestman, 1999; McLean et al., 2003; Jonsson & Segesten, 2004; Pross, 2006; Clebourn-Jacobs, 2013; Phoenix, 2014). Importantly, identification with clients, in particular children, was found a strong predictor for a stress reaction, thus the more personalised the experience, the more likely they were to experience vicarious traumatisation symptoms. High profile cases and the influence of multimedia were found to exaggerate the negative effects of trauma work within and outside the therapy room. Unexpected or premature endings were found to leave therapists vulnerable to the effects of vicarious trauma as they were left with unprocessed trauma material.

All participants implemented certain protective practices including training and supervision, to help sustain them in their work and protect their sense of self. However, certain practices were identified which threatened wellbeing where these were viewed as inadequate. Most difficulties were found to stem from funding cuts within primary care leading to unrealistic timeframes in which to

deliver trauma treatment. Importantly, this had a significant detrimental effect on the emotional wellbeing of participants, increased the risk of leaving the profession through disillusionment and had a potentially damaging effect on the treatment and post-traumatic recovery of clients. This is an area where EMDR's ability to shield therapists from any damaging effects of hearing detailed trauma narrative together with its rapid treatment results, could have major benefits for therapist welfare, treatment costs and reducing waiting lists in the future.

On the whole, most negative changes reported by participants were considered relatively short-term and appear well managed, supporting findings of Barrington and Shakespear-Finch (2013) who argued therapists reduce their psychological distress of trauma work by adjusting existing beliefs to incorporate the traumatic stories and make meaning of their experience. Due to the high prevalence of negative change reported within this study, raising the profile of vicarious trauma through education and trauma-specific training and providing a culture which recognises the seriousness of vicarious trauma and acknowledges it as not just 'part of the job' (Hoff, 2009) is important in helping therapists recognise and deal with changes immediately they occur.

Whether working with trauma-focused CBT or EMDR, participants placed a high priority on helping clients towards recovery and worked hard to facilitate this. It is without doubt all participants enjoyed elements of their trauma work and gained a sense of professional and personal satisfaction from delivering treatment. All were fuelled by their work, passionate about the post-traumatic recovery they had witnessed and respectful of their clients courage to trust in the therapeutic process.

Throughout the doctoral process I have reflected on my position as researcher and that of a CBT and EMDR therapist (see sections 1.0 and 6.2). As a part of a caring profession, it saddens me that therapists and clients alike are being let down by failings such as shortened treatment sessions and enforced therapy breaks within some service provisions. Although acutely aware of some failings within my own primary care IAPT service before I started the doctorate process, the time and process of undertaking this piece of research only served to

illuminate and exacerbate them. To retain my professional sense of identity, an appropriate standard of care to clients and a duty of care to myself, I made the decision to resign from my part-time employed position working for a private NHS provider. Since leaving, I continue to enjoy working with this valuable client group and others in my capacity as an independent private practitioner.

7.2. Concluding Statement

This study makes an important contribution to the existing knowledge base on vicarious trauma and forms part of a larger body of evidence with the scope to promote further research in the future. Key findings add originality, importance and value to professional practice. Findings show views and perceptions of the world and those in it may change for therapists as they become drawn into the client's trauma world.

> 'The expectation that we can be immersed in suffering and loss daily and not be touched by it, is as unrealistic as expecting to be able to walk through water without getting wet.' (Remen, 1996:52)

However, by adopting ways of working which help facilitate therapists wellbeing, ensuring good quality training, promoting education of vicarious trauma and investing in appropriate support, these changes can be successfully managed.

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APPENDICES

(Appendix A): Databases, search terms and results generated from the literature search.

Databases, search terms and results generated from the literature search

Database searched: Google Scholar

- Vicarious trauma and mental health therapists
  Number of hits: 16,400
- Vicarious trauma
  Number of hits: 15,500
- Vicarious trauma and qualitative studies
  Number of hits: 12,300
- Vicarious trauma and Secondary trauma and qualitative studies
  Number of hits: 7,470 hits

Database searched: British Library

- Cognitive behavioural therapy or CBT and PTSD
  Number of hits: 2
- Eye movement desensitisation or EMDR and PTSD
  Number of hits: 0
- Cognitive behavioural therapy and trauma
  Number of hits: 0
- EMDR and trauma
  Number of hits: 0

Database searched: Cochrane

- Cognitive behavioural therapy or CBT and EMDR or EMD and PTSD
  Number of hits: 647
- Cognitive behavioural therapy and trauma
  Number of hits: 2
- EMDR and trauma
  Number of hits: 1

Database searched: CINAHL

- Eye Movement desensitisation or EMDR and trauma
  Number of hits: 643
- Cognitive behavioural therapy or CBT and trauma
  Number of hits: 147

Database searched: AMED

- Eye Movement desensitisation or EMDR and trauma
  Number of hits: 191
- Cognitive behavioural therapy or CBT and trauma
  Number of hits: 31

Database searched: PubMed

- Eye Movement desensitisation or EMDR and trauma
  Number of hits: 29
- Cognitive behavioural therapy or CBT and trauma
  Number of hits: 16

Database searched: Science Direct

- Eye Movement desensitisation or EMDR and trauma
  Number of hits: 157
- Eye Movement desensitisation or EMDR and vicarious trauma
  Number of hits: 144
- Cognitive behavioural therapy or CBT and trauma
  Number of hits: 5,022
- Cognitive behavioural therapy or CBT and vicarious trauma
  Number of hits: 4,992

Database searched: PsychInfo

- Eye Movement desensitisation or EMDR and trauma
  Number of hits: 1,191
- Eye Movement desensitisation or EMDR and vicarious trauma
  Number of hits:1,102
- Cognitive behavioural therapy or CBT and trauma
  Number of hits: 28,656
- Cognitive behavioural therapy or CBT and vicarious trauma
  Number of hits: 28,578

Database searched: Medline

- Eye Movement desensitisation or EMDR and trauma
  Number of hits: 292
- Eye Movement desensitisation or EMDR and vicarious trauma
  Number of hits: 286
- Cognitive behavioural therapy or CBT and trauma
  Number of hits: 5,228

- ***o*** Cognitive behavioural therapy or CBT and vicarious trauma
  Number of hits: 5,054

Database searched: EBSCO HOST - PsycArticles, PsycInfo, AMED, CINAHL Plus, eBook collection, MEDLINE, e-journals

- o Vicarious trauma or vicarious traumatization or vicarious traumatisation
  Number of hits: 2,437

- o Vicarious trauma or vicarious traumatization or vicarious traumatisation
  Limiters: narrowed by language - English, narrowed by date – 1985-2014
  Number of hits: 2,110

- o Vicarious trauma or vicarious traumatization or vicarious traumatisation or secondary traumatic stress
  Limiters: narrowed by language - English
  Number of hits: 2,377

- o Vicarious trauma or vicarious traumatization or vicarious traumatisation or secondary traumatic stress and mental health and therapists
  Limiters: narrowed by language - English
  Number of hits: 2,377

- o Vicarious trauma or vicarious traumatization or vicarious traumatisation or secondary traumatic stress and mental health and therapists and quantitative research.
  Number of hits: 2,200

  Limiters:
  Narrowed by date (1985 – 2014) - *Number of hits: 2,160*

  Narrowed by date and language (English) - *Number of hits: 1,941*

  Narrowed by date, language and subject (vicarious traumatisation) - *Number of hits: 257*

  Narrowed by date, language and subjects (vicarious traumatisation and vicarious experiences) - *Number of hits: 78*

  Narrowed by date, language and subjects (vicarious traumatisation, vicarious experiences health and mental health treatment and prevention) - *Number of hits: 28*

- o Vicarious trauma or vicarious traumatization or vicarious traumatisation or secondary traumatic stress and mental health and therapists and qualitative research
  Number of hits: 2,105

  Limiters:
  Narrowed by date (1985 – 2014) - *Number of hits: 2,065*

  Narrowed by date and language (English) - *Number of hits: 1,855*

  Narrowed by date, language and subject (vicarious traumatisation) - *Number of hits: 255*

  Narrowed by date, language and subjects (vicarious traumatisation and vicarious experiences) - *Number of hits: 78*

  Narrowed by date, language and subjects (vicarious traumatisation, vicarious

experiences health and mental health treatment and prevention) - *Number of hits: 28*

(Appendix B: Example of various online CASP appraisal forms)

CASP (2010). In: Aveyard, H. (Ed). *Doing a Literature Review in Health and Social Care: A Practical Guide* (Second Edition). Open University Press: England. Public Health Research Unit, University Of Oxford. Forms available at: http:// www.phru.nhs.uk/casp/casp.htm.

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(Appendix C: ICD-10 Diagnostic criteria for PTSD)

F43.1 Post-traumatic stress disorder

A. Exposure to a stressful event or situation (either short or long lasting) of exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone.

B. Persistent remembering or "reliving" the stressor by intrusive flash backs, vivid memories, recurring dreams, or by experiencing distress when exposed to circumstances resembling or associated with the stressor.

C. Actual or preferred avoidance of circumstances resembling or associated with the stressor (not present before exposure to the stressor).

D. Either (1) or (2):
(1) Inability to recall, either partially or completely, some important aspects Of the period of exposure to the stressor
(2) Persistent symptoms of increased psychological sensitivity and arousal (not present before exposure to the stressor) shown by any two of the following:
a) Difficulty in falling or staying asleep;
b) Irritability or outbursts of anger;
c) Difficulty in concentrating;
d) Hyper-vigilance;
e) Exaggerated startle response.

E. Criteria B, C and D all occurred within six months of the stressful event, or the end of a period of stress. (For some purposes, onset delayed more than six months may be included but this should be clearly specified separately.)

(Appendix D: DSM-5 Diagnostic criteria for PTSD)

The symptoms of PTSD are mostly the same in DSM-5 as compared to DSM-IV (Appendix E). However, a few key alterations include:

- The three clusters of DSM-IV symptoms are divided into four clusters in DSM-5: intrusion, avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity. DSM-IV Criterion C, avoidance and numbing, was separated into two criteria: Criteria C (avoidance) and Criteria D (negative alterations in cognitions and mood). The rationale for this change was based upon factor analytic studies, and now requires at least one avoidance symptom for PTSD diagnosis.
- Three new symptoms were added:
    - Criteria D (negative alterations in cognitions and mood): persistent and distorted blame of self or others, and persistent negative emotional state
    - Criteria E (alterations in arousal and reactivity): reckless or destructive behaviour
- Other symptoms were revised to clarify symptom expression.
- Criterion A2 (requiring fear, helplessness, or horror happen right after the trauma) was removed in DSM-5. Research suggests that Criterion A2 did not improve diagnostic accuracy.
- A clinical subtype "with dissociative symptoms" was added. The dissociative subtype is applicable to individuals who meet the criteria for PTSD and experience additional depersonalization and derealisation symptoms.
- Separate diagnostic criteria are included for children ages 6 years or younger.

(Appendix E: DSM-IV-TR Diagnostic criteria for PTSD)

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

    - (1) The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.

    - (2) The person's response involved intense fear, helplessness, or horror. Note: In children, this may be expressed instead by disorganized or agitated behavior.

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

    - (3) Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.

    - (4) Recurrent distressing dreams of the event. Note: In children, there may be frightening dreams without recognizable content.

    - (5) Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience; illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). Note: In young children, trauma-specific reenactment may occur.

    - (6) Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

    - (7) Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

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

    - (8) Efforts to avoid thoughts, feelings, or conversations associated with the trauma

    - (9) Efforts to avoid activities, places, or people that arouse recollections of the trauma

    - (10) Inability to recall an important aspect of the trauma

    - (11) Markedly diminished interest or participation in significant activities

    - (12) Feeling of detachment or estrangement from others

    - (13) Restricted range of affect (e.g., unable to have loving feelings)

    - (14) Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal lifespan)

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

    - (1) Difficulty falling or staying asleep
    - (2) Irritability or outbursts of anger
    - (3) Difficulty concentrating
    - (4) Hypervigilance
    - (5) Exaggerated startle response

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

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

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

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

(Appendix F: Approval Letter)

(Approval Letter)

Date: 22nd May 2012
Name: Caroline Folland

Dear Caroline,

Re: Application for ethical approval for study 'An IPA study to explore how CBT and EMDR therapists engaged in trauma work make sense of their experiences and interpret the effects of this work'

Thank you for submitting your application for the above mentioned study which was considered by the Nursing and Allied Health Professionals Research Ethics Committee on 11th May 2012.

Your study has been **approved** and you are able to proceed. The committee commended your application and would like to use it as an exemplar for other students. If you are happy for your application to be used in this way, please could you email xxxxxxxxxxx

Please note, if any change to the study described in the application or to the supporting documentation is necessary, you are required to make a resubmission to the Nursing and Allied Health Professionals Research Ethics Committee

Yours Sincerely

xxxxxxxxxxx
Joint Chair
Nursing and Allied Health Professionals Research Ethics Committee

(Appendix G: Ethical clarification and conditions letter)

Clarification and Conditions Letter

Date: Thursday 13 June 2013
Name: Caroline Folland

Dear Caroline

Title: An IPA study to explore how CBT and EMDR therapists engaged in trauma work make sense of their experiences and interpret the effects of this work.

Thank you for submitting your ethical approval application form.

Your project has been looked at by the School of Health Committee on 4 June 2013. The following comments/suggestions were made:

The following comments/suggestions were made:

- To include in the consent form exactly what the participants need to do if they want to withdraw.
- To make clear the participants can withdraw up until the study is sent for marking or perhaps to the point of analysis. There does need to be a date set rather than just stating that there is a time-limit.
- It is not clear if any participants will be recruited from the NHS, it is assumed this is not the case. Obviously if it is, then, the student will need to go through IRAS. Section 4 outlines how participants will be sought from a primary care provider (xxxxxxxxxxx) – is this an NHS organisation?
- Including the Director of Studies contact details on the forms would be sensible.
- Is it necessary to provide the caveat about when confidentiality can be broken? It does not need to be in bold? Perhaps state that work will be undertaken via your specific code of conduct instead.

It was recommended that the application be approved by the first supervisor subject to clarification and conditions and that the first supervisor confirm in writing to the committee that amendments have been undertaken.

Yours sincerely

Professor xxxxxxxxxxx
(Chair, School of Health REC)

(Appendix H: Emails with Research and Development Directorate for clarification on NHS R&D approval for study)

Sent: 08 August 2012 10:17
To: Caz Folland
Subject: Telephone call re: Request for ethical approval for an IPA study.

Hi Caz

Thank you for sending the documents to R&D. We would assess your project as research. I need to find out about whether the XXXXXXXXXXX staff are NHS staff and the person who can help me with this is away until next week.

As soon as I have spoken to her on whether your study will require local R&D approval I will let you know.

Kind regards
XXXXXXXXXXX
R&D Clinical Trials Coordinator for XXXXXXX, PCT and CFT
Research and Development Directorate

On 06/08/2012 at 16:15, in wrote:

Hi XXXXXXXXXXX

Further to our telephone conversation, I enclose a copy of my application for ethical approval to Derby University which has been approved.

As discussed in our conversation, I work for XXXXXXXXXXX on a part time basis (contact details below), who hold the primary care contract for psychological services in XXXXXXXXXXX and am currently privately funding a professional doctorate through my own private practice at Derby University. As part of the requirement of the course, we have to do a research study which is all new to me! It is my intention to carry out qualitative research using interpretative phenomenological analysis (IPA). The research would involve interviewing staff of XXXXXXXXXXX who work with the company delivering either trauma focused CBT or EMDR, to gain an insight into their experiences of delivering these treatment modalities. XXXXXXXXXXX have agreed to me contacting their staff to request volunteers to participate in the small pilot study (2/3 participants) and further main study (4/8 participants).

I would therefore like to know if:

1. Do I need NHS approval (R&D or otherwise) as the participants are not employed NHS staff but work within the primary care contract with NHS patients (although no patients will be used for the research) under a private company?

2. If I use any therapists in private practice, presumably no approval is necessary?

3. If I do need approval, who and where should I send the forms to?

Hope this all makes sense!

Thank you very much for your help.

Caz Folland
XXXXXXXXXXX

(Appendix I: Confirmation email from Research and Development Directorate that NHS R&D approval is not required for study)

XXXXXXXXXXX
Sent: 13 August 2012 12:07
To: Caz Folland
Subject: RE: Telephone call re: Request for ethical approval for an IPA study.

Hi Caz

I have followed up your research proposal with the Assistant Research Manager and XXXXXXXXXXX. XXXXXXXXXXX have confirmed that their staff are part of a private organisation and are not NHS staff. As your research does not involve NHS staff or NHS patients you do not require NHS R&D approval.

I would advise you to let XXXXXXXXXXX know about the study to ensure that they are happy for you to contact other employees.

Good luck with your research.

kind regards
XXXXXXXXXXX

R&D Clinical Trials Coordinator for XXXXXXXXXXX, PCT and CFT
Research and Development Directorate

(Appendix J: Participant letter explaining purpose of the study)

Date

Dear

Thank you for your enquiry in relation to my research study. As you will be aware, part of the recommendations within the NICE guidelines for PTSD (2005:4) is the implementation of a course of trauma-focused psychological treatment of either trauma-focused cognitive behavioural therapy (CBT) or eye movement desensitization and reprocessing (EMDR). Due to demand on therapists working in the trauma field, increasing discussion regarding therapist reactions and the potential for a negative impact when working directly with trauma clients, is emerging.

I am presently studying for a Professional Doctorate in Health and Social Care (CBT). For the purposes of this course I am required to undertake a research study. The main aim of my study is to explore how CBT and EMDR therapists engaged in trauma work make sense of their experiences and interpret the effects of this work with a view to identifying any protective practices that may help inform clinical practice and ameliorate vicarious trauma. The objectives of the study are; (i) to carry out interviews with the selected participants to explore their experiences of working with trauma, (ii) to use an interpretative phenomenological analysis (IPA) framework to analyse the data produced from the study, and (iii) to write-up the study findings for my final thesis.

I would like to invite you to take part in the above study which puts you in an excellent position to share some useful information with me, based upon your experiences. The participation of all those who are kind enough to take part in my study will be highly valued, helping to develop future psychological services for post-traumatic stress disorder and trauma.

Your participation would entail a tape recorded interview with me at a time and place convenient to you, or by telephone. The interview would last for approximately 45-60 minutes whereby I will ask you about your experiences of your trauma work. Any information you give will remain anonymous and be used solely for the purposes of my research. Anonymity will be ensured by supplying all participants with an identifiable reference number for use in place of personal details within the research study. Only raw, unedited data transcripts will be seen by the research team and any data used for any wider purposes will be edited as previously stated for anonymity. ***However, it is important I make you aware that the exception to this is if you disclosed any information of either harm to yourself or another during the interview. If this were the case, I would be obliged to stop the session and report the disclosure to your clinical supervisor or other appropriate person.***

You will be offered a time-limited right to withdraw from my study, without explanation, notice or prejudice at any time prior, during or after the interview, together with opportunities to review transcripts for validity and to withdraw any specific comment made during your interview, which you do not want to appear

in the public domain (e.g. if the research findings are published). If you do wish to withdraw from the study, please contact me by the 31st March, 2014 when the final analysis stage begins.

Enclosed is some further information for your perusal and consideration which I would ask you to read carefully and contact me with any questions in relation thereto. If after consideration you would still like to take part in my study, I would be obliged if you would kindly sign and return the consent form in the enclosed stamped addressed envelope. Upon receipt, I will contact you to arrange a convenient time for the interview to take place.

If you are aware of any other potential participants who may be pertinent to my research study, I would be obliged if you would also kindly pass on their name and contact details so I can send them out an information pack for their consideration.

I thank you for your time and attention in considering this matter.

Yours sincerely

Caz Folland
Principal Researcher

University email : xxxxxxxxxxx
Personal mobile no: xxxxxxxxxxx

(Appendix K: Nominated participant letter explaining purpose of the study)

Date

Dear

Your name has been put forward by .... as they considered you may be interested in taking part in a research study I am currently undertaking as part of a Professional Doctorate in Health and Social Care (CBT).

Part of the recommendations within the NICE guidelines for PTSD (2005:4) is the implementation of a course of trauma-focused psychological treatment of either trauma-focused cognitive behavioural therapy (CBT) or eye movement desensitization and reprocessing (EMDR). Due to demand on therapists working in the trauma field, increasing discussion regarding therapist reactions and the potential for a negative impact when working directly with trauma clients is emerging.

For the purposes of my Professional Doctorate, I am required to undertake a research study. The main aim of my study is to explore how CBT and EMDR therapists engaged in trauma work make sense of their experiences and interpret the effects of this work with a view to identifying any protective practices that may help inform clinical practice and ameliorate vicarious trauma. The objectives of the study are; (i) to carry out interviews with the selected participants to explore their experiences of working with trauma, (ii) to use an interpretative phenomenological analysis (IPA) framework to analyse the data produced from the study, and (iii) to write-up the study findings for my final thesis.

I would like to invite you to take part in the above study which puts you in an excellent position to share some useful information with me, based upon your experiences. The participation of all those who are kind enough to take part in my study will be highly valued, helping to develop future psychological services for post-traumatic stress disorder and trauma.

Your participation would entail a tape recorded interview with me at a time and place convenient to you, or by telephone. The interview would last for approximately 45-60 minutes whereby I will ask you about your experiences of your trauma work. Any information you give will remain anonymous and be used solely for the purposes of my research. Anonymity will be ensured by supplying all participants with an identifiable reference number for use in place of personal details within the research study. Only raw, unedited data transcripts will be seen by the research team and any data used for any wider purposes will be edited as previously stated for anonymity. ***However, it is important I make you aware that the exception to this is if you disclosed any information of either harm to yourself or another during the interview. If this were the case, I would be obliged to stop the session and report the disclosure to your clinical supervisor or other appropriate person.***

You will be offered a time-limited right to withdraw from my study, without explanation, notice or prejudice at any time prior, during or after the interview, together with opportunities to review transcripts for validity and to withdraw any specific comment made during your interview, which you do not want to appear in the public domain (e.g. if the research findings are published).). If you do wish to withdraw from the study, please contact me by the 31st March, 2014 when the final analysis stage begins.

Enclosed is some further information for your perusal and consideration which I would ask you to read carefully and contact me with any questions in relation thereto. If after consideration you would still like to take part in my study, I would be obliged if you would kindly sign and return the consent form in the enclosed stamped addressed envelope. Upon receipt, I will contact you to arrange a convenient time for the interview to take place.

If you are aware of any other potential participants who may be pertinent to my research study, I would be obliged if you would also kindly pass on their name and contact details so I can send them out an information pack for their consideration.

I thank you for your time and attention in considering this matter.

Yours sincerely

Caz Folland
Principal Researcher

University email: xxxxxxxxxxx
Personal mobile no: xxxxxxxxxxx

(Appendix L: Interview schedule)

1. Can you tell me about your experiences of working with trauma clients?

2. Has there ever been a time when you feel you have become affected in a negative way by this type of work? (*Prompt: Impact upon personal or professional life?)*

3. What did you find was most upsetting/distressing? (*Prompt: How did you feel? What did you think?)*

4. Has this changed your practice in any way?

5. What treatment modality were you using at the time and do you think this had any significance? (*Prompt: T-F CBT or EMDR?)*

   Why did you choose this treatment modality over the other? (*Prompt: Could there have been any other reasons, perhaps unconscious, why you might have chosen this modality?)*

6. What 'protective' practices do you put into place when working with trauma? (*Prompt: What do you do to look after yourself? What do you do that helps you do this type of work?)*

7. Can you tell me about any positives of working in this field?

Does participant want a nominated support contacted?
Remind participant of right to withdraw.
Inform participant of next stage in research process.

(Appendix M: Consent form)

Title of Project: An IPA study to explore how CBT and EMDR therapists engaged in trauma work make sense of their experiences and interpret the effects of this work.

Name of Researcher: CAROLINE FOLLAND. Email: XXXXXXXXXXX
Personal mobile no: XXXXXXXXXXX

Director of Studies: XXXXXXXXXXX. University of Derby, Kedleston Road, Derby, DE22 1GB. xxxxxxxxxxxx

1. I confirm that I have read and understood the information sheet and have had the opportunity of ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw from the above study up until the 31st March, 2014, without giving a reason and without penalty. If I do wish to withdraw, I confirm I will contact the **researcher** on the contact details above.

3. I agree to take part in the above study and consent to my interview being audio-taped. I also understand that I can ask for the audio-tape to be turned off at any time.

4. I understand that all information given will be treated in the strictest confidence and will only be used for the purpose of this study unless I disclose any information of either harm to myself or another during the interview. If this were the case, I understand the researcher would be obliged to stop the session and report the disclosure to my clinical supervisor or other appropriate person.

5. I confirm I have not been signed off work in the last twelve months due to any mental health problem and consider myself fit to take part in this study.

6. I confirm I have asked my nominated supports (below) if they will agree to be contacted by the researcher, if needed, in case of any distress during or after my interview and these are the people I would like contacted.

Name of participant	**Signature**	**Date**
Name of researcher	**Signature**	**Date**
Caroline Folland		

Nominated supports	**Telephone Number**	**Date**
1st: 2nd: 3rd:		

One copy for participant and one copy for researcher.

(Appendix N: Company support information and contact numbers)

SUPPORT CONTACT DETAILS

XXXXXXXXXXX SUPPORT SERVICES (office hours only)

1. EAP work scheme.

xxxxxxxxxxx will be able to provide you with the approved list of Therapists from the Employee Assistance Programme and will notify them that you will be in contact. Utmost confidentiality will be maintained under all circumstances.

You will be offered up to six sessions initially. Funding of 60% towards further sessions may be agreed if necessary however you will need to pay the remaining 40% charge. If more than six sessions are needed, the EAP provider must contact us in writing for approval before arranging any further appointments.

Further details can be accessed on the Intranet.

2. Your line manager or locality manager.

xxxxxxxxxxx recommend that you approach the Personnel Manager or your Line Manager if you are comfortable in doing so, to see if any additional support can be offered at work; this may include extra supervision, a temporary reduction in hours, or additional admin support etc.

3. xxxxxxxxxxx **- supervisor.**

LOCAL SERVICES : OUT OF HOURS

1. The Samaritans - Phone xxxxxxxxxxx

2. Nightlink - Phone: XXXXXXXXXXX (5pm - midnight). Texting service XXXXXXXXXXX (5pm - midnight).

OTHER SERVICES

BABCP www.babcp.com Home page - “Find a Therapist”

BACP www.bacp.co.uk Home page - “Seeking a Therapist”

(Appendix O: General support information and contact numbers)

SUPPORT CONTACT DETAILS

1. **BABCP** www.babcp.com Home page - "Find a Therapist"

2. **BACP** www.bacp.co.uk Home page - "Seeking a Therapist"

3. **SUPERVISION.**
   You are recommended to approach your supervisor to see if any additional support can be offered to you if participating in this study causes any negative effects upon your practice; this may include extra supervision, training etc.

LOCAL SERVICES

1. **The Samaritans -** Phone xxxxxxxxxxx (24-hour helpline)
   Website: www.samaritans.org.uk

2. **Rethink** - Phone: xxxxxxxxxxx
   xxxxxxxxxxx FREE end_of_the_skype_highlighting
   Website: www.rethink.org

(Appendix P: Information on proposed study for company intranet)

VOLUNTEERS WANTED TO TAKE PART IN A RESEARCH STUDY

As you will be aware, part of the recommendations within the NICE guidelines for PTSD (2005:4) is the implementation of a course of trauma-focused psychological treatment of either trauma-focused cognitive behavioural therapy (CBT) or eye movement desensitization and reprocessing (EMDR). Due to demand on therapists working in the trauma field, increasing discussion regarding therapist reactions and the potential for a negative impact when working directly with trauma clients is emerging.

I am presently studying for a Professional Doctorate in Health and Social Care (CBT). For the purposes of this course I am required to undertake a research study. The main aim of my study is to explore how CBT and EMDR therapists engaged in trauma work make sense of their experiences and interpret the effects of this work with a view to identifying any protective practices that may help inform clinical practice and ameliorate vicarious trauma. The objectives of the study are; (1) to carry out interviews with the selected participants to explore their experiences of working with trauma, (2) to use an interpretative phenomenological analysis (IPA) framework to analyse the data produced from the study and, (3) to write-up the study findings for my final thesis.

I would like to invite you to take part in the above study. This puts you in an excellent position to share some useful information with me, based upon your experiences. The participation of all those who are kind enough to take part in my study will be highly valued, helping to develop future psychological services for Post Traumatic Stress Disorder or trauma.

Your participation would entail a private interview with me at a time and place convenient to you, or by telephone. This interview would last for approximately 45-60 minutes. If you decide to take part in this study, I can ensure that information given will remain anonymous and be used solely for the purposes of my research.

If you feel you may like to take part in my study or would like further information, please contact me via my personal contact details below (to ensure anonymity of potential participants) and provide me with a preferred contact address and phone number and I will send you out an information pack for your further reading and consideration.

If you are aware of any other potential participants who may be pertinent to my research study, I would be obliged if you would also kindly pass on their name and contact details so I can send them out an information pack for their consideration.
I thank you for your time and attention in considering this matter.

Caz Folland
Principal Researcher

University email : XXXXXXXXXXX
Personal mobile no: XXXXXXXXXXX

(Appendix Q: Jismail information on study for second recruitment phase)

VOLUNTEER TRAUMA FOCUSED *CBT & EMDR THERAPISTS (WORKING IN PRIVATE PRACTICE)* WANTED TO TAKE PART IN A RESEARCH STUDY

I am presently studying for a Professional Doctorate in Health and Social Care (CBT). For the purposes of this course I am required to undertake a research study.

The main aim of my study is:

- To explore how CBT and EMDR therapists engaged in trauma work within their private practice, make sense of their experiences and interpret the effects of this work with a view to identifying any protective practices that may help inform clinical practice and ameliorate vicarious trauma.

The objectives of the study are:

- (i) to carry out a recorded interview lasting approximately 45-60 minutes, to explore your personal experiences of working with PTSD or trauma.
- (ii) to use an interpretative phenomenological analysis (IPA) framework, to analyse the data produced from the study and to write-up the study findings for my final thesis.

The participation of all those who are kind enough to take part in my study will be highly valued; helping develop future psychological services and promoting therapist wellbeing. If you would like to take part in my study or would like further information, please contact:

Caroline Folland
Principal Researcher
University email : xxxxxxxxxxx
Mobile no: xxxxxxxxxxx

(Appendix R: Example of exploratory comments)

ORIGINAL TRANSCRIPT	EXPLORATORY COMMENTS
P. Okay, well trauma work is my bread and butter it's what I mainly do (R. Okay). Lots of road traffic accident work, lots of insurance work, and in the other sort of [pause] work I do, I much prefer doing PTSD related work (R. Okay) and I really enjoy working with people affected by trauma and yeah, I think I'm good at it (R. Okay), which helps.	Bread and butter main role. Mainly do – what else do you do? RTA, insurance work. Preference for PTSD work. Enjoy work. Other sort of work? Enjoys working with people affected by trauma. Does he enjoy it because he thinks he's good at it? Feels good at it (builds confidence).
R. So what is it you enjoy?	
P. The challenge I think. I enjoy [pause]. I think it's one of those, one of those things where with good interventions you can get people from A to B quickly. It feels quite dynamic when working with trauma (R. Okay). It feels that [pause] yes, it can really make a difference in peoples' lives.	Unsure of what part enjoys – I think? Enjoys challenge. Good interventions help move quickly. It feels dynamic – what is 'it'? Can really make a difference.
R. Okay. And when, when you're talking about good interventions can you say a little bit more about that?	
P. Either obviously, the sort of trauma focus CBT or EMDR (R. Yeah). Although I find I tend to do CBT first rather than EMDR (R. Yep, um) and I think partly that's because I [pause], whilst I find the EMDR very effective, (R. Yeah) I always have a problem describing it to clients (R. Okay) cos it sounds so much like new age hippy bollocks [R. Laughing] (R. Okay) and I always think if I come straight out with, y'know, I'm going to do this treatment that's evidence based and really effective and I'm going to wave my fingers at them [both laugh]	Uses CBT first. EMDR effective but problems describing it To clients. Is this partly why he does CBT first? New age hippy bollocks – not much credibility. Clients will run if describes straight away – go running, not engage in. Fear around clients thinking he is 'bonkers'. Is the delay in order to prove his worth as a good therapist?

(Appendix T: Example 2 of independent audit of anonymised data)

P. Okay, well um.. trauma, trauma work is my bread and butter it's what I mainly do (R. Okay). Erm.. lots of, lots of road traffic accident work, lots of insurance work, erm.. and in the, the other sort of [pause] work I do, I much prefer doing erm.. PTSD related work (R. Okay) and erm.. I, I really enjoy working with people affected by trauma and erm.. yeah I erm.. yeah, I think, I think I'm good at it (R. Okay). Which helps.

main theme
Road traffic accidents, insurance work
PTSD bias
enjoyment
re-assuring self.

R. So what is it you enjoy?

P. The challenge I think. I enjoy [pause] um.. I think it's one of those, one of those things where with good interventions you can get people from A to B quickly. It feels, it feels quite dynamic when working with trauma (R. Okay). Erm.. it feels that [pause] yes, yes, it can really make a difference in peoples' lives.

Enjoys challenge
quick results.
make a difference

R. Okay. And when, when you're talking about good interventions can you say a little bit more about that?

P. Erm.. either obviously, sort of, the sort of trauma focus CBT or EMDR (R. Yeah). Erm.. although I find, I find I tend to, I tend to do CBT first rather than EMDR (R. Yep, um) and I think partly that's because I [pause], whilst I find the EMDR very effective, (R. Yeah) I always have, I always have a problem describing it to clients (R. Okay) cos it sounds, it sounds so much like new age hippy bollocks [R. Laughing] (R. Okay) and I always think if I come straight out with, y'know, I'm going to do this, this, this treatment that's evidence based and really effective and I'm going to wave my fingers at them [both laugh] they are going to go running (R. Okay). So I always, I always wait a little while, to, to, to introduce that and I, I always, I must admit I always, I always look at sort of erm.. y'know? Deal with my psych-education. Talk about fear, talk about avoidance, talk about habituation. Erm,usually go through panic (R. Mmhm) and I think I've got quite a, y'know, a sort of a varied tool box so to speak (R. Yeah) and I kinda get, y'know, I suppose EMDR for me is always the, erm.. the, the, the, the big gun I use when all the others don't, [pause] don't work (R. Okay) I guess. (R. Okay). If that makes any sense to you?

CBT bias
effectiveness
difficulty describing
fear of scaring clients
emotions
metaphore to describe
EMDR - when others don't work
questioning reply

(Appendix U: Initial emergent themes from pilot study)

Participant 0812F1	Participant 0812T1	Participant 0812T2
<u>**Experience**</u> Young in service Images/negatives thoughts when first started Confidence <u>**Therapist distress - professional**</u> Physical changes – nauseous, heart racing, sweating Emotional changes – fear, frustration, anxiety Intrusive images/ thoughts Client dropout Loss of focus EMDR – somatic symptoms Fear of outcome – uncertainty – "the negative one's stick". Nature/severity of trauma <u>**Therapist distress - personal**</u> Images Negative thoughts Flashbacks Dreams Disturbed sleep with intrusive images on wakening Emotional changes – fear, frustration, anxiety Personal triggers EMDR – more traumatized <u>**Organisational responsibilities**</u> Unclear guidelines Training Caseload management Supervision - Developing techniques Good - Feedback from colleagues - Reminders of techniques - Being able to offload - Peer and group both have merits	<u>**Experience**</u> Not much experience at EMDR Newly qualified IAPT CBT practitioner Confidence levels <u>**Therapist distress – professional**</u> Visual images Emotional changes – upset Physical changes – tears Intrusive images/thoughts Nature/severity of trauma Role of imagination – putting self in position of third party Organisational pressures – time slots <u>**Therapist distress - personal**</u> Disturbed sleep Awakening with negative thoughts Intrusive thoughts Emotional build up Role of imagination <u>**Organisational responsibilities**</u> Training Resources Caseload management Supervision - working through trauma effects	<u>**Experience**</u> Not much recent experience of TF CBT. <u>**Therapist distress – professional**</u> Emotional changes – stressed, anxious Personal triggers Intrusive thoughts Role of imagination – running riot, putting self in position of client Organisational pressures – time slots, questioning abilities, longer working days Not having time to debrief/come down is an issue Client dropout Nature/severity of trauma <u>**Therapist distress - personal**</u> Role of imagination Intrusive thoughts Permanent changes – "everything does into memory, so it probably will always be there" <u>**Organisational responsibilities**</u> Training Supervision Caseload management Organisational pressures Legal and ethical issues

(Appendix U: cont'd)

<u>**Positives of working with trauma**</u> Positive feedback – motivational, boosts ego or confidence Wanting to help people Feeling as if you're making a difference Stimulation Feeling connected/in tune with client Increased self awareness <u>**Bias**</u> EMDR <u>**Trauma focused CBT**</u> Guided Taking them through an account <u>**EMDR**</u> Patient led Patient focused Incredible results More beneficial to client Major breakthroughs Good successes More confident at using method Enjoys variety – doing something different Uses hand taps – physically aches with eye movements (shoulder) More traumatized with this method – pluses and minuses Position to client	<u>**Positives of working with trauma**</u> Enjoy work Keen to work with trauma clients Seeing recovery/growth in client Increased self awareness <u>**Bias**</u> CBT due to training needs – didn't want to split focus <u>**Trauma focused CBT**</u> Become more involved with clients narrative <u>**EMDR**</u> More detached, more removed as not hearing narrative Not emotionally involved	<u>**Positives of working with trauma**</u> Seeing recovery of client Seeing clients reactions to process Helping client <u>**Bias**</u> EMDR <u>**Trauma focused CBT**</u> Quite intense Hearing narrative worse – video running in head Feel like "part of it" More contained <u>**EMDR**</u> More detached as not hearing narrative Don't have to reveal everything Less affected Facilitating process Position to client 'Time out' when client processing Enjoy modality Profound effect on people Good results

(Appendix U: cont'd)

Protective factors	Protective factors	Protective factors
Longer session times - gap between patients/spaced Supervision Managing caseload Therapist rituals – drink, wash, notes, breathing techniques Preparation – reading notes, room set up, positioning self, airing room Researching/having interest in subject area Exercise	Longer session times - gap between patients/spaced Supervision Managing caseload Therapist rituals – drink, notes, time to reflect Preparation for session Researching subject area Increased self- awareness to look after self	Longer session times - gap between patients/spaced Supervision Managing caseload – working autonomously Therapist rituals – drink, notes, time to reflect Treat self – takeaway coffee Exercise Getting back to normal life Reprocessing material

(Appendix V: Frequency chart of the 54 emergent themes from the Pilot study)

	THEMES	Julie	Susan	Helen
1	**Therapist experience**	X	X	X
2	**Memory recall**	X		
3	**Performance anxiety**		X	
4	**Processing feelings through interview**	X		
5	**General trauma work**		X	X
6	**Use of visual aids**		X	
7	**Impact on personal life**	X	X	X
8	**Impact of professional life**	X	X	
9	**Supervision**	X	X	X
10	**Training**	X	X	
11	**General CBT comments**	X		
12	**Positives of CBT**			X
13	**Negatives of CBT**	X	X	X
14	**General EMDR comments**	X		X
15	**Positives of EMDR**	X	X	X
16	**Negatives of EMDR**	X	X	X
17	**Intrusive thoughts**	X	X	X
18	**Intrusive images**	X		X
19	**Hearing narrative**	X	X	X
20	**Ethical responsibilities**	X	X	X
21	**Organisational responsibilities**	X	X	X
22	**Time**	X	X	X
23	**Comparisons to other working practices**			X
24	**Judgement of others**	X		X
25	**Client distress**			X
26	**Respect**	X	X	
27	**Preparing the client**	X	X	X
28	**I to us/me to we etc.**		X	X
29	**Questioning self**	X	X	X
30	**Use of laughter**			X
31	**Use of repetition**		X	
32	**Use of metaphor**	X	X	X
33	**Use of imagination**		X	
34	**Managing caseloads**	X	X	X
35	**Treatment effectiveness**	X		X
36	**Therapeutic relationship**	X		X
37	**Significant life events**	X		

(Appendix V: cont'd)

	THEMES	Julie	Susan	Helen
38	**Self-awareness**	X	X	
39	**Cognitive changes**	X	X	X
40	**Change in therapist emotions**	X	X	X
41	**Competency**	X	X	
42	**Therapist assumptions**	X		
43	**Client disclosure**			X
44	**Descriptive words for trauma work**	X	X	X
45	**Therapist expectations on self**	X	X	X
46	**Preference for model**	X	X	X
47	**Nature of trauma**	X	X	X
48	**Positives of work**	X	X	X
49	**Permanent changes to self**			X
50	**Change during treatment**	X		
51	**Protective practice**	X	X	X
52	**Barriers to treatment**	X		
53	**Personal triggers**	X		X
54	**Change in therapist physiology**	X	X	

(Appendix W: Frequency chart of the 79 emergent themes from the combined study)

	THEMES	Julie	Susan	Helen	Paul	Angela	Adrian	Claire	Laura	Justin	Jenny	David
1	**Therapist experience**	X	X	X	X	X	X	X	X	X	X	X
2	**Contradiction in earlier response**				X	X					X	X
3	**Memory recall**	X				X						
4	**Performance anxiety**		X			X					X	
5	**Inaudible data**				X		X	X		X		
6	**Loss of focus**				X					X		
7	**Processing feelings through interview**	X								X	X	
8	**Explanation of modality/theory**							X		X		
9	**Interview effect on researcher**				X					X	X	
10	**Background of therapist**								X	X	X	
11	**Client presentations**							X	X	X	X	
12	**General trauma work**		X	X		X			X	X		
13	**Use of visual aids**		X									
14	**Impact on personal life**	X	X	X	X	X	X	X	X		X	
15	**Impact of professional life**	X	X		X	X	X	X	X			
16	**Use of supervision**	X	X	X	X	X	X	X	X	X	X	X
17	**Training**	X	X		X	X	X	X	X	X	X	X
18	**General CBT comments**	X			X		X				X	
19	**Positives of CBT**			X						X		X
20	**Negatives of CBT**	X	X	X					X	X		X
21	**General EMDR comments**	X		X	X		X					
22	**Positives of EMDR**	X	X	X		X		X		X		X
23	**Negatives of EMDR**	X	X	X		X		X		X		X
24	**Intrusive thoughts**	X	X	X	X	X	X	X	X	X	X	X
25	**Intrusive images**	X		X	X	X		X	X	X		

(Appendix W: cont'd)

	THEMES	Julie	Susan	Helen	Paul	Angela	Adrian	Claire	Laura	Justin	Jenny	David
26	**Hearing narrative**	X	X	X	X	X	X	X	X	X	X	X
27	**Ethical responsibilities**	X	X	X	X	X	X	X	X	X	X	X
28	**Organisational responsibilities**	X	X	X			X	X	X		X	
29	**Time**	X	X	X	X	X	X	X	X	X	X	X
30	**Comparisons - other working practices**			X	X		X	X	X	X	X	
31	**Judgement of others**	X		X	X			X	X	X	X	
32	**Amount of trauma history/longevity**								X	X		
33	**Client distress**			X	X	X	X	X	X	X		X
34	**Respect**	X	X		X	X		X	X	X		
35	**Preparing the client**	X	X	X		X		X	X	X	X	X
36	**Insurance work**				X	X						X
37	**I to us/me to we etc**		X	X	X	X		X				
38	**Questioning self**	X	X	X	X	X	X	X		X	X	X
39	**Use of laughter**			X	X	X			X	X	X	X
40	**Use of repetition**		X		X		X	X	X	X	X	X
41	**Use of metaphor**	X	X	X	X	X	X	X		X	X	X
42	**Use of medication**									X		
43	**Use of imagination**		X	X	X				X	X	X	
44	**Managing caseloads**	X	X	X	X			X	X	X	X	
45	**Treatment effectiveness**	X		X	X			X	X	X		X
46	**Belief in method**				X			X				X
47	**Therapeutic relationship**	X		X	X			X	X	X	X	
48	**Being emotionally open (therapist)**									X		
49	**Significant life events**	X								X	X	
50	**Self-awareness**	X	X		X				X	X	X	
51	**Change in mental health**					X						
52	**Change in therapist emotions**	X	X	X	X	X	X	X	X	X	X	X

(Appendix W: cont'd)

	THEMES	Julie	Susan	Helen	Paul	Angela	Adrian	Claire	Laura	Justin	Jenny	David
53	**Change in treatment modality**				X							
54	**Competency**	X	X		X						X	X
55	**Therapist assumptions**	X			X			X	X	X	X	
56	**CPD difficulties**						X					
57	**Client disclosure**			X				X				
58	**Therapist disclosure**									X	X	
59	**Behaviour that aids thinking**						X					X
60	**Descriptive words for trauma work**	X	X	X	X	X	X	X	X	X	X	X
61	**Therapist expectations on self**	X	X	X	X	X	X		X	X	X	X
62	**Bias/preference**	X	X	X	X	X	X	X		X		X
63	**Nature of trauma**	X	X	X	X	X	X	X	X	X	X	X
64	**Positives of work**	X	X	X	X	X	X	X	X	X	X	X
65	**Permanent changes to self**			X								
66	**Change during treatment**	X				X	X		X			
67	**Change in therapist behaviour**	X			X	X				X	X	
68	**Protective practice**	X	X	X	X	X	X	X	X	X	X	X
69	**Barriers to treatment**	X			X	X				X	X	
70	**Personal triggers**	X		X	X	X	X	X	X	X	X	X
71	**Therapist stamina**									X		
72	**Therapist traits**				X							X
73	**Complex presentations**			X	X			X		X		
74	**Change in therapist physiology**	X	X		X							
75	**Moving clients on**				X							
76	**Clarification**				X	X		X			X	X
77	**Unknown outcomes**				X	X						
78	**Cognitive changes**	X	X	X	X	X	X	X	X	X	X	X
79	**Links between clients**				X							

(Appendix X: Summary of super-ordinate and stand-alone themes for the combined study)

	SUMMARY OF SUPER-ORDINATE THEMES/THEMES
1.	**COMPARISONS BETWEEN EMDR AND TF-CBT:** • Preference for particular model • Participant training • Personal experience of model • Treatment effectiveness
2.	**THERAPIST DIFFICULTIES:** • Personal triggers • Hearing trauma narrative • Use of imagination • Use of visual aids • Barriers to treatment
3.	**CHANGES WITHIN THERAPIST:** • Cognitive changes • Emotional changes • Physiological changes • Behavioural changes
4.	**THERAPIST EXPECTATIONS** • Expectations of self • Expectations of clients • Expectations of other professionals
5.	**THERAPIST JUDGEMENT** • Judgement of self • Judgement of clients • Judgement of other professionals
6.	**ETHICAL CONSIDERATIONS**

	SUMMARY OF SUPER-ORDINATE THEMES/THEMES Cont'd.
7.	**PROTECTIVE PRACTICE:** • General self-care • Managing caseloads • Therapist self-awareness • Supervision • Competence/training
8.	**POSITIVES OF TRAUMA WORK** • Post-traumatic recovery • Client feedback • Therapeutic relationship
9.	**USE OF LAUGHTER DURING INTERVIEW**
10.	**CLIENT CHANGE DURING TREATMENT**
11.	**COMPARISON TO OTHER WORKING PRACTICES**
12.	**USE OF METAPHOR**
13.	**USE OF REPETITION**
14.	**USE OF MEDICATION**

(Appendix Y: Extract from the BABCP Standards of conduct, performance and ethics)

1. You must act in the best interests of service users.
2. You must maintain high standards of assessment and practice.
3. You must respect the confidentiality of service users.
4. You must keep high standards of personal conduct.
5. You must provide (to us and any other relevant regulators and/or professional bodies) any important information about your conduct and competence.
6. You must keep your professional knowledge and skills up to date.
7. You must act within the limits of your knowledge, skills and experience and, if necessary, refer the matter to another practitioner.
8. You must communicate properly and effectively with service users and other practitioners.
9. You must effectively supervise tasks that you have asked other people to carry out.
10. You must get informed consent to give treatment (except in an emergency).
11. You must keep accurate records.
12. You must deal fairly and safely with the risks of infection.
13. You must limit your work or stop practising if your performance or judgement is affected by your health.
14. You must behave with honesty and integrity and make sure that your behaviour does not damage the public's confidence in you or your profession.
15. You must make sure that any advertising you do is accurate.

(Extract taken from the BABCP Standards of conduct, performance and ethics. The full 16 page document is available to download at www.babcp.com)

(Appendix Z: Extract from the BACP Ethical Framework)

Principles of counselling and psychotherapy

Principles direct attention to important ethical responsibilities. Each principle is described below and is followed by examples of good practice that have been developed in response to that principle. Ethical decisions that are strongly supported by one or more of these principles without any contradiction from others may be regarded as reasonably well founded. However, practitioners will encounter circumstances in which it is impossible to reconcile all the applicable principles and choosing between principles may be required. A decision or course of action does not necessarily become unethical merely because it is contentious or other practitioners would have reached different conclusions in similar circumstances. A practitioner's obligation is to consider all the relevant circumstances with as much care as is reasonably possible and to be appropriately accountable for decisions made.

Being trustworthy: honouring the trust placed in the practitioner (also referred to as fidelity)
Being trustworthy is regarded as fundamental to understanding and resolving ethical issues. Practitioners who adopt this principle: act in accordance with the trust placed in them; strive to ensure that clients expectations are ones that have reasonable prospects of being met; honour their agreements and promises; regard confidentiality as an obligation arising from the client's trust; restrict any disclosure of confidential information about clients to furthering the purposes for which it was originally disclosed.

Autonomy: respect for the client's right to be self-governing
This principle emphasises the importance of developing a client's ability to be self-directing within therapy and all aspects of life. Practitioners who respect their clients autonomy: ensure accuracy in any advertising or information given in advance of services offered; seek freely given and adequately informed consent; emphasise the value of voluntary participation in the services being offered; engage in explicit contracting in advance of any commitment by the client; protect privacy; protect confidentiality; normally make any disclosures of confidential information conditional on the consent of the person concerned; and inform the client in advance of foreseeable conflicts of interest or as soon as possible after such conflicts become apparent. The principle of autonomy opposes the manipulation of clients against their will, even for beneficial social ends.

Beneficence: a commitment to promoting the client's well-being
The principle of beneficence means acting in the best interests of the client based on professional assessment. It directs attention to working strictly within one's limits of competence and providing services on the basis of adequate training or experience. Ensuring that the client's best interests are achieved requires systematic monitoring of practice and outcomes by the best available means. It is considered important that research and systematic reflection inform practice. There is an obligation to use regular and on-going supervision to enhance the quality of the services provided and to commit to updating practice by continuing professional development. An obligation to act in the best interests of a client may become paramount when working with clients whose capacity for autonomy is diminished because of immaturity, lack of understanding, extreme distress, serious disturbance or other significant personal constraints.

Non-maleficence: a commitment to avoiding harm to the client
Non-maleficence involves: avoiding sexual, financial, emotional or any other form of client exploitation; avoiding incompetence or malpractice; not providing services when unfit to do so due to illness, personal circumstances or intoxication. The practitioner has an ethical responsibility to strive to mitigate any harm caused to a client even when the harm is unavoidable or unintended. Holding appropriate insurance may assist in restitution. Practitioners have personal and professional responsibility to challenge, where appropriate, the incompetence or malpractice of others; and to contribute to any investigation and/ or adjudication concerning professional practice

which falls below that of a reasonably competent practitioner and/or risks bringing discredit upon the profession.

Justice: the fair and impartial treatment of all clients and the provision of adequate services
The principle of justice requires being just and fair to all clients and respecting their human rights and dignity. It directs attention to considering conscientiously any legal requirements and obligations, and remaining alert to potential conflicts between legal and ethical obligations. Justice in the distribution of services requires the ability to determine impartially the provision of services for clients and the allocation of services between clients. A commitment to fairness requires the ability to appreciate differences between people and to be committed to equality of opportunity, and avoiding discrimination against people or groups contrary to their legitimate personal or social characteristics. Practitioners have a duty to strive to ensure a fair provision of counselling and psychotherapy services, accessible and appropriate to the needs of potential clients.

(Extract taken from the BACP Ethical Framework for Good Practice in Counselling & Psychotherapy. The full 15 page document is available to download at www.bacp.co.uk)