“Working with the real survivors of life”.

A grounded theory of managing the demands of trauma work in clinicians working with adult survivors of complex trauma.

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Doctorate in Clinical Psychology

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Declaration of own work
I confirm that all of the work contained within this thesis is my own, except where indicated and that I have read and understood the plagiarism rules and regulations, composed and undertaken the work myself and clearly referenced/ listed all sources appropriate.

Signed: C. Crittenden
Research Portfolio Abstract

**Background:** There is an emerging literature suggesting that clinicians can go through a process of personal change when engaging in psychotherapeutic work with trauma survivors, which parallels that experienced by clients themselves. The current evidence regarding the relationship between engaging in psychological therapy and compassion satisfaction, vicarious post-traumatic growth and vicarious resilience is inconclusive. A number of methodological weaknesses in the existing literature were identified. The review highlights the need for future research to examine the contextual, demographic and psychological factors which allow therapists to experience positive psychological outcomes from their trauma work.

**Objective:** This study aims to explore vicarious post-traumatic changes in clinicians who work with adult survivors of complex trauma and the role of organisational factors in these changes.

**Method:** Grounded theory methodology was used to analyse interview data with twelve participants (nine female and three male), all of whom had high complex trauma caseloads.

**Results:** The study generated a theory proposing that undertaking trauma work involves the interplay between numerous challenges pertaining to clinicians’ expectations of themselves, therapeutic challenges and organisational neglect. Engaging in trauma work with clients leads to psychological and emotional changes in therapists. A lack of organisational support further contributes to such changes, leaving clinicians feeling isolated and overwhelmed. In order to cope with these challenges, clinicians develop coping mechanisms in the form of emotional detachment and accessing external supports. Alongside this, clinicians identify positive effects of trauma work arising from the therapeutic relationship. These positive outcomes appear to mediate the more negative effects of trauma work, relating to psychoemotional changes and lack of organisational support.
Conclusion: These findings suggest a need for a greater understanding of the degree of reciprocity between clients, clinicians and services and the provision of trauma-informed services both for clients and clinicians.
Systematic Literature Review

Title: What is the relationship between engaging in psychological therapy with survivors of trauma and compassion satisfaction, vicarious post-traumatic growth and vicarious resilience in trauma therapists? A systematic review.

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1 Produced according to submission guidelines of Journal of Psychotramatology (see appendix 1 of thesis)

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Abstract

Objectives: This review systematically examined the literature on positive psychological outcomes in trauma therapists engaging in psychological therapy with survivors of trauma, specifically compassion satisfaction and vicarious post-traumatic growth.

Method: Relevant literature was identified from online database searches and hand searches of 3 key journals. Nine studies met the inclusion criteria for the review. These were quality assessed against predefined criteria and the findings synthesised.

Results: The 9 quantitative studies appraised were assessed as ranging from ‘reasonable’ to ‘excellent’ quality. Six studies examined the relationship between indirect exposure to traumatic and compassion satisfaction as measured by the Professional Quality of Life Scale (ProQOL, Stamm, 2005). Across the six studies examining compassion satisfaction the number of years working with trauma clients was positively associated with compassion satisfaction. Four studies examined the relationship between indirect exposure to traumatic material and vicarious post-traumatic growth in trauma therapists. All four studies measured Post-traumatic growth using the Post-traumatic Growth Inventory (Tedeschi & Calhoun, 1996).

Conclusions: The current evidence regarding the relationship between engaging in the psychological therapy and compassion satisfaction, vicarious post-traumatic growth and vicarious resilience is inconclusive. No studies were identified which examined vicarious resilience. The findings range from VPTG moderating the negative impact of secondary traumatic stress (Samios et al., 2012) whilst Linley et al., (2005) and Howard (2011) found no association between engaging in psychological therapy with survivors of trauma and VPTG. All six studies used the ProQOL scale as a measure of CS and found high potential for CS. A number of methodological weaknesses in the existing literature were identified. The review highlights the need for future research to examine the contextual, demographic and psychological factors which allow therapists to experience positive psychological
outcomes from their trauma work.

Keywords: trauma therapist(s), compassion satisfaction, vicarious post-traumatic growth, adversarial growth, vicarious resilience.
Introduction

There is a growing body of literature examining the impact of trauma work on trauma therapists. The deleterious effects of such work have been widely examined, whilst there is an emerging literature investigating the positive effects of working with trauma. It has been argued that a comprehensive understanding of the negative impact of caring for trauma survivors can not be gained without considering the potential positive outcomes that derive from being in a helping role (Stamm, 2002).

Within the trauma literature three positive psychological outcomes from engaging in trauma therapy consistently appear: compassion satisfaction (CS), vicarious resilience (VR) and vicarious post-traumatic growth (VPTG).

Compassion Satisfaction describes “the sense of fulfilment or pleasure that therapists derived from doing work well” (Larsen & Stamm, 2008, pg. 282). As such CS is not exclusive to trauma therapists but to individuals inhabiting a helping role, whereby they develop a greater sense of self, spirituality and understanding of resilience (Stamm, 2002). Previous research has highlighted the essential role of compassion in successful therapeutic work (Rigg, 2012). Given that the therapist is second only to patients as a predictive factor of therapeutic success (Wampold, 2001) it is essential that therapists and their employers ensure that they are functioning at their best within the therapeutic alliance.

The second positive psychological effect arising from indirect exposure to traumatic material is VR. This is conceptualised as the positive changes experienced by therapists, as a result of witnessing the resilience of their clients during the process of therapy (Hernandez, Gangsei, & Engstrom, 2007). Therapists in this study described noticing changes in their perceptions of the human capacity to overcome adversity, with a greater sense of hope, spirituality and changed perspective on personal challenges and difficulties (Hernandez, Engstrom, & Gangsei, 2010).

Recent evidence has also highlighted the potential for growth following indirect exposure to traumatic material, known as VPTG (Arnold et al., 2005; Ben-Porat &
Post-traumatic Growth has been described as “positive psychological change experienced as a result of the struggle with highly challenging circumstances” (Tedeschi & Calhoun, 2004, p.1). Growth of this nature is thought to lead to increased insight into personal strengths, self-confidence, self-compassion and a heightened appreciation of what is important in life (Arnold et al., 2005).

To date no current models of VPTG or post-traumatic growth have been developed. However post-traumatic growth theorists (Joseph & Linley, 2005) postulate that it is the rebuilding process, which results in increased overall well-being. Cognitive processes act to reduce the discrepancy between pre- and post- trauma perspectives leading to accommodation of new trauma-related material, which facilitates growth. However, studies have reported that trauma clinicians describe the process of growth on an emotional rather than a cognitive level (Splevins et al., 2010).

Benatar (2000) further elaborated on the process of PTG, introducing the idea of Positive Self-Transformation, the reported change in the self-system of therapists working with survivors of Childhood Sexual Abuse. The qualitative interviews in Benatar’s study revealed that the positive experiences described by therapists included themes of self-esteem, empowerment, wisdom, validation and healing. This is consistent with Splevins (2010), in which interpreters working with asylum seekers and refugees reported higher levels of self-compassion, greater acceptance towards others and increased wisdom.

Previous research (Hernández et al., 2010, Ben-Porat & Itzhaky, 2009) highlighted the need to increase awareness of both the positive and negative changes of therapeutic trauma work. Until recently the majority of research has focused on the adverse outcomes of engaging in therapeutic trauma work (Chouliara et al., 2009). However, a recent metasynthesis (Cohen & Collens, 2012) investigated the experience of vicarious trauma and vicarious post-traumatic growth in trauma workers and highlighted the need for a more balanced account of the impact of trauma work on therapists to be considered. Furthermore, previous research suggests the positive changes or psychological outcomes in therapists engaging in trauma work, such as CS, may moderate the negative changes such as compassion fatigue (Conrad
& Kellar-Guenther, 2006). This further highlights the need to gain a better understanding of the individual and organisational factors which promote positive changes in therapists. To date no systematic reviews have examined the relationship between engaging in psychological therapy with trauma survivors and positive psychological outcomes in trauma therapists. Moreover, to the author’s knowledge, no reviews have been conducted of research examining the factors that influence CS, VR and VPTG among trauma therapists exclusively. In synthesising the findings from the studies, this review aims to address the following questions:

- What contextual factors are associated with VR, VPTG and CS in trauma therapists?
- What positive or negative outcomes are associated with VPTG, CS and VR in therapists?
- What personal and demographic factors are related to VR, VPTG and CS in trauma therapists?
- What psychological processes are associated with VR, VPTG and CS in trauma therapists?

Method

Protocol

A selection protocol was developed prior to undertaking the literature search to include papers that met eligibility criteria (see Appendix 10). As suggested in guidance for undertaking reviews in healthcare produced by (York University’s Centre for Reviews and Dissemination, 2009), the present review aimed to minimise bias and maintain transparency by having a protocol with a predefined method and scope. The systematic review protocol is provided in Appendix 12.
Inclusion and exclusion criteria

Given the limited research in this area, a decision was taken to include all published and unpublished studies written in English with no date restriction applied to the search. Studies were limited to those published in English due to lack of resources for texts to be translated. Studies were eligible if they investigated and included a psychometrically validated measure of CS and/or VPTG and/or VR. Studies which employed a quantitative methodology were included within the review. For the purposes of the review the following inclusion criteria were applied when defining ‘trauma therapists’: 1) trauma therapists or counsellors working in a psychotherapeutic capacity with survivors of trauma; 2) therapists recruited from trauma specialist membership groups or clinical settings; 3) therapists must have professional status or registration and 4) must not have directly shared their client’s trauma experience (for example professionals exposed to the September 11th attacks in 2001).

Literature search strategies

The literature search was initially conducted in January 2014. A comprehensive literature review was carried out to ensure that a similar review had not been conducted. This revealed that only one similar review that been carried out, a metasynthesis investigating Vicarious Trauma and Vicarious Post-traumatic Growth in trauma workers (Cohen & Collens, 2012). To the author’s knowledge no reviews have systematically examined the quantitative literature in this area. Furthermore, Cohen & Collens (2012) metasynthesis was limited to VPTG excluding the opportunity for a wider review of the positive effects resulting from trauma work. In addition, no reviews to date have been examined the factors that are related to and/or influence VPTG, CS and VR among trauma therapists exclusively.

Systematic searches were carried out in February 2014 using the following databases: Ovid (including EMBASE (1947-2014), PsycINFO (1806-2014), Medline (1946-2014) and EBSCO (including CINAHL Plus (1990-2014), MEDLINE with Full Text (1990-2014), Psychology and Behavioral Sciences Collection (1965-2014), Spocus (1960-2014), PsycArticles (1860-2014) and ProQuest (Dissertations and Theses Full
Text, PILOTS (1871-2014), Social Services Abstracts and Sociological Abstracts (1979-2014)). All publication years provided by these databases were included until the date of the search conducted 22\textsuperscript{nd} February 2014. In an attempt to capture those studies of interest not indexed by the chosen databases a search using Google Scholar was also carried out.

The same search string was used for each database: (“vicarious post-traumatic growth” OR “adversarial growth” OR “compassion satisfaction” OR “Vicarious resilience” OR “positive outcome*” OR “countertransference” OR “positive change*” OR “quality of life”) AND (“Trauma Therap*” OR “Trauma counselor*”).

**Information sources**

The author contacted the first authors of included studies and key review articles to include any unpublished studies that might meet inclusion criteria. Eleven authors were contacted by email one of which could not be contacted due to a lack of valid email address. Three authors responded suggesting three studies which were already included within the review. Furthermore, manual searches of the references of studies included within the review, in addition to hand searches of three journals (Journal of Traumatic Stress, European Journal of Psychotraumatology and International Journal for the Advancement of Counselling were also conducted).

**Study selection**

Figure 1 (Moher et al., 2009) presents details of each stage of the selection process. Stage 1 involved screening 1030 titles for relevance; Stage 2 comprised reviewing 309 abstracts to ascertain their suitability in accordance with the predefined inclusion and exclusion criteria; Stage 3, the full text of 21 studies were reviewed to see if eligibility criteria were met, resulting in a selection of 9 studies included in methodological appraisal and assessment.
Figure 1. Flow chart of systematic review study selection

Records identified through database search n = 1075 (Proquest: 937, EBSCO: 12, EMBASE: 16 Scopus: 51, PsychArticles: 59)

Additional records identified through reference list and hand searching n=4

Duplicate records removed n= 49

Records excluded n=721

Titles screened n=1030

Records excluded n=288

Abstracts screened n=309

Full-text articles assessed for eligibility n= 21

Full-text articles excluded, with reasons n=12

Full text articles selected n= 9
Assessment of methodological quality

Quality assessment criteria were developed in order to address the review question. The quality criteria were based on guidance from the Scottish Intercollegiate Guidance Network (SIGN, 2008) and the University of York Centre for Reviews and Dissemination (CRD, 2009). A systematic review (Jarde, Losill & Vivies, 2012) examining methodological quality assessment tools of non-experimental studies was also consulted during the development of the quality assessment tool.

Studies were rated using ten quality criteria items including five dimensions of quality: research questions and objectives; sampling; design and method; statistical analysis; and generalisability. The quality criterion for each study were based upon one of the following six outcome ratings: ‘well-covered’; ‘adequately addressed’ ‘poorly addressed’, ‘not addressed’, ‘not reported’ and ‘not applicable’. For each study an overall quality rating was provided in order to avoid a poor score in one criterion skewing the overall score of an otherwise good quality study. The quality ratings were: ‘Excellent’, ‘Very good’, ‘Reasonable’ and ‘Limited’. Further descriptions of these ratings are presented in Appendix 12.

All studies were assessed by the first author and an independent reviewer. The individual item ratings, sub-totals for each domain and overall scores for each study were assessed in five studies (55%). Scoring discrepancies between raters were reviewed and amended. Exact agreement occurred on 94% (47/50) of methodological quality ratings; and differing by one point (e.g. well-covered versus adequately addressed) on 4% (2/50) of items.
<table>
<thead>
<tr>
<th>Authors /Country of Origin</th>
<th>Research objectives</th>
<th>Sample size (N) and Participants</th>
<th>Construct measured</th>
<th>Type of instrument used</th>
<th>Analyses</th>
<th>Key results</th>
</tr>
</thead>
<tbody>
<tr>
<td>(S1) Brockhouse, Msetfi, Cohen &amp; Joseph (2011) UK</td>
<td>To assess the moderating effect of sense of coherence and perceived organisational support on growth.</td>
<td>$N= 118$ Registered UK trauma therapists (27% Private practices or clinics, 32%, the public sector and 41% a combination of these settings) 8% response rate</td>
<td>Vicarious exposure to trauma Empathy Sense of coherence Organisational support VPG</td>
<td>Jefferson Physician empathy scale Sense of Coherence scale Perceived Organisational Support Scale PTGI</td>
<td>Intercorrelations Regression analyses Moderation analyses</td>
<td>VPTG was associated with older age, personal strength and appreciation of life. Therapists working in non-private practice settings and receiving more supervision reported higher levels of spiritual change. Therapists with higher empathy and lower sense of coherence reported higher levels of VPTG. Therapists’ self-reported empathy was positively correlated with New Possibilities and Appreciation for Life.</td>
</tr>
<tr>
<td>(S2) Craig &amp; Sprang (2010) USA</td>
<td>The impact of using evidence-based practices on CF, burnout, and CS in a random, national sample of self-identified trauma specialists.</td>
<td>$N= 532$ trauma therapists (44% clinical psychology and 46% clinical social work, 9% unknown) 27% response rate</td>
<td>Burnout CF CS</td>
<td>ProQOL Scale-III. Trauma Practices Questionnaire</td>
<td>$t$-tests ANOVA Hierarchical regression</td>
<td>Therapists with more experience reported higher levels of CS. Therapists level of evidence-based practices predicted statistically significant decreases in CF and burnout, and increases in CS.</td>
</tr>
<tr>
<td>(S3) Howard (2011) USA</td>
<td>To what extent does the time practicing as a trauma clinician directly predict vicarious post-traumatic growth in this sample of trauma therapists?</td>
<td>$N= 63$ trauma therapists 50% response rate</td>
<td>VPG</td>
<td>PTGI Assessment of Self-Care Spiritual Involvement and Beliefs Scale-Revised The Trauma Symptom Inventory</td>
<td>Multiple regressions</td>
<td>Therapists’ Spiritual beliefs and practices, and years of clinical practice were correlated with vicarious traumatisation but failed to reach significance in the regression models.</td>
</tr>
<tr>
<td>Authors /Country of Origin</td>
<td>Research objectives</td>
<td>Sample size (N) and Participants</td>
<td>Construct measured</td>
<td>Type of instrument used</td>
<td>Analyses</td>
<td>Key results</td>
</tr>
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</tr>
<tr>
<td>(S4) Linley, Joseph &amp; Loumidis (2005) UK</td>
<td>The potential positive effects of trauma work on therapists, with a focus on the associations of the personality construct ‘sense of coherence’ with both positive and negative changes. The associations between SOC and positive and negative changes following vicarious exposure.</td>
<td>N= 85 Trauma therapists (36% Clinical Psychologist, 22% Psychiatrist, 18% Psychotherapist, 9% Counsellor or 14% Other occupation) 56% response rate</td>
<td>SOC VPG</td>
<td>Trauma work experience Sense of Coherence Scale PTGI CiOQ</td>
<td>Pearson product-moment correlations</td>
<td>Therapists’ higher scores on SOC were associated with higher scores on positive changes and lower scores on negative changes. Trauma work experience was not found to be associated with scores on the SOC, nor with either the CiOQ or the PTGI.</td>
</tr>
<tr>
<td>(S5) McKim &amp; Smith-Adcock (2013) USA</td>
<td>What is the relationship between workplace and individual-level variables and trauma counsellors’ CS? Which predictor variables explain the most variance in CS?</td>
<td>N= 98 trauma counsellors (50% Psychologists, 26% Social workers, 22% Professional counsellors) (17% response rate)</td>
<td>CF CS</td>
<td>ProQOL Scale The Psychologist’s Burnout Inventory Stressful Life Experiences—Short Form</td>
<td>Multiple Regression Analysis</td>
<td>Counsellors’ perceived control of the workplace, personal trauma history and years of clinical experience were significantly positively related to CS.</td>
</tr>
<tr>
<td>(S6) Samios, Abela &amp; Rodzik (2013) Australia</td>
<td>Examined whether the negative effects of STS on therapist adjustment would be buffered by CS and whether the broaden-and-build theory of positive emotions could be applied to examine the factors that relate to CS</td>
<td>N= 53 therapists (5 Psychologists, 5 Counselors and 3 Social Workers) All of them have provided therapeutic services to survivors of sexual violence. (51% response rate)</td>
<td>STS CS Adjustment Positive emotions Positive reframing</td>
<td>ProQOL Scale Depression, Anxiety and Stress Scales Bradburn Affect Balance Scale Brief Cope</td>
<td>Hierarchical multiple regression Non-parametric bootstrapping</td>
<td>CS has the potential to elevate the negative effects of STS on anxiety in therapists who work with sexual violence survivors. The broaden-and-build theory of positive emotions provides a theoretical basis for the further examination of CS in trauma therapists.</td>
</tr>
<tr>
<td>Authors /Country of Origin</td>
<td>Research objectives</td>
<td>Sample size (N) and Participants</td>
<td>Construct measured</td>
<td>Type of instrument used</td>
<td>Analyses</td>
<td>Key results</td>
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<tr>
<td>(S7) Sodeke-Gregson, Holttum &amp; Billings (2013) UK</td>
<td>Investigate the reported levels of CS and CF in a national sample of UK therapists working with adult trauma clients in specialist trauma and secondary-care services.</td>
<td>N= 253 trauma therapists (69% Clinical/Counselling Psychology, 29% Psychiatry, Nursing and other; 2% social work)</td>
<td>CS Burnout STS</td>
<td>Demographic and background information questionnaire Coping Strategies Inventory ProQOL Scale (Version 5)</td>
<td>Multiple regressions</td>
<td>Older therapists and more time spent in research and development activities increases the potential for CS. Therapists’ perceived level of support from management and supervision was positively associated with CS.</td>
</tr>
<tr>
<td>(S8) Leonard (2008) USA</td>
<td>To examine the relationships among workplace variables and levels of CF and CS for therapists working with traumatized clients and/or clients in crisis.</td>
<td>N= 98 trauma therapists (50% psychologists, 26% social workers, 23% professional counselors) 28% response rate</td>
<td>CS CF</td>
<td>ProQOL Scale Psychologist’s Burnout Inventory Stressful Life Experiences Screening-Short Form</td>
<td>Correlational Analysis Regression analyses</td>
<td>CS was positively related to workplace factors (i.e., control and overinvolvement) and individual variables (i.e., personal trauma history and years of clinical experience).</td>
</tr>
<tr>
<td>(S9) Samios, Rodzik &amp; Abel (2012) Australia</td>
<td>To examine the moderating role of post-traumatic growth in the relationship between STS and adjustment in a sample of therapists who frequently work with sexual violence survivors</td>
<td>N= 61 therapists who had worked with survivors of sexual violence survivors. (86% psychologists; 8% counsellors and 4% social workers) 51% response rate</td>
<td>VPG STS Adjustment</td>
<td>STS ProQOL Scale PTGI Depression and Anxiety subscales Sense of Coherence Scale Satisfaction with Life Scale Bradburn Affect Balance Scale</td>
<td>Hierarchical multiple regression analyses</td>
<td>STS was also related to post-traumatic growth, providing support for the integrated meaning-making model. Post-traumatic growth was a positive predictor of positive indicators of adjustment and personal meaning but was unrelated to negative indicators of adjustment.</td>
</tr>
</tbody>
</table>

CS = Compassion Satisfaction  
CF = Compassion Fatigue  
VPTG = Vicarious Post-traumatic Growth  
CiOQ = Change in Outlook Questionnaire  
ProQOL = Professional Quality of Life  
PTGI = Post-traumatic Growth Inventory
Results

Study selection

A total of 1079 records were identified through the literature search (see Figure 1). Table 2 provides a summary of the number of studies excluded and reasons for their exclusion.

<table>
<thead>
<tr>
<th>Number of studies excluded</th>
<th>Reasons for exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>192</td>
<td>Different subject/research focus</td>
</tr>
<tr>
<td>49</td>
<td>Duplicate record</td>
</tr>
<tr>
<td>120</td>
<td>Sample included non-trauma therapists</td>
</tr>
<tr>
<td>3</td>
<td>Not written in English</td>
</tr>
<tr>
<td>406</td>
<td>CS or VPTG or VR not investigated</td>
</tr>
<tr>
<td>8</td>
<td>Therapists working with perpetrators of trauma not survivors</td>
</tr>
<tr>
<td>15</td>
<td>Therapists have a shared experience of trauma</td>
</tr>
<tr>
<td>273</td>
<td>Qualitative study</td>
</tr>
<tr>
<td><strong>1066</strong></td>
<td><strong>Total number of studies excluded</strong></td>
</tr>
</tbody>
</table>

Table 2. Overview of excluded studies

Included studies

Table 1 presents the nine quantitative studies selected for review. The studies originated from three different countries between 2005-2013; UK (S1, S4 and S7), Australia (S6 and S9) and USA (S2, S3, S5 and S8). The sample size ranged from \( n=53 \) to \( n=532 \), including a total of 1492 trauma therapists.

From the nine studies identified, two were unpublished theses and seven were published studies. Of these, four examined VPTG and five focused on CS. No studies were identified which examined VR within trauma therapists. All nine studies employed a cross-sectional design using statistics of association to examine the relationship between indirect exposure to trauma compassion satisfaction and VPTG. A summary of study characteristics and main findings are presented in Table 1.
Methodological quality of studies

Table 3 provides methodological quality ratings for each of the studies. The overall methodological quality of the studies ranged from excellent to reasonable. All nine studies were cross-sectional in design, addressed an appropriate, clearly focused and well defined research question drawn from theoretical models and previous research.

Sampling

The representativeness of the samples selected for each study varied. The samples were diverse, incorporating a wide range of professional backgrounds, training, experience and clinical setting. The information regarding therapist’s demographic information, professional background, personal history of trauma and work characteristics varied across studies. All samples had predominately female therapists. This gender bias may be representative of the caring professions. However, studies recruiting from trauma special interest groups need to be interpreted with caution. Sabin-Farell & Turpin (2003) highlight that therapists with lower levels of secondary traumatic stress (perhaps due their motivation and interest in the trauma field) are more able and willing to take part in research.

The studies reviewed varied with regard to how much information was provided in relation to the number of participants approached, the number who actually took part and the number who declined, or only completed part of the questionnaires. Only seven of the nine studies provided information about response rate. In the remaining two studies the recruitment method of the selected studies (for example through therapists organisational networks) made it difficult or impossible to determine the response rate.

Samples size varied greatly between studies and only two of the nine studies provided power calculations. The response rate was relatively low in comparison to previous studies (such as a national survey of psychologists’ abuse history, their training and competence in the area of abuse (Pope & Feldman-Summers, 1992) and an empirical
study examining the effects of trauma work on trauma therapists (Pearlman & MacIan, 1995); with rates varying across studies (8%-56%) and across sub-samples within the same study (11.6% and 17%; S8). The low response rates highlight the potential for selection bias and could be attributed to concerns regarding participants’ confidentiality, as seen in studies investigating vicarious traumatisation (Way et al., 2004).

The description of therapists’ caseloads varied across the studies. The majority of studies provided limited information regarding the nature and severity of trauma their clients had been exposed to. This could be attributed to client confidentiality and the ethical challenges of gathering this information (Chouliara et al. 2009).

**Design, outcome measures and statistical analysis**

All studies adopted a cross sectional design limiting the potential inferences to be made about the directionality of the relationships (S9 and S1). None of the studies included a comparison group. All studies employed self-report measures, introducing the possibility of bias due to social desirability. Furthermore, the use of internet-based surveys, used by majority of the studies, introduces the possibility that someone other than the intended person completed the questionnaire (Leonard, 2008). This therefore raises questions regarding the potential for performance bias in the included studies.

Table 1 presents the measures used to assess VPTG and CS for each study. All studies measuring CS used a version of the Professional Quality of Life Scale (ProQOL; Stamm, 2005). The ProQOL is a 30-item self-report questionnaire measuring CS and compassion fatigue (including burn out and secondary traumatic stress). Whilst the ProQOL is designed to be used in its continuous form, cut scores have been outlined by Stamm (2010) with scores on the CS subscales which are less than 44 falling within the 25º percentile, scores less than 50 are within the 50º percentile and scores over 57 falling within the 75º percentile. Previous studies (Stamm, 2010) have demonstrated test validity in the ProQOL with alpha reliabilities for the scales ranging from good to excellent reliability (CS: SD= 10; α.88). Convergent validity has been demonstrated using multi-trait multi-method analysis (Campbell & Fiske, 1959). Only three studies in the current review (S2; S7 and S8) reported details regarding the
validity and reliability of the ProQOL (Stamm, 2005).

All four studies measuring VPTG used the PTGI (Taku et al., 2008; Tedeschi & Calhoun, 1996). The PTGI is a 21-item self-report questionnaire consisting of five subscales: Relating to Others, New Possibilities, Personal Strength, Spiritual Change and Appreciating of Life. Tedeschi & Calhoun (1996) reported that the internal consistency coefficient of the PTGI to be .90. PTGI demonstrates satisfactory internal consistency, test-retest (.71) reliability, and discriminant validity (Weinrib et al., 2006; Shakespeare-Finch & Enders, 2008). However Bitsch, Elklit & Christiansen (2011) and Moore et al., (2010) argue that growth is not adequately defined within the PTGI and suggest that perhaps the inventory measures coping, positive reframing or adaption. In the current review, three studies (S3, S4 and S9) reported details of the psychometric properties of the PTGI (Tedeschi & Calhoun, 1996). However no studies provided details of the validity and reliability for the use of PTGI within the trauma therapist population.

In terms of confounding factors, there was variability within the studies with regard to the reporting of personal trauma history, with some studies including this within their investigation (S3, S5 and S8). However some studies (S4; S2, S6 and S9) chose not to gather this information. As a result studies are unable to differentiate between therapists personal response to trauma and their clients’ traumatic material (Chouliara et al., 2009). In relation to growth, no studies included the type of trauma events or time elapsed since vicarious exposure within their analysis. With regard to the level of CS no studies allowed for or measured the intensity of exposure to trauma. Some studies did measure personality characteristics (such as empathy, sense of coherence, self care, spirituality, change in outlook, coping strategies, mood and resilience) and organisational support (S1, S3, S4, S9 and S7).

The majority of studies utilised statistics of association (e.g. correlation or regression analysis). Analyses in all studies were appropriately reported and justified, with the majority outlining how parametric assumptions were explored. One study seemed to be particularly robust (S2) with regard to statistical variables. This study, and those of Study 7 and Study 3 were the only studies to report being sufficiently powered.
Quality of reporting and generalisability

The generalisability of the papers reviewed was adequately addressed across all studies. The variability in the amount of information provided may be related to journal word restrictions, especially when comparing published studies with unpublished theses. The primary factor in limiting the generalisability of studies was the low response rate and lack of information about those who chose not to participate in the study. The recruitment method for all the studies may have led to bias in sampling with only highly motivated therapists choosing to participate (Leonard, 2008). Furthermore, the lack of information about non-responders prevents an exploration of whether non-responders and responders were systematically different. The findings of these studies should therefore be generalised with caution, as they may not be representative of the trauma therapist population.

Synthesis of results

The relationship between engaging in psychological therapy with survivors of trauma and Compassion Satisfaction and Vicarious Post-Traumatic Growth?

Four studies examined the relationship between vicarious exposure to trauma and VPTG in trauma therapists, with all studies employing the PTGI as a measure of growth. VPTG ranged from a mean of 40.46 (SD=21.82, S1) to 47 (SD=22.62, S4), which is considerably lower than that of Tedeschi and Calhoun (1996) original study (M=69.75, SD=20.47). None of the included studies employed cut-off scores that would allow for identification of VPTG.

Samios et al., (2012) indicated that the negative impact of secondary traumatic stress on therapist working with survivors of sexual violence was moderated by post-traumatic growth. Brockhouse et al., (2011) found that having a strong sense of
coherence (defined as an individual’s view of the world, specifically focusing on comprehensibility, manageability and meaningfulness) negatively predicted growth, whilst empathy was a positive predictor of post-traumatic growth. Linley et al., (2005) found no association between engaging in psychological therapy with survivors of trauma and VPTG. Howard (2011) failed to find a significant relationship between engaging in psychological therapy with survivors of trauma and VPTG.

Six studies investigated the relationship between vicarious exposure to trauma and CS with all studies using the ProQOL scale as a measure of CS. All six studies found high potential for CS, in accordance with Stamm’s (2010) guidelines. The average range of CS (scoring less than 50 on the CS subscale of the ProQOL) ranged from 38.8% (S7) to 46% (S2). Sodeke-Gregson et al., (2013) found that from their sample of trauma therapists 53% had average potential for CS, whilst 38% had high potential and 8% had low potential for CS.
### Table 3. Ratings of study quality for included studies.

<table>
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<tr>
<th>Study</th>
<th>1</th>
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<td>N/APP</td>
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<td>Reasonable</td>
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<td>N/ADD</td>
<td>N/APP</td>
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<td>W/C</td>
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</tr>
<tr>
<td>Leonard (2008)</td>
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<td>N/ADD</td>
<td>N/APP</td>
<td>A/A</td>
<td>N/APP</td>
<td>N/APP</td>
<td>W/C</td>
<td>A/A</td>
<td>N/ADD</td>
<td>A/A</td>
</tr>
</tbody>
</table>

**Legend:**
- **W/C:** Well covered
- **N/ADD:** Not Addressed
- **A/A:** Adequately Addressed
- **P/A:** Poorly Addressed
- **N/A:** Not Reported
- **N/APP:** Not Applicable

### Notes:
- **1:** The study addresses an appropriate and clear focused question.
  - **6:** Compassion satisfaction, Vicarious Post-traumatic Growth and Vicarious Resilience is measured in a valid and reliable way.
- **2:** The characteristics of the participants are representative of the trauma therapists.
  - **7:** Confounding variables were taken into account.
- **3:** Adequate response rate.
  - **8:** Appropriate analyses used.
- **4:** Characteristics of non-responders included.
  - **9:** Sample size was sufficient for analysis and sufficiently power.
- **5:** Compassion Satisfaction, Vicarious Post-traumatic Growth and Vicarious Resilience were defined and operationalised.
  - **10:** The findings could be generalised to similar populations.

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Systematic Review 22
Contextual characteristics

Organisational support and specialised trauma training

Brockhouse et al., (2011) found that perceived organisational support (as measured by the Perceived Organisational Support Scale) did not predict VPTG. Therapists receiving more supervision reported higher levels of spiritual change (as measured by the PTGI). Three studies examined the relationship between organisational support and CS. Leonard (2008) found that therapists with more of a sense of control over their work environment (as measured by Psychologist’s Burnout Inventory, Ackerley et. al., 1988) had higher ratings of CS. Consistent with these findings, McKim & Smith-Adcock (2013) found that therapists with greater perceived control over work activities (as measured by Psychologist’s Burnout Inventory, Ackerley et al., 1988) reported higher levels of CS. Sodeke-Gregson et al., (2013) found that therapists’ perceived supportiveness of their manager and perceived supportiveness of supervision were significant positive predictors CS. Furthermore, time spent engaging in research and development activities positively predicted CS. Craig & Sprang (2010) was the only study to examine specialist trauma training with individuals receiving training in trauma, reporting significantly more CS than those without training.

Years of clinical experience with trauma survivors and vicarious exposure

Two studies examined the relationship between years of experience working with survivors of trauma and VPTG. Howard (2011) found no statistically significant relationship between the number of years practicing as a trauma therapist and VPTG. This is consistent with Linley et al., (2005) findings, in which no association was found between trauma work experience (consisting of frequency of therapists work with trauma clients and the total amount of time spent in therapy with clients per month) and VPTG. However, Brockhouse et al., (2011) found that the cumulative amount of vicarious exposure to trauma work predicted VPTG.

Three studies examined the relationship between years of experience working with survivors of trauma and CS. Leonard (2008) found that CS was positively correlated
with reported years of clinical experience (defined as the number of years working in clinical practice). Craig & Sprang (2010) found that years of clinical experience predicted higher potential for CS. However in this study the definition of clinical experience is not outlined. Furthermore, recent findings by McKim & Smith-Adcock (2013) found a significant relationship between years of clinical experience (defined as years working as a therapist) and CS.

Positive or negative outcomes associated with VTPG and CS

Samios et al., (2012) found that depression and anxiety (as measured by the Depression, Anxiety and Stress Scales, Lovibond & Lovibond, 1995) were unrelated to VPTG. However, VPTG was a positive predictor of adjustment (including depression and anxiety as measured by the Depression, Anxiety and Stress Scales, life satisfaction as measured by the Satisfaction with Life Scale (Diener, Emmons, Larsen, & Griffin 1985) and personal meaning, as measured by the meaningfulness subscale of the Sense of Coherence Scale (Antonovsky, 1987). Furthermore, the authors found that VPTG has a direct impact on positive affect (as measured by Bradburn Affect Balance Scale, Bradburn, 1969) for therapists. Using the same sample, Samios et al., (2013) found that therapists with high levels of CS were protected from the negative effects of secondary traumatic stress on anxiety. Therapists’ level of CS was found to have no association with secondary traumatic stress and increased depression. The authors found a direct pathway between positive emotionality and CS.

Personal and demographic factors

Two studies examined the relationship between age and positive psychological outcomes. Brockhouse et al., (2011) found that older age was associated with VPTG. More recently, Sodeke-Gregson et al., (2013) found that older therapists had an increased potential for CS. Two of the ten studies examined the role of personal trauma history in relation to CS. Leonard (2008) found higher levels of therapists’
personal trauma history (as measured by the Stressful Life Experiences-Short Form, Stamm 1997) were associated with higher levels of CS. Consistent with these findings, McKim & Smith-Adcock (2013) found that counsellors with greater personal trauma experiences had higher levels of CS. Furthermore, Howard (2011) found a significant correlation between therapists’ personal trauma history and VPTG. However, regression analysis revealed that personal trauma history did not predict VPTG.

**Psychological processes associated with VPTG and CS**

**Sense of coherence and empathy**

Sense of coherence was examined in relation to VPTG (S1 and S4). Both studies used the Sense of Coherence scale (Antonovsky, 1987) with Brockhouse et al., (2011) using the short form of the scale. No statistically significant relationship was found between sense of coherence and VPTG (as measured by the PTGI). However, higher sense of coherence was found to result in higher scores of positive change (such as valuing relationships) and lower scores on negative changes (such as lacking trust in other people) as measured by the Change in Outlook Questionnaire (Williams & Joseph, 1993). Furthermore, Brockhouse et al., (2011) investigated the role of empathy in relationship to VPTG. The authors found that empathy (as measured by the Jefferson Physician empathy scale, Hojat et al., 2002) and sense of coherence directly predicted growth. Interestingly, the authors found that empathy was a significant moderator ($\beta = -.20; p = .018$) of the relationship between vicarious exposure to trauma and a specific aspect of growth, relating to others. Moreover, higher levels of empathy were related to higher levels of growth with the exception of spiritual change.

**Clinical Setting and Therapeutic orientation**

One study examined the role of clinical setting on VPTG. Brockhouse (2011) found that therapists working in non-private practice settings reported higher level of spiritual change (as measured by the PTGI). Furthermore, only one study
investigated the relationship between therapeutic orientation and CS. Sodeke-Gregson et al., (2013) found that level of CS in trauma therapists was associated with evidence-based practice. This specifically related to the use of NICE guideline-evidenced models such as trauma focused cognitive behavioural therapy. This was consistent with Craig & Sprang’s (2010) findings that evidence-based practices (as measured by the Trauma Practices Questionnaire, Sprang & Craig, 2007; Craig & Sprang, 2009) predicted statistically significant increases in CS.

**Discussion**

The relationship between engaging in psychological therapy with survivors of trauma and VPTG, CS and VR is inconclusive. No studies were identified which examined vicarious resilience. The findings range from VPTG moderating the negative impact of secondary traumatic stress (Samios et al., 2012) whilst Linley et al., (2005) and Howard (2011) found no association between engaging in psychological therapy with survivors of trauma and VPTG. Six studies investigated the relationship between vicarious exposure to trauma and CS. All six studies used the ProQOL scale as a measure of CS and found high potential for CS with the average range of CS between 38.8% (S7) to 46% (S2).

**Strengths of review**

This is the first systematic review exploring VPTG and CS in trauma therapists. In addition, unpublished studies were included within the review as suggested by Lipsey and Wilson (2001) in order to reduce the likelihood of upward bias within published studies. As a quality measure, a random selection of five studies were independently rated by a second rater. These studies were selected by using the online research randomiser (www.random.org) thereby limiting the potential for subjective bias in methodological analysis.
Limitations of review and future research

This review is not without its limitations. Firstly, the restricted use of studies published in English may have excluded potentially relevant studies. Secondly, as no studies were identified which examined vicarious resilience future research is required to add to the literature in this area, and establish further links among variables hypothesised to predict VR, VPTG and CS in trauma therapists. As more research is conducted in this area, meta-analytic techniques could be used to investigate the effect sizes for associations among variables hypothesised to predict VPTG and CS.

Thirdly, the measures of vicarious post-traumatic growth were designed to measure growth from direct trauma and not vicariously. This raises questions about the validity of vicarious post-traumatic growth within these studies and the conclusions drawn in this review. Future research could include measures designed to assess vicarious post-traumatic growth amongst those indirectly exposure to trauma. As a larger body of evidence develops in this area, reviews could include studies employing measures designed to assess VPTG in therapists. Finally future studies should include comparison groups or between group comparisons within the same sample in order to allow causal inferences to be made about the relationship between constructs.

Implications for clinical practice

The findings of the review have implications for recruitment, training and supervision of trauma therapists. The review highlights the importance of potential for both VPTG and CS as a result of engaging in psychotherapeutic work with trauma clients. The need for organisational support in the form of support from managers and supervisors as well as the need for therapists to have control over workplace activities has been highlighted. The findings also emphasise the potential for years of clinical experience and evidence based practice in predicting CS. Furthermore, therapists’ personal trauma history was associated with higher level of CS. These findings highlight the need for future research particularly in relation to demographic and contextual factors, such as the therapeutic orientation, in relation to CS and VPTG.
**Conclusion**

Until recent years there was limited research investigating the positive psychological outcomes of engaging in psychological therapy with trauma survivors. A number of good quality cross-sectional studies have been carried out across three countries UK, USA and Australia. The studies highlight the relationship between engaging in psychological therapy with survivors of trauma and positive psychological outcomes (specifically CS and VPTG). The current review suggests the need for future research to examine the contextual, demographic and psychological factors which allow therapists to experience positive psychological outcomes from their trauma work. High quality research in this area will allow a better understanding of the factors that promote and sustain therapists’ wellbeing.
References


Stress, 24, 735–742.


Thesis Aims and Objectives

1) To examine the process of vicarious post-traumatic change in clinicians who work with adult survivors of complex trauma.

2) To explore the impact of organisational factors (supervision, training and peer support) in relation to psycho-emotional changes.

3) To develop a substantive theory which reflects the experiences of clinicians working with adult survivors of complex trauma.
Title: A grounded theory of managing the demands of trauma work in clinicians working with adult survivors of complex trauma.

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Abstract

Background: There is an emerging literature suggesting that clinicians can go through a process of personal change when engaging in psychotherapeutic work with trauma, which parallels that experienced by clients themselves.

Objective: The current study aimed to explore vicarious post-traumatic changes in clinicians who work with adult survivors of complex trauma and the role of organisational factors on these changes.

Method: Grounded theory methodology was used to analyse interview data with twelve participants (nine female and three male), all of whom had a high complex trauma caseload.

Results: The study generated a theory proposing that undertaking trauma work involves the interplay between numerous challenges pertaining to clinicians’ expectations of themselves, therapeutic challenges and organisational neglect. Engaging in trauma work with clients leads to psychological and emotional changes in therapists. A lack of organisational support further contributes to such changes, leaving clinicians feeling isolated and overwhelmed. In order to cope with these challenges, clinicians develop coping mechanisms in the form of emotional detachment and accessing external supports. Alongside this, clinicians identify positive effects of trauma work arising from the therapeutic relationship. These positive outcomes appear to help therapists to manage the negative effects of trauma work, relating to psychoemotional changes and lack of organisational support.

Conclusion: These findings suggest a need for a greater understanding of the degree of reciprocity between clients, clinicians and services and the provision of trauma-informed services both for clients and clinicians.

Keywords: complex trauma, vicarious traumatisation, vicarious post-traumatic growth, trauma informed organisational culture, compassion satisfaction.

Article Word Count: 5991
Introduction

Herman (1992) first used the term ‘complex posttraumatic stress disorder’ (CPTSD) to explain psychological symptoms, including difficulties related to: emotion regulation, inter- and intra-personal difficulties, self-perception and the perception of the perpetrator (Spermon, Darlington & Gibney, 2010). Courtois and Ford (2009) further define CPTSD as “involving traumatic stressors that (1) are repetitive or prolonged; (2) involve direct harm and/or neglect and abandonment by caregivers or ostensibly responsible adults; (3) occur at developmentally vulnerable times in the victim’s life, such as early childhood; and (4) have great potential to compromise severely a child’s development” (p1).

To date empirical research has endeavoured to gain a greater understanding of complex trauma from the perspective of survivors, in order to develop effective interventions (Warshaw, Sullivan & Rivera, 2013). However, it has been suggested that therapists can go through a process of “deep personal transformation” when engaging in psychotherapeutic work with trauma clients (Pearlman, 1999, p.51). This transformation allows therapists to experience personal changes, which “parallel those experienced by clients themselves” (Rosenbloom, Pratt & Pearlman, 1995, p.67). More recently, Knight (2013) emphasised the importance of organisations normalising and validating these parallel processes within supervisory structures. A number of possible negative and positive psycho-emotional and vicarious changes have been proposed, namely Vicarious Traumatisation (VT), Secondary Traumatic Stress (STS), Vicarious Post-traumatic Growth (VPTG) and Compassion Satisfaction (CS).

Negative Psychoemotional Impact

VT is thought to lead to disrupted cognitive schemas and intrusive trauma imagery, as a result of empathic engagement with clients’ trauma experiences (Pearlman & MacIan, 1995). VT developed from Constructivist Self-Development Theory as proposed by McCann and Pearlman (1992). At the core of the theory is the belief that all individuals hold self and world schemas leading to expectations about the world. It
is these fundamental schemas, including trust, control and safety, which are impacted by empathic engagement with traumatic experiences, leading therapists to challenge their own worldview. STS (the stress related emotional and behavioural response of individuals working in a supportive capacity with survivors of trauma) has also been demonstrated as an outcome of trauma related work. Dalton (2001) found that the amount of non-evaluative supervision received by social workers was inversely related to levels of STS. Supervisees reported lower levels of STS with greater amounts of supervision, suggesting that the amount and accessibility of supervision plays a role in reducing symptoms of STS.

**Positive Psychoemotional Impact**

Empirical research highlights the possibility of positive change following indirect exposure to traumatic material, known as PTG (Arnold et al., 2005; Linley et al., 2005; Linley & Joseph, 2007; Tehrani, 2007; Ben-Porat & Itzhaky, 2009; Bauwens & Tosone, 2010). PTG has been described as “positive psychological change experienced as a result of the struggle with highly challenging circumstances” (Tedeschi & Calhoun, 2004, p.1). Growth of this nature is thought to lead to increased insight into personal strengths: self-confidence; self-compassion and a heightened appreciation of what is important in life (Arnold et al., 2005). In addition, CS has been demonstrated as a potential positive outcome of engaging in trauma work. CS, in relation to trauma work, is thought to comprise of three elements: degree of job satisfaction; perceived level of competency and degree of control regarding workload and level of peer support (Stamm, 2002). This is consistent with McKim & Smith-Adcock’s (2013) findings, whereby counsellors’ perceived control over work related activities were significantly related to CS.

**Organisational Implications: Trauma-Informed Organisational Culture**

Larsen & Stamm (2008) suggest that the quality of life of clinicians comprises of both positive and negative influences on a number of systemic levels, both individual and organisational. An understanding of both factors is essential in appreciating the impact of trauma work on clinicians (Hernández et al., 2010). Much of the current research regarding VT is theoretical and focuses upon individual rather than
organisational interventions preventing VT. Recent findings highlight the importance of considering professional and workplace expectations on clinicians’ well being (Graham & Micheal, 2014).

Hernández et al., (2010) explored the impact of trauma on therapists and developed an integrative training framework in order to allow therapists and their supervisors to attend to both the positive and negative ways they are impacted by their work. The study highlighted the importance of therapists viewing themselves and their clients within an integrated system in which reciprocity plays a fundamental part of the interplay between VT and PTG. The recommendations highlighted by Hernández et al., (2010) have also been suggested by previous studies such as Ben-Porat & Itzhaky (2009). The authors argued that the implementation of organisational structures, in which therapists are given the space to process their difficulties and nurture self compassion, can greatly influence their ability to manage the emotional distress they face in their professional lives. This is further supported by Walker (2004), who emphasises the importance of exploring emotional impact within the supervisory relationship in order to respond to trauma-related dynamics, such as denial and secrecy.

Empirical findings have emphasised the importance of trauma-informed services, clinical practice and organisational cultures. In implementing such practices it aims to impact each level of the systemic structure, with the impact of indirect trauma being considered for every member of the service (Arledge & Wolfson, 2001). In creating and maintaining an informed organisational culture it enhances organisational resilience, increasing the likelihood of effective clinical practice.

**Present Study**

While there is growing evidence supporting vicarious PTG following primary trauma in the general population (Calhoun & Tedeschi, 1999; Helgeson et al., 2006, Weinrib et al., 2006; Park et al., 2008) there are far fewer studies investigating this phenomenon in therapists engaging in complex trauma work (Arnold et al., 2005, Linley et al., 2005; Tehrani, 2007, Ben-Porat & Itzhaky, 2009; Bauwens & Tosone,
Quantitative methods have been used to investigate both positive and negative impacts (Chouliara, Hutchison & Karatzias, 2009; Linley et al., 2003; Linley & Joseph, 2007). Such methods are hypothesis driven, testing for the presence or lack of VT or VPG. However, Sabin-Farrell & Turpin (2003) reported that empirically valid and reliable measures of VT were as yet unavailable and that qualitative methods would allow for an explorative, broader examination of vicarious post-traumatic experiences.

At present, there is no existing model of VPG or VT that specifically applies to clinicians working in the field of complex trauma. In order to increase our understanding a number of methodological limitations need to be addressed (Chouliara et al., 2009). In addition, there is a lack of research investigating the impact of supervision and training on post-traumatic changes amongst clinicians. The current study aimed to explore vicarious post-traumatic changes in clinicians who work with adult survivors of complex trauma and the role of organisational factors on these changes.

**Method**

**Design**

Qualitative methods are best suited to examining phenomena where little is known about them (Morse & Field, 1995), and therefore a constructivist grounded theory method (Charmaz, 2006) was adopted. This methodology was indicated as it values inter-subjectivity, requires systematic and deductive analysis and would allow a broader examination of the vicarious post-traumatic changes within clinicians who engage in therapeutic work with clients of complex trauma. The social constructivist position requires a reflexive stance in relation to the gathering and interpretation of the narratives, whilst acknowledging the prior knowledge of the researcher in creating a theoretically derived explanation.
Participants and procedure

All 12 participants were NHS clinicians who currently engage in individual therapeutic work with adult clients of complex trauma. Inclusion criteria were that their complex trauma clients made up at least 50% of their current caseload, a minimum of two years experience of working with adult clients of complex trauma, and a good understanding of the English language. Therapists providing purely directive psycho-educational support for adult clients of complex trauma and not delivering psychotherapeutic interventions were excluded. Table 1 provides demographic information for the sample.

Following ethical approval from the University of Edinburgh Ethics Committee, an email was sent to all heads of departments in the local NHS board inviting therapists to take part in the research. Those interested in participating were asked to contact the lead researcher by email and were provided with an information sheet and consent form outlining the nature and purpose of the study. This indicated a requirement to talk about a clinical case, not known to the researcher, involving therapeutic work with a survivor of complex trauma (using the definition provided by Courtois & Ford, 2009). A purposive sampling technique was used, by recruiting participants who have the potential to provide rich data on the topic under investigation (Coyne, 1997). Subsequent recruitment followed initial coding of transcripts. This allowed for theoretical sampling of further participants until the researchers considered that theoretical sufficiency (Dey, 1999) had been achieved.

Interview

Interviews were carried over a 5-month period at the participant’s place of work or the lead researcher’s office. Prior to the interview, participants completed a questionnaire to gather the information provided in Table 1.

Interviews ranged from 35 minutes to 1h 21 minutes. A semi-structured interview schedule was devised and amended following a pilot interview. In accordance with Charmaz’s (2006) principles of qualitative interviewing, all participants were asked to
describe a clinical case in order to tap into specific autobiographical memories. Each interview was digitally recorded, transferred to a digital file and transcribed verbatim (following principles employed by Jefferson, 2004) by the lead researcher. All transcripts were anonymised and digital recordings deleted. All interview data were stored and the analysis was supported by the computer software NVivo 10.

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Table 1

**Participant Characteristics**

Key: CBT= Cognitive Behavioural Therapy   CAT= Cognitive Analytic Therapy
PP= Psychodynamic Psychotherapy          IPT= Interpersonal Therapy
GS= Group Supervision                     IS= Individual Supervision
F= Female                                  M=Male
PT= Part time                               FT= Full time
Analysis

<table>
<thead>
<tr>
<th>Stage</th>
<th>Steps Taken</th>
</tr>
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<tr>
<td>Stage 1</td>
<td>Open coding</td>
</tr>
<tr>
<td></td>
<td>Line-by-line coding of the raw data, which reflected the actual words used by interviewees, and assisted in identifying key concepts within the data. A code was attached to each unit of meaning.</td>
</tr>
<tr>
<td>Stage 2</td>
<td>Focused coding</td>
</tr>
<tr>
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<td>Focused coding was employed to allowed large segments of data to be synthesised. Comparative methods, across interviews, were adapted in order for the researcher to establish inter-relationships between categories, which allow theory generation. This allowed subsequent interviews to seek further information, through theoretical sampling, which developed properties of emerging categories and enabled consideration of the diversity in the data.</td>
</tr>
<tr>
<td>Stage 3</td>
<td>Theoretical analysis</td>
</tr>
<tr>
<td></td>
<td>The third stage involved theoretical analysis, building relationships between categories, which were woven together to generate a substantive theory. The categories, which were most meaningful, prominent and had greatest explanatory power, rose to the level of theoretical concepts. Clustering was used to support the memo writing process (Charmaz, 2006) and to allow the researcher to examine the relationship between the focused codes. This process was repeated until theoretical sufficiency occurred with no new insights emerging. In conjunction with examining the existing literature, the categories were integrated to develop a model.</td>
</tr>
</tbody>
</table>

Table 2 Grounded theory procedure
Quality Assurance

The research process, including design and interpretation, was guided by Weed’s (2009) quality considerations for grounded theory research. In order to keep the process of analysis as transparent as possible, memos were kept in order to document the development of, and connection between, the themes as they developed. Memos were also used throughout the research process and at each phase of analysis to aid the development of theoretical categories. The memos also allowed the researcher to be explicit about their reflections as well as alerting the researcher to potential personal biases (Elliot & Lazenbatt, 2005). An audit trail of analysis was used to chart the analytic process, including extracts from the raw data. In terms of theoretical sensitivity, the researcher’s role in the research process this was explicitly considered and documented in the memos. The researcher had some experience of working with adult clients of complex trauma and had pre-existing collegial relationships with some of the participants. Given the nature of the analytic process within grounded theory, triangulation of the data was ensured with multiple interviews and comparison both within and across interviews. Member checking was conducted to ensure the acceptability and authenticity of the model. A random sample of six participants were selected using the online research randomiser (www.random.org) and were contacted by email. All respondents agreed that the model accurately reflected their experiences of clinical practice.

Results

Figure 2 illustrates the key categories and sub-categories which arose from the exploration of the influence of organisational factors on the psychoemotional impact in clinicians who work with adult survivors of complex trauma. Within this, participants described their experience in three broad categories: ‘Challenges’, ‘Psychoemotional impact’ and ‘Coping’.
Findings were integrated to create a grounded theory of the experience of clinicians.

**Figure 2: Organisation of categories**

- **Challenges**
  - Personal Challenges
  - Organisational challenges
  - Challenges from clients
    - Interpersonal trauma dynamics
    - Level of experience
      - Team expectations
      - Lack of recognition
      - Policy drivers
      - Supervision needs
      - Resources and training
      - Intensive emotions
      - Intrusive imagery
      - Preoccupied with clients

- **Psychoemotional impact**
  - Emotional impact
  - Organisational influence
    - Isolation
    - Hypervigilance
    - Cynicism
  - Change of perspective
    - Detachment
    - Therapeutic benefits
    - Accessing support
    - Behavioural changes
    - Educative others
    - Advocating

- **Coping**
  - Retreating behind models
  - Boundaries
  - Compartmentalising
  - Intellectualising
  - Humour
who work with adult clients of complex trauma. The theory is illustrated in Figure 3 outlining the researcher’s interpretation of the interview data.

Figure 3: Managing the demands of trauma work

The theory proposes that undertaking trauma work involves the interplay between challenges pertaining to clinicians’ expectations of themselves, therapeutic challenges and organisational neglect. The therapeutic challenges of being viewed as neglectful and inadequate but also idealised by clients parallel the clinicians’ experience of the organisations employing them. Clinicians faced a discrepancy between their expectations and what their organisations offered in terms of supervision, resources and training. Engaging in trauma work with clients leads to psychological and emotional changes in therapists. A lack of organisational support further contributes to such changes, leaving clinicians feeling isolated and overwhelmed. In order to cope with these challenges, clinicians develop coping mechanisms in the form of emotional detachment (intellectualising and ‘retreating behind models’) and accessing external
supports (personal therapy and friends). In addition, Clinicians described taking an advocate role for their clients and educating others about the impact of trauma. Alongside this, clinicians draw on the positive effects of trauma work which arise from the therapeutic relationship (such as having a sense of privilege and personal effectiveness). These positive outcomes appear to mediate the more negative effects on clinicians relating to lack of organisational support.

**Analysis**

**Challenges**

Participants articulated the challenges they face in meeting the expectations from these different domains: primarily their clients, their organisation and their own personal expectations.

*Therapeutic Challenges*

All participants narrated the challenge of meeting their client’s expectations of the therapeutic relationship. Within the therapeutic interaction, clinicians experienced being perceived by clients as inhabiting a number of different roles which are likely derived from trauma related interpersonal dynamics. In relation, to a clinical case, one participant described being idealised:

She had a neglectful and abusing experience from her mother. She doesn't know what is a realistic thing is and she has selected me as the ideal figure to save her (P1).

Equally, participants described being perceived by clients such as inadequate, neglectful and intrusive.

…they blame you if it's not going right and you’re not being good enough” (P1).
…the patient can find you neglectful for not listening, or if you do listen and ask then they find that intrusive (P3).

Challenges associated with the organisation

Clinicians described the challenge of managing their colleague’s expectations of them:

I work in a Multiple Disciplinary Team, they don't understand the sophistication of the relational dynamics and they feel quite threatened by them. I had a meeting with the keyworker and the person concerned. And umm there were unrealistic expectations at that meeting and I guess looking back I should have worked with the keyworker to get the expectations down a wee bit, because part of the personality stuff that was going on the person had incredibly, overly high expectations of me (P1).

Furthermore, participants described the challenge of meeting the organisations’ expectations of them and the influence of policy drivers:

We had a sort of change of management and supervisor who was more structured and focused on how they worked and wanted more of a throughput to the service (P2).

Participants described a lack of understanding and recognition from the organisation of the impact of complex trauma on both clients and clinicians:

About three quarters of the people that come through the door have complex trauma issues. I don’t think they are picked up I don’t think they are recognised um and um to be honest I don’t think the impact on the staff across the board is recognised (P2).

Alongside this, clinicians equally described the challenge of not having their own expectations met by their organisation regarding supervision and training:
The supervision arrangements where I work aren’t enough to sort of support me in working at an emotional level with complex trauma. We have to fight really hard to try and get more than just that basic level of supervision and training (P2).

Some participants described feeling challenged by the dual role of supervisor and line manager:

You become very reliant on that supervisor being somebody who you feel confident in but you take your emotional stuff to supervision but also of that person as your manager I think it is even more difficult to be vulnerable I think and to talk about struggling with feelings (P2).

In contrast, two participants described feeling “lucky” by not being pressured to meet organisational demands and having their supervision needs taken seriously:

I think we are really fortunate that we are not under pressure to have really high caseloads or to be seeing lots of complex cases back to back. There is definitely that kind of culture within the team of having a balance of caseloads and kind of managing your own diaries. The other bits of the work are seen as important as clients, you know, so doing consultations or training (P11).

**Personal challenges**

When talking about their clinical cases, participants described the challenge of meeting their own personal expectations of attending to their clients needs:

When I was first starting out I think what I took to saving everybody, you know. You want to help everybody. You want to make a difference. You want to feel like you can make a difference to everybody (P2).

This was linked to the feeling of responsibility participants have for their client’s safety and emotional wellbeing:
I feel very responsible that they are safe (P9).

I was only one of her few social contacts (P12).

The sense of responsibility was described as being associated with the severity of client’s trauma symptoms:

I think it’s almost in some ways almost feels like that sense of responsibility almost feels proportional to that sliding scale of intensity severity (P4).

This sense of responsibility was also linked to the exclusive role participants held within their teams and the perceived lack of understanding with regard to trauma related dynamics from their team members:

There is an inflated sense of responsibility because it is more exclusive to the work that we do (P9).

**Psychoemotional Impact**

Participants described the psychological and emotional impact of facing the challenges described in category 1. The initial psychological and emotional impact of hearing trauma disclosures and “dealing with intensive emotions” (P4), was described by all participants. These emotions ranged from feeling “frustrated” (P6, 10 and 12) to an increased sense of “vulnerability” (P7, 8 and 11). One participant also described feeling both “sad”, “tearful”, “numb” and “detached” (P3). Three participants described feeling “shocked” (P2, 7, and 8). Participants reported experiencing a range of negative psychoemotional impacts such as intrusive imagery:

I found myself dreaming about skeletons and so this patient was very invasive and it was very disturbing (P3).
Difficult parts of the session that would be replaying in your mind (P5).

The difficulty carrying the knowledge of the client’s experiences was described by one participant as a “toxic burden” (P12). Participants also spoke about being preoccupied with clients outside of work:

Client work, um, it’s probably more in my kind of conscious mind outside of work at the end of the day (P2).

The organisational challenges were described by participants as having a psychoemotional impact on them:

The pressures of working in the health service can be overwhelming (P10).

Some clinicians described feeling isolated and neglected by the structures and individuals in place to support them:

I don't feel that people want to hear how difficult or complicated it is working with these patients sometimes (...). It’s very, very difficult to sort of wave the flag around and no one paying attention sorta thing. It makes you feel very alone. (P1).

A change of perspective

Participants explained that their clinical work impacted their perspective on the world, leading them to feel more cynical and hyper vigilant:

I have a sense that sexual abuse and trauma is everywhere and that is a reality of life. It’s insidious. It can’t be escaped (P6).

If one of my friends becomes upset or goes into a crisis I might catch myself imagining that they are not going to be able to have the resources to cope (P3).
Coping

All participants narrated the development of self-preservation strategies which allow them to ‘cope’ with the challenges they face in relation to their work.

Detachment

Participants described a range of coping and defence mechanisms, primarily emotional detachment:

When you are listening to this stuff emotionally, you don’t let yourself connect with it because it would just be too difficult having to feel you can connect with it without the kind of support we are talking about. You find a way of surviving by kind of, um, detaching emotionally from stuff (P2).

Detachment took many forms such as intellectualising, using humour and ‘retreating behind models’:

Just to make light of it even though it, yeah, it’s black humour, um, but I like black humour anyway so it’s something that I find helpful as a way of coping (P4).

You retreat behind models and you keep things quite intellectual, um, so I think that is what I have done in the absence of having, you know, a sort of containing supervision space. I think that is something that I kind of learnt as a defensive strategy (P2).

Accessing support

Participants discussed their experience of current or previous personal therapy being a coping mechanism in allowing them to share and express psychoemotional impact of their work:
I think I find it generally helpful to go to therapy when you have an intense affect and just to express it (P3).

However, four participants made no reference to personal therapy in relation to their work with clients and instead relied on colleagues, friends and family for emotional support:

It is very common for me to go home and then offload it. I think that’s probably one of my survival things (P2).

*Therapeutic benefits*

All participants expressed a sense of privilege from their clinical work:

You do get surprised by people’s capacity for cruelty but such an enormous privilege to be part of a system that is there to try and fix that (P12).

Within this, participants described the rewards, sense of satisfaction and personal effectiveness they gain from being part of clients’ therapeutic progress and witnessing their resilience:

There is something about the human capacity to survive and grow, even under these awful, awful conditions, that can be quite inspiring and uplifting. Um, it can feel good to be part of someone’s process of recovery (P11).

Participants reported having a renewed perspective as a result being in therapeutic relationship with clients:

When you do vicariously pick up a sense of freeing up, when someone has really been able to let something go and then start a fresh with it, kind of made you see life in a, just like, what’s really important? It’s not necessarily your pension or the next job in three years, kind of, sort of, more of I think the growth that I have seen in a patient, it’s like they just kind of appreciate the
basics and whatever. So yes I think you pick up a bit of that renewed perspective sometimes (P3).

Behavioural changes

Some participants explained that their clinical work had led to educating others about the impact of trauma and advocating for survivors of trauma.

I often find myself kind of making that point to people that may not know and they may assume that if you have been raped once you are going to be damaged and have trouble, which isn’t the case. I often find myself wading in about that and advocating for patients (P3).

Discussion

The aim of this study was to explore vicarious post-traumatic changes in clinicians who work with adult survivors of complex trauma and the role of organisational factors on these changes. To the author’s knowledge, this is the first model to explore these factors within clinicians who work primarily with adult survivors of complex trauma.

The findings revealed that clinicians face challenges within three domains of their trauma work, relating to personal, professional and clinical issues. Many of these challenges arise from the expectations that clinicians have of themselves, those placed on them by the organisation they work within and the expectations that they perceive their clients to have of them. These findings contribute to recent literature examining the influence of personal, professional and workplace expectations on professional practice and well-being (Graham & Micheal, 2014). The expectations therapists expressed having of themselves; particularly their sense of responsibility for clients could be viewed as an indication of VT, specifically relational disturbance and over identification. This is in keeping with Lee et al’s., (2011) meta-analysis which revealed that job stress specifically client over-involvement and identification was the most significant positive correlation with burn out.
In keeping with previous research in the area, engaging in trauma work with clients leads to psychological and emotional changes in therapists. Consistent with Pearlman and Saakvitne (1995) model of vicarious traumatization organizational, interpersonal, developmental and historical factors influenced the changes described by clinicians. In order to counteract the overwhelming impact of engaging in this type of work, clinicians develop a number of defence mechanisms. The literature suggests that defense mechanisms plays a role in response to vicarious posttraumatic responses. Adams and Riggs (2008) found therapists utilizing an adaptive defense style such as suppression, sublimation and humour, illustrated lower levels of vicarious trauma. This compliments, Herman (1992) observation that avoidant and intrusive defense mechanisms arise as a result of vicarious traumatization.

Consistent with previous findings (Walker, 2004; Ben-Porat & Itzhaky, 2009) there was a spectrum of coping mechanisms employed and variation in terms of the degree to which such coping mechanisms were utilised. This appeared to be related to the perceived level of organisation support. Namely, those clinicians working within services in which the emotional impact of trauma work on clinicians is not acknowledged, tended to rely on detachment related coping strategies such as intellectualising and ‘retreating behind models’. Such findings are consistent with Lee et al., (2011) meta-analysis illustrating a negative correlation between detachment, (specifically depersonalization) and burnout (Lee et al., 2011). These findings are consistent with Cieslak et al., (2014) meta-analysis of the relationship between job burnout and STS among workers with indirect exposure to trauma, which illustrated the strong associations between job burnout and STS. Sadly, only three clinicians (two of which were from the same service) described working within a trauma-informed service culture, in which there was an awareness and acknowledgment of the emotional impact of trauma work on clinicians. This was evidenced by emotion-focused supervision, balanced caseloads, collegial support and value placed on (and time afforded to) undertaking indirect clinical work. Within these services, participants described their workplace promoting CS whilst acknowledging the potential for STS and VT. Tippany, White cress and Allen Wilcoxon (2004) emphasis the potential for supervision to reduce the potential for vicarious trauma by
normalising countertransference reactions thereby altering cognitive and image distortions, which may arise from trauma work. This highlights the need for trauma informed care models to be implemented routinely in all services dealing with clients who have experienced trauma.

The findings also identified the role of the positive effects of therapeutic trauma work in helping clinicians to maintain motivation and continue their clinical practice. Such findings are consistent with previous studies, with clinicians consistently reporting VPTG (Arnold et al., 2005; Linley & Joseph, 2007) and CS (McKim & Smith-Adcock, 2013), as playing a key role in allowing them continue working with this client group. In contrast to previous research which suggests that CS will only emerge in clinicians working in trauma informed services (McKim & Smith-Adcock, 2013), the current study found that elements of CS were apparent amongst clinicians who described working in a non-trauma informed service and in those who did not have control over their caseload management. This raises the question of whether autonomy and control, in relation to clinical work, is an essential component of CS.

In line with previous research (Knight, 2013) the findings also suggested a parallel processes which play out for clinicians and their clients. The present study highlighted the potential for organisations and clinicians to engage in their own trauma-related dynamics, with clinicians feeling that their expectations are not meet by their organisation and instead are left feeling neglected by their employers. Despite this, the current study revealed that clinicians experienced a degree of both VT and VPTG in relation to their work, which is consistent with other research (Arnold et al., 2005; Linley et al., 2005; Linley & Joseph, 2007). These findings evidence the need for organisational cultures which acknowledge and manage the therapeutic, organisational and personal challenges for trauma clinicians, thereby addressing the psychoemotional impact of this work but also increasing the potential for growth and increased resilience in these clinicians.
Clinical Implications

The preliminary findings have a number of implications for clinicians and organisations working with clients. At an organisational level, the findings suggest a need for services, teams and managers to have a greater understanding of the challenges faced both by clients and clinicians engaging in therapeutic trauma work. Services with a lack of appreciation of the potential reciprocal roles between clients, clinicians and services may not have an appreciation of the need for clinicians to have balanced and manageable caseloads, and a sense of control regarding time management. Equally imperative seems to be understanding and acknowledgment by the service of the importance of clinicians carrying out indirect clinical work (delivering training, supervision and consultation). Furthermore, the findings are consistent with Figley’s (1995) multi-factor compassion stress and fatigue model. This further emphasises the need for clinicians and organisations to consider the role of empathy, traumatic material, caseload management, life events and having a sense of competency in relation to preventing and mitigating compassion fatigue.

The findings also highlight the need for clinicians in this field to have dedicated time to reflect on the potential impact that their work has them. Most participants identified expressed that the interview had been the first time they had reflected on their experience in this way, particularly in relation to the emotional impact, and they welcomed the opportunity. This would suggest that current organisational and service structures, such as supervision, might not pay sufficient attention to these issues.

Limitations and recommendations for future research

The current study suffers from a number of limitations, which need to be taken into consideration. The substantive theory derived from the clinician’s narratives is a preliminary model created from a modest sample size. Further research is needed in order to establish whether this theory can add clinical value for other clinicians working with a high complex trauma caseload. The decision was taken not to ask
clinicians about their personal history of trauma following advice during the ethics procedure; however this could be considered a limitation of the study. There is also a lack of consistency regarding the therapeutic modality utilised by each clinician. However this is a reflection of the different approaches used in relation to complex trauma. Furthermore, the pre-existing relationship of the researcher with many of the participants may be a both an advantage and disadvantage within the study and needs to be considered in relation to the current findings. Future studies could test the theoretical model using a mixed methods approach in order for triangulation of quantitative data, qualitative data and current literature.

Conclusions

The issues raised by clinicians’ emphasise the need to promote an organisational culture in which importance and value is placed on facilitating an integrated supportive team environment with trauma-informed supervision, whereby process-issues are explored within the supervisory relationship. The findings also indicate that organisations and clients would benefit from education regarding the positive vicarious post-traumatic changes and the value in nurturing the conditions which facilitate these.
References


Knight, C. (2013). Indirect Trauma: Implications for Self-Care, Supervision, the


McKim, L.L., & Smith-Adcock, S. (2013). Trauma Counsellors’ Quality of Life.


Extended Results

This chapter outlines the development of the grounded theory ‘Managing the demands of trauma work’, which arose from participant narratives. Three core categories were identified and are presented in relation to their respective subcategories, which depict the concepts and processes forming each of the core categories. The chapter starts with a depiction of the core categories as presented in Figure 2. In addition to the quotes outlined the journal article, an explanation of these core categories and their associated subcategories will be outlined with exemplar verbatim extracts from the interview data.

The overarching theme was ‘Managing the demands of trauma work’. Participants described their experience in terms of three broad categories: Challenges, Psychoemotional impact and Coping.

All twelve participants described the personal, organisational and clinical challenges from clinical work. Within this category participants spoke about the sense of responsibility they feel for their clinical work and the challenges of therapeutic progress. The therapeutic relationship also presented a challenge for participants in terms of the potential for interpersonal dynamics to emerge such as clients perceiving therapists as neglectful, inadequate, abusive, and ‘special’. Clinicians also faced challenges from their organisation with participants describing unrealistic team expectations, the demands of policy drivers, a lack of acknowledgement of the impact of complex trauma both on clinicians and clients and not having their supervision and training needs met.

The second category to emerge was the psychoemotional impact of engaging in clinical work with clients. Clinicians described the emotional impact of experiencing a range of intensive emotions, feeling incompetent, intrusive imagery and being preoccupied with clients. Participant also noticed a change in perspective, becoming hyper vigilant and cynical. Alongside this clinicians described the organisational influence upon the psychoemotional impact of therapeutic work feeling overwhelmed and isolated as a result of both the clinical work and lack of organisational support.
The third category to emerge was the *coping* mechanisms clinicians use to counteract the psychoemotional impact of their work. Participants spoke about adopting emotional detachment strategies such as intellectualising, compartmentalising and humour. Within this category, participants described protecting themselves by having clear boundaries and ‘retreating behind models’. Participants spoke about accessing emotional support from personal therapy, friends and family as a form of coping. Furthermore, clinicians coped by making behavioural changes such as educating others about the impact of trauma and advocating for clients. Alongside this clinicians spoke about the benefits from therapeutic work helping them cope with the challenges and psychoemotional impact of their work. Participants identified a sense of privilege, personal effectiveness and a renewed perspective as the positive effects of trauma work helping clinicians to maintain motivation and continue their clinical practic
Figure 2: Organisation of categories

Managing the demands of trauma work

Challenges
- Personal Challenges
  - Responsibility
  - Expectations for progress
- Organisational challenges
  - Interpersonal trauma dynamics
- Challenges from clients
  - Intrusive imagery
  - Preoccupied with clients
  - Intensive emotions
- Level of experience
  - Team expectations
  - Lack of recognition
  - Policy drivers
  - Supervision needs

Psychoemotional impact
- Emotional impact
  - Hypervigilance
  - Optimism
- Organisational influence
  - Isolation
- Change of perspective
  - Detachment

Coping
- Therapeutic benefits
- Accessing support
- Behavioural changes

Extended Results
Interview findings by category

Challenges

Personal challenges

Responsibility

Five participants described the sense of responsibility they felt in relation to their clinical work. The responsibility related to managing client safety and risk.

Excerpt: Participant 9

“I feel very responsible that they are safe“.

The level of responsibility was mediated by the severity of client’s trauma symptoms:

Excerpt: Participant 4

“I think it’s almost in some ways almost feels like that sense of responsibility almost feels proportional to that sliding scale of intensity severity”.

Participants also explained the sense of responsibility they felt in being one of the only people to hear about client’s experiences but also being one of their only supports:

Excerpt: Participant 12

“One of my ladies who was referred in after a road traffic accident and has a history of abuse (...) and we got to the point where she was very depressed and withdrawn from everything and I was one of her only social contacts”.

Extended Results
Another participant explained the sense of responsibility she feels in being available for clients:

**Excerpt**: Participant 6

“I guess because I have been in that job for so long there is a sense of, if anybody comes back I will still be here”.

Participants described their emotional experience of having this sense of responsibility for their client’s safety, which linked with participants’ experience of the emotional impact they reported from engaging in clinical work:

**Excerpt**: Participant 2

“Are they going to be ok? It triggers anxiety and vulnerability in me probably and a sense of responsibility for them I think is probably where that comes from”.

*Level of experience*

Participants explained that their level of experience related to their expectations for themselves within their clinical work with clients:

**Excerpt**: Participant 9

“Rather than getting too bogged down with the 'always a big happy ending' kind of thing (...) for some women I think there is no way out. Some of the cases we have here you do find yourself thinking ‘my god (...) how are we ever going to overcome that’ so there’s no point getting too melodramatic about it (...) there are some situations where some women just cannot get away from”.

**Excerpt**: Participant 2
“When I was first starting out I think what I took to saving everybody you know you want to help everybody you want to make a difference you want to feel like you can make a difference to everybody”.

Excerpt: Participant 5

“Having faith in your therapy and having faith in your ability and confidence and I think that just comes with experience”.

Therapeutic progress

Participants described the challenges they faced in relation to therapeutic progress. Participants described struggling with the pace of therapy both in terms of knowing how to adjust the pace of therapy in accordance of with the client’s needs but also managing expectations in terms of the speed of therapeutic progress.

One participant explained that clients can become “stuck” within their relational patterns, which could also be replicated within the therapeutic relationship at times:

Excerpt: Participant 6

“Sometimes with people who are stuck and maybe don’t see some of the patterns”.

Challenges associated with the organisation

Team expectations

Clinicians described the challenge of managing the teams’ expectations of them and the lack of understanding of the relational dynamics, which can take place between clients, clinicians and services.

Excerpt: Participant 1

Extended Results
“I work in a Multiple Disciplinary Team, they don't understand the sophistication of the relational dynamics and they feel quite threatened by them. I had a meeting with the keyworker and the person concerned. And umm there were unrealistic expectations at that meeting and I guess looking back I should have worked with the keyworker to get the expectations down a wee bit, because part of the personality stuff that was going on was that the person had incredibly, overly high expectations of me”.

**Negative cases**

Participants 11 and 12 made no reference to the experience of feeling challenged by their services expectations.

**Lack of recognition**

Seven participants described a lack of understanding and recognition of the impact of complex trauma on clients and clinicians:

**Excerpt: Participant 2**

“About three quarters of the people that come through the door have complex trauma issues um I don’t think they are picked up I don’t think they are recognised um and um to be honest I don’t think the impact on the staff across the board is recognised”.

Participants who worked in services, in which they felt there was a lack of acknowledgement of the potential impact of trauma work on them, also described not feeling that their supervision needs were adequately addressed:

**Excerpt: Participant 2**
“There hasn’t been, probably for me, enough of an opportunity to talk about how the emotional impact of my work, you just have to get on with it to some extent”.

**Excerpt:** Participant 6

“There is a bit of a lack of recognition of supervision needs. I’m hoping that changes“.

Some clinicians described feeling neglected, by the structures and individuals in place to support them in carrying out their work effectively:

**Excerpt:** Participant 1

“So you know I don't feel that people want to hear how difficult or complicated it is working with these patients sometimes so (...). I find it quite difficult. It’s very, very difficult to sort of wave the flag around and no one paying attention sorta thing”.

Seven participants described wishing for these feelings of neglect to be addressed:

**Excerpt:** Participant 9

“You need more support, praise and acknowledgement to know that you are doing the right thing. I sometimes feel that the NHS doesn't acknowledge the work that we do”.

*Negative cases*

Participants 11 and 12 made no reference to the experience of neglect in relation to their work with clients.

*Policy drivers*

Participants described the influence of policy drivers and the demands placed on them:

Extended Results
Excerpt: Participant 7

“Meeting targets is hard”.

Excerpt: Participant 10

“The pressures of working in the health service can be overwhelming”.

and the impact of these demands on their clinical work in terms of providing an effective service:

Excerpt: Participant 8

“We've rolled out other areas with no extra resources (...) previously I would have the capacity to work weekly with some women but now I have to be fortnightly because I'm covering south as well, there’s only me and two others, so if someone cancels an appointment it's a month before they're seen again which is not good”.

Supervision needs

These unrealistic expectations appeared in participant’s description of caseload management and supervision needs:

Excerpt: Participant 2

“I am not sure there is a recognition at senior level within our team about the impact of that on the team and what that means in terms of our supervision and training needs”.

And

Excerpt: Participant 2

Extended Results
“I don’t feel particularly that the supervision arrangements where I work are enough to sort of support me in working at an emotional level with complex trauma”.

Participants described supervision needs being challenged by management:

Excerpt: Participant 2

“From within the service, because is a medical nurse based service, we have one hour a month of supervision. Our manager essentially gets questioned when we ask for more than one hour a month of supervision, because that is not the guidelines within the service, so its about a lack of recognition I think for the unique needs of psychologists”.

And

Excerpt: Participant 7

“I get a decent amount of supervision but that has been challenged recently”.

Clinicians spoke about fighting against the current supervision arrangements and expectations:

Excerpt: Participant 2

“Within the service, because of the work that we do, we have to fight really hard to try and get more than just that basic level of supervision. It just doesn’t feel enough. So there is that side of it that we are always wanting more supervision and I think our manager does feel a little bit of like the pressure from above not to give us the space for too much supervision. I think peer supervision lately has provided a convenient opportunity to have that box ticked”.

Participants described the dual role of supervisor and line manager:
Excerpt: Participant 2

“You know my supervisor is first and foremost a manager and doesn’t sort of work in a way where they kind of recognise the emotional impact and would not encourage talking about the emotional impact of the work that you are doing”.

One participant spoke about the difficulty of having a supervisor as a line manager:

Excerpt: Participant 7

“I really really don’t think that is helpful. I think supervision needs to feel safe and especially for the kind of work that we are doing. I think it does need to be separate from my manager responsibilities. It’s not always easy being supervised by your manager because boundaries do get crossed”.

Resources and training

Participants spoke about the discrepancy between the expectations of clinical work and training needs:

Excerpt: Participant 2

“You know you need to have models which recognises the emotional impact because CBT won’t recognise the emotional impact on you it’s a very intellectual model. I’m continually argue to try and get training whether its DBT or whether it compassion focused therapy. You fight tooth and nail to try and skill yourself up. I suppose you are fighting against the system”.

And:

Excerpt: Participant 2
“I think again within the service that we work in it is very difficult to justify or to argue a case for training in other psychological therapies. The problem is with the matrix and everything and Psychologists are up here doing this highly complex work but that then means that these psychologists have to have the training and skills of the models to do that work. Someone asks for that training and you get told, “well no you can’t go on that training because there isn’t money or training” or “we can’t support you in doing this”.

Negative cases
Participants 11 and 12 made no reference to the experiences challenges from their organisation.

Challenges associated with clients

Interpersonal trauma dynamics

All participants described the challenges of managing the interpersonal dynamics between them and their clients and being mindful not to re-enact the client’s attachment relationships, created within their trauma experiences, such as neglect, intrusion and abuse. One participant described the therapeutic relationship as a “stormy rocky road” (Participant 3).

When asked to draw on particular clinical case Participant 3 described the challenge of engaging in and maintaining a therapeutic relationship and being perceived as neglectful:

Excerpt: Participant 3

“We just won’t talk about it but then that feels very neglectful and the patient can find you neglectful for not listening or if you do listen and ask then they find that intrusive”.

Extended Results
Furthermore, all participants acknowledged the challenge of providing ‘good enough’ care for these clients and meeting their expectations:

**Excerpt:** Participant 1

“They blame you if it's not going right and your not being good enough”.

Some participants described the powerful nature of the therapeutic relationship and the potential for this relationship to be viewed as abusive:

**Excerpt:** Participant 1

“I would say that is a deeply unpleasant relationship where she is positioning me as the abuser most of the time”.

Some participants described being idealised and positioned within a ‘special’ relationship:

**Excerpt:** Participant 1

“She had a neglectful and abusing experience from her mother. She doesn't know what is a realistic thing is and she has selected me as the ideal figure to save her mmm (...) so that's the sort of dynamics we've been working with”.

**Excerpt:** Participant 6

“It’s being aware of that kind of special relationship sometimes that people can try and pull you into. I think she struggles to let people in and she has let me in. I am conscious that I don’t want to get into that special therapists role but she does struggle to speak to other people”.

One participant also described the difficulty of managing the therapeutic relationship and the ruptures that take place within this relationship:
Excerpt: Participant 12

“What happens is you have a little therapeutic rupture because you see their reaction to the fact that you are closing down and not listening”.

All participants described the challenges posed to them in engaging in therapeutic work with clients.

Psychoemotional impact

Emotional impact

Intensive emotions

Participants explained the challenge of “dealing with intensive emotions” (Participant 4) in relation to client’s trauma experiences and disclosures.

Three Participants described feeling “shocked” (Participant: 2, 7, 8 and 11) and “overwhelmed” (Participant: 4, 6,10 and 11) and while hearing about the client’s traumatic experiences.

Excerpt: Participant 6

“There was that sense of feeling totally out of my depth”.

Three participants explained feeling “frustrated” (Participant 6, 10 and 12) and an increased sense of “vulnerability” (Participant 7, 8 and 11). One participant also described feeling both “sad”, “tearful”, “numb” and “detached” (Participant 3).
Intrusive imagery

Some participants reported being “traumatised” by intrusive imagery and dreams:

**Excerpt:** Participant 7

“She described a lead up to an incident of abuse but it was very visual. The image just stuck with me and made me think of just how wee she must have been, and how powerless she must have been. I suppose you put your own image onto that and that stuck with me, as the way she described it I could totally see it and her it. It just made me think of how small she was and that stuck with me a wee bit and it would come into my head a bit in the week”.

**Excerpt:** Participant 3

“I found myself dreaming about skeletons. This patient was very invasive and it was very disturbing”.

Negative cases

Participant 4 made no reference to changes in mood in relation to his work with clients.

Preoccupied with clients

Four participants described being preoccupied and worried about clients outside of work:

**Excerpt:** Participant 2

“Client work um its probably more in my kind of conscious mind outside of work at the end of the day.”

**Excerpt:** Participant 6

Extended Results
“Know you get the odd thing popping into your mind at home”.

Excerpt: Participant 5

“Difficult parts of the session would be replaying in my mind (P5)”.

Organisational influence

Isolation

Participants described feeling isolated in a number of ways. For example, the lack of acknowledgement of the unique needs of clinicians working with clients and the lack of immediate collegial support after hearing clients’ disclosures:

Excerpt: Participant 8

“We do a lot of clinics so we could be all over the place and after a session you can be left with it and you know” (P8).

Excerpt: Participant 7

“It would be lovely to have that link to other psychology teams as sometimes you feel quite isolated, so it would be great to have those links”.

and lack of resources:

Excerpt: Participant 10

“Basically we have four people plus one locum, who is about to leave. In the department and it’s basically two of us running the show”.

Clinicians also described not feeling supported by their service:

Extended Results
**Excerpt: Participant 1**

“It's just the service that doesn't really understand. OK. I don't think the service is good for Psychologists. OK. It's not supportive no matter what it says”.

**Change of perspective**

*Hyper vigilance*

**Excerpt: Participant 7**

“I had a client who talked about abuse when she was young, she presented with depression but she was quite graphic and I remember that sticking with me (...) it was sexual abuse between siblings (...) and I remember my partner at the time, there was a "stay away from me" sort of thing (...) it troubled me for a couple of weeks and so I didn't have a great time then, I didn't feel that supported”.

**Excerpt: Participant 5**

“If I have been listening to a horrific abusive story. I have noticed that my perceptions can kind of change and then when I am with my partner, it can have a knock on impact. There has to be a reality check, “this is a safe situation this isn’t a disclosure””.

Participants described a reduced sense of safety:

**Excerpt: Participant 5**

“Your sense of safety and knowledge of what can actually happen in the world it opens your eyes. I don’t know if that is particularly a good thing, all the time”.

Extended Results
**Cynicism**

**Excerpt: Participant 6**

“I have a sense that sexual abuse and trauma is everywhere and that is a reality of life. I suppose a bit cynical. I do wonder whether I have a sense that the world is actually quite, not a nasty place, but that sexual abuse and trauma is everywhere and that is a reality of life I suppose. A bit cynical um not I don’t know it just seems as if the world out there, you know, is just, insidious it can’t be escaped”.

For some participants this change to their perspective of the world also impacted their personal relationships:

**Excerpt: Participant 3**

“If one of my friends becomes upset or goes into a crisis I might catch myself imagining that they are not going to be able to have the resources to cope”.

**Coping**

**Detachment**

‘*Retreating behind models*’

**Excerpt: Participant 2**

“You retreat behind models and you keep things quite intellectual um so I think that is what I have done in the absence of having, you know, a sort of containing supervision space”.

“I didn’t have some model to put between me and the person”.

Extended Results
**Boundaries**

**Excerpt:** Participant 11

“I always felt like it was important to kind of keep my own boundaries, as much as I could, but I never feel like I had to kind of enter their world necessarily”.

**Excerpt:** Participant 7

“I feel now that I have a good structure and boundaries”.

One participant reflected on the challenge of negotiating boundaries with clients:

**Excerpt:** Participant 1

“One of the most challenging bit’s about this work is about boundaries and having boundaries and where they are going to be and getting the support for that”.

**Compartmentalising**

**Excerpt:** Participant 4

“I think just, I suppose, I try and keep quite a clear kind of mind-set, so this is work and leave it at work, um not that I am needing maybe to say that to myself, but just sort of subconsciously being aware of that. I think when I get home there is, um, I am keen for it not to spill over so I can make sure I am busy and occupied with other things when I get home”.

“I suppose if there were occasions where maybe it was still in my thoughts when I get home, it’s maybe acknowledging that. I had a busy day today with hearing difficult things and then kind of just even saying that is enough to tell me to close it off”.

Extended Results
“I said to my partner yeah I had a full on afternoon of three patients complex trauma and, um you know, just almost making light of it in that sense was enough to kind of put it in its place and leave it at work”.

Excerpt: Participant 9

“I have really firm boundaries (...) what I wear for work, my bags, jewellery I wear for work, my briefcase, my hand bag (...) I keep a lot of things quite separate because I don't want the reminders of work in my home. My briefcase is locked away out of sight, I don't look at my diary at home unless my supervisor call and I need to check my diary. I very very rarely take work home. I don't like it being in my space (...) because that’s my personal space and I don't want it, with all due respect, to be contaminated with these issues. I want it to be kept separate and I find that it works for me”.

Intellectualising

Excerpt: Participant 2

“Intellectualising is a safer way of working”.

“I don’t think I ever really expressed hearing those things and to some extent I think I probably convinced myself that I wasn’t sort of bothered about it. I suppose a way of coping with it, that I developed quite early on, was probably not coping with it in a way. Not really talking about it. I talk about it in supervision but probably not the emotional impact on me probably, quite kind of matter of fact. I intellectualise it’s a way of, kind of, keeping the whole thing a bit out of harms reach”.

Humour

Humour also emerged as a core detaching mechanism, as a means of coping with their work, for example:

Extended Results
Excerpt: Participant 4

“Just to make light of it, even though its black humour. I like black humour anyway so it’s something that I find helpful as a way of coping”.

Excerpt: Participant 12

“There is banter and it is a challenge”.

**Therapeutic benefits**

*Personal effectiveness*

All participants described having a sense of personal effectiveness and purpose as a result of their work with clients:

Excerpt: Participant 1

“I'm not impotent and I have a purpose. That feels good”.

Excerpt: Participant 2

“I think there is probably something about the process as well, going in session-to-session trying to be as kind of effective, compassionate and caring practitioner as I can. You know when I leave work at the end of the day makes me feel like I have kind of done something purposeful and useful. Then you know when you talk to people outside of work about the kind of work that you do, you are always kind of surprised about the feedback. How difficult a job it must be and to do and there is little things that just remind you from time to time that the stuff you are doing is tough. The stuff that you are doing is good work and you know it’s good that you are there for people with these kinds of problems to help them”.

Excerpt: Participant 6

Extended Results
“To have that opportunity to provide a different relationship pattern to someone, for some point of their lives. You know if they are able to kind of change the way they look at themselves, even if the difficulties they have kind of remain. If they can see that the way they think about themselves isn’t set in stone or that there is something that they can do, then that is, really you know, I get a lot from that”.

“There is a huge sense of purpose”.

Excerpt: Participant 11

“Just it is really good work. I just get humbled by them and that can be quite touching”.

“There is something about the human capacity to survive and grow even under these awful, awful conditions that can be quite inspiring and uplifting. It can feel good to be part of someone’s process of recovery”.

Excerpt: Participant 12

“It is good to feel that you have contributed to social trauma services”.

_Sense of privilege_

Excerpt: Participant 3

“I think that it’s quite a privilege to be able to do a job where which is as creative as that and listening, so that’s quite sustaining”.

Excerpt: Participant 7

“It is such a privilege in a way for them to tell you and maybe they have not told many people and certainly not in any depth”.

Extended Results
Excerpt: Participant 9

“I really love what I do and I feel fortunate to say that, I don't hate my job. I feel very privileged to be in the position I am in”.

Excerpt: Participant 12

“You do get surprised by peoples capacity for cruelty but such an enormous privilege to be part of a system that is there to try and fix that”.

Renewed perspective

Excerpt: Participant 3

“When you do vicariously pick up a sense of freeing up, when someone has really been able to let something go and then start a fresh with it, kind of made you see life in a, just like, what’s really important? It’s not necessarily your pension or the next job in three years, kind of, sort of, more of I think the growth that I have seen in a patient, it’s like they just kind of appreciate the basics and whatever. So yes I think you pick up a bit of that renewed perspective sometimes”.

Excerpt: Participant 11

“I have just learnt so much, you know, about being human”.

Excerpt: Participant 10

“You know it almost like my eyes have been opened later on in life and you know that is quite, I think it does affect you, you know, your view of the work”.

“Yes um I think I have become more open to the possibility. I was totally naïve. I would say at the beginning of my training, in fact almost couldn’t quite believe it,
which is an awful thing to admit, you know that I think there was that disbelief. The disbelief was because it was so incongruent with my own sort of beliefs about the world and then my beliefs started to change. I think now I am much more, perhaps with friends or you know people outside work, open to the possibility that things could have happened to anyone, you know. I think you, know you, tend to see the world in a way that you have experienced it and that, you know, I am expanding my experiences of the world.

One participant described the vicarious experience of working with a client who was able to change her perspective:

**Excerpt: Participant 3**

“I suppose but she really caught up in having to a certain job and what people thought of her and it was all bad and she did quite well actually using CAT and she managed to really free herself a bit from that but what is important for her and I think that just transferred a bit to me on and off in the short term when I would find myself like worrying in a neurotic way about what am I going to do in the future how am I going to live or something of you know because she was working through it and I think it really does make sense you know. Just living for the moment”.

**Accessing support**

**Friends, family and colleagues**

**Excerpt: Participant 5**

“Accessing support, obviously I am talking about my experiences of accessing support, in social circles for me has been really, really helpful” (P5).

**Excerpt: Participant 2**
“It is very common for me to go home and just kind of off load. I think I do a lot of offloading. I think I do a lot of taking on all this stuff and then go home and then offload it. I think that is one of my survival things”.

**Excerpt:** Participant 11

“Just the whole team is really supportive”.

“I would certainly feel you know comfortable to go and talk to anybody if I felt I needed extra support or kind of extra supervision on any of the cases”.

**Excerpt:** Participant 8

“I remember coming back to the office and talking to X, who has been here for years so she's heard a lot, and just saying how horrendous it was. I didn't want to tell her, as it could have traumatised her as well, but she said "no just tell me". She wasn't shocked, but I was (...) just thinking that this was the worst thing I had ever heard (...) but the fact that she was here helped me”.

**Excerpt:** Participant 9

“We're all very, very busy so sometimes it's about grabbing space. We all know that we can pick up the phone at any time, even after work and talk to each other, so it's not like we go totally out of the loop”.

**Excerpt:** Participant 12

“I feel we are really fortunate as there are lots of standard sessions and support. Lots of ad hoc catching folk and having a chat and a lot of teasing each other as we tend to know each other well”.

*Personal Therapy*
Participants discussed their experience of current or previous personal therapy being a protective factor in allowing them to carry out their work:

**Excerpt: Participant 11**

“I certainly have had a good experience of therapy. I found that absolutely invaluable. I felt like I learnt loads about myself through that and it made a really big difference”.

And the support of current therapeutic input:

**Excerpt: Participant 3**

“I think I find it generally helpful to go to therapy when you have an intense affect and just to express it. Thinking about that patient with the horrified skull image it was awful she was getting thinner and thinner. I find it generally helpful to go and speak to someone about it, if you know it’s not going to, you know, look shocked it’s just, I don’t know what it is, but it just is helpful”.

**Negative cases**

Participants 2, 4, 8 and 7 made no reference to personal therapy in relation to their work with clients.

**Behavioural change**

**Educating others**

Six participants spoke about their experience of educating others about complex trauma:

**Excerpt: Participant 1**
“I would say is, in terms of other things I've enjoyed. Like if I feel that I'm affecting things. Like I'm in a working party group on complex trauma and I feel that I have influenced that in someway, like in relation to my own service”.

Excerpt: Participant 7

“I do get frustrated with other people when they don't know and don't really understand abuse and sometimes (...) they'll say sometimes, like, 'Aye bet they didn't hit them'. So you kind of positively try to discuss that with them if they're talking about the TV or something on the news, I suppose I'm trying to educate people about things, I think that's a positive thing”.

Advocating

Three participants described their experience of advocating for clients:

Excerpt: Participant 3

“I find myself talking about and getting annoyed at, the sort of blame culture you know. Like in the 70’s the BBC should have done this and that procedure have failed with, rather than, you know, this was kind of omnipotent man. A man who was very abusive but that the blame can go around and the guilt, which gets going, can come out. I often find myself wading in about that and advocating for patients”.

“Press response to child abuse scandals and things. I might find myself quite critical of the response, you know like, I think it is a commonish perception, maybe amongst health professionals, that when people have been abused they are going to be messed up, have personality disorders or victims or whatever. Actually most people manage it, especially if they had been someone around to help them and so I often find myself kind of making that point to people. They may assume that if you have been raped once you are going to be damaged and have trouble, which isn’t the case”.

Extended Results


## Appendices

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Appendix 1. Author guidelines for European Journal of Psychotraumatology

Preparing for submission Submission to *European Journal of Psychotraumatology* is taken to imply that the same manuscript is not under consideration by another journal. If the manuscript forms part of a book currently in press, the authors should specify details of the publisher and expected date of publication.

Please note that the submitting author will be the principal contact for editorial correspondence, throughout the peer review and proofreading process, if applicable.

*Please observe that the journal adheres to a 'double blind' review process and thus the title page revealing the identity of the authors should be uploaded separately.* Please see [Ensuring a Blind Review](#).

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Types of papers The Journal welcomes:

- Original basic and clinical research articles (click [here](#) to download guidelines) that consolidate and expand the theoretical and professional basis of the field of traumatic stress (max 6000 words incl. references, excl. tables/figures)
- Review articles including meta-analyses (max 6000 words incl. references, excl. tables/figures)
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- Study protocols that describe proposed or ongoing research, including the rational, hypothesis, and methodology of the study (max 6000 words incl. references, excl. tables/figures)(click [here](#) for more information and an example)
- Case reports (click [here](#) to download guidelines) examining a single individual or event in a real-life context (max 3000 words incl. references, excl. tables/figures)
- Clinical practice papers sharing experience from the clinic (max 6000 words incl. references, excl. tables/figures)
- Letters to the Editor debating articles already published in the Journal (max 1000 words incl references)
- Book Reviews (max 1000 words)
- PhD thesis Summary (in the form of a supplement)

In exceptional cases the word limit can be exceeded, but in principle this should be avoided. Supplementary material, like large tables, data sets, protocols, videos, questionnaires, non-English versions of the article can be uploaded as supplementary material and will thus also be available online.
Checklists and guidelines Please make use of checklists that are available for a number of study designs, including randomized controlled trials (CONSORT). Here you will also find guidelines for meta-analyses (MOOSE) and on studies of diagnostic accuracy (STARD). Further useful links are those to systematic reviews Cochrane Reviewers' Handbook and PRISMA, and to observational studies (STROBE).

Cover Letter In the cover letter, the corresponding author should reveal whether the submitted article – or very similar work - has been previously published or orally presented, or is under consideration elsewhere. If the manuscript forms part of a book currently in press, the authors should specify details of the publisher and expected date of publication.

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Should you choose to become a member after you have submitted the paper, or if it turns out after you have submitted your paper that you are a member anyway, you will nonetheless be charged the full publication fee. Therefore please check your membership status BEFORE submission and indicate this in the cover letter, including membership details.

The authors are also encouraged to list at least 2 potential reviewers with full name, institution, email address and area of expertise. Please note: the suggested reviewers should not be from the authors’ own institute, nor a co-author of any published paper/papers of the present author/authors. The Editors reserve the right of final selection.

Acknowledgements All contributors who do not meet the criteria for authorship should be listed in an acknowledgments section. Examples of those who might be acknowledged include a person who provided purely technical help, writing assistance, or a department chairperson who provided only general support. Financial and material support should also be acknowledged.

Conflict of interest and funding Authors are responsible for disclosing financial support from the industry or other conflicts of interest that might bias the interpretation of results.

Ethics and consent When reporting experiments on patients or animals, please indicate whether the procedures followed were approved by your local ethics committee and/or in accordance with the Helsinki Declaration of 1975, as revised in 2008 (http://www.healthscience.net/resources/declaration-of-helsinki/).

Language All articles should be written in English - British or American as long as consistency is observed. SI units should be used. Please subject the manuscript to professional language editing before submitting the final version if you are not a native speaker.

Translations ESTSS acknowledges the very important role played by scientific literature published in countries where English is not the first language, and seeks to increase visibility of literature that would otherwise be accessible only within the
borders of those countries. For this reason, the Journal encourages authors to submit their paper in the original language as well, for co-publication with the official English-language version. The English abstract will be translated into German (Rita Rosner), French (Louis Jehel and Yann Quidé), Italian (Laura Porry), Spanish (Dani Mosca and Dolores Mosquera), Russian (Marina Scherbak), Turkish (Gözde Koçak), and Polish (Martyna Kowalska). If anyone would like to translate the abstract into another language please contact the Editor, and we would be very happy to display this translation as well. The translations can be found by clicking on the link below the English abstract or by clicking on Supplementary files (highlighted) in the column to the right (Reading Tools).

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**MANUSCRIPT LAYOUT - research articles**

(Click [here](http://www.ejpt.net/index.php/ejpt/about/editorialPolicies#custom-1) to download the guidelines in PDF format) Wherever possible, the paper should follow the traditional layout: Title, Biographical details, Abstract, Keywords, Background, Objective, Method, Results, Discussion, Conclusions, References, Tables, Figures.

**Title** The title should be informative and accurate and at the same time trigger the interest of the reader. A short running head will be derived from the title to appear on each page of the paper.

**Title page** Organize the title page in the following way: 1) title of manuscript, 2) name of *all* author(s), 3) name of department(s) and institution(s), 4) email addresses of *all* authors (listed by authors’ initials) and 5) name and *full* postal and email address of the corresponding author who also acts as ‘Guarantor’ for all parts of the paper. *Please observe that the journal adheres to a ‘double blind’ review process and thus the title page revealing the identity of the authors should be uploaded separately.* Please see [Ensuring a Blind Review](http://www.ejpt.net/index.php/ejpt/about/editorialPolicies#custom-1).

**Abstract** Articles must include a structured abstract of 200-300 words providing sufficient information for a reader to be able to decide whether or not to proceed to the full text of the article. The abstract should be structured in the following way (incl. these headings): Background, Objective, Method, Results, Discussion, Conclusions.

**Keywords** After the abstract, please give 5-10 key words for readers looking for material by key word searching on Internet. Avoid using the same words as in the title.

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Section headings Please do not number section headings. Use a maximum of three levels of headings made clear by orthographic indicators, i.e. capitals, italics, bold etc.

Quotations Please use double quotation marks. Quotations longer than 40 words should appear in a separate paragraph, indented by tapping a ca 1cm right margin, without quotation marks.

Citation and reference system The European Journal of Psychotraumatology applies to the APA system. Check for full details here or here (oral presentation).

APA style uses the author-date citation system allowing the readers to find the sources cited in the text in the reference list, where each source is listed alphabetically.

Style in the text:

To insert a citation in text, include the author’s surname and year of publication. For a direct quotation, include the page number of specific location of the phrase or sentences in the original work. EXAMPLES:

Kessler (2003) found that among epidemiological samples ...
Early onset results in a more persistent and severe course (Kessler, 2003)
In 2003, Kessler’s study of epidemiological samples showed that …
Training materials are available (Department of Veterans Affairs, 2001, 2003)
Several studies (Derryberry & Reed, 2005a, 2005b, in press-a, Rothbart, 2003a, 2003b) show...

Style in the reference list:

All citations should be listed in the reference list, with the exception of personal communications and classical works. Put references in order by the author’s surname or first author’s surname if there is more than one author. Use the hanging indent paragraph style. Double-space the entire reference list. EXAMPLES:

Journal:


doi:10.1037/0278-6133.24.2.225

Book:

Electronic book with DOI:


Chapter in book:


Electronic documents:

Make sure the version you are citing is the most recent one. Include journal volume number and inclusive page numbers if this information is available. Use the copy-paste function of your word processor to capture the article DOI and place it at the end of the reference. If there is no DOI, cite the home page URL.
Appendix 2. NHS Lothian Research and Development Site Specific Approval

University Hospitals Division

Queen’s Medical Research Institute
47 Little France Crescent, Edinburgh, EH16 4TJ

CPP/SS/approval

26 November 2012

Miss Claire Gittoes
Department of Clinical and Health Psychology
University Of Edinburgh
Teviot Place
Edinburgh
EH8 9AG

Dear Miss Gittoes

| Lothian R&D Project No: 2012/P/PSY/36 |
| Title of Research: Vicarious posttraumatic changes in practitioners who work with adult survivors of complex trauma |
| Patient Information Sheet: Version 1 | Consent Form: Version 1 dated 13 September 2012 |
| dated 13 September 2012 |

I am pleased to inform you that this study has been approved for NHS Lothian and you may proceed with your research, subject to the conditions below. This letter provides Site Specific approval for NHS Lothian.

Please note that the NHS Lothian R&D Office must be informed if there are any changes to the study such as amendments to the protocol, recruitment, funding, personnel or resource input required of NHS Lothian. This includes any changes made subsequent to management approval and prior to favourable opinion from the REC.

Substantial amendments to the protocol will require approval from the ethics committee which approved your study and the MHRA where applicable.

Please inform this office when recruitment has closed and when the study has been completed.

I wish you every success with your study.

Yours sincerely,

[Signature]

Dr Christine P Phillips
Deputy R&D Director

Cc Paul Dearie, QA Manager
Appendix 3. University Ethical Approval

Application for Level 2-3 approval

Re: University of Edinburgh Ethics Level 2-3 approved

Comments from Ethical Review:

Thank you for your response, this has now been reviewed and approved by an independent reviewer.

Signature: Dr. S O’Rourke

Position: Ethics Tutor

Date: 23.11.2012
Appendix 4. Participant Information Sheet

Participant Information Sheet

Study: Vicarious post-traumatic changes in practitioners who work with adult survivors of complex trauma.

You are being invited to take part in a research study. Before you decide whether or not to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish. Contact us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the study?
To gain a clearer understanding of the psychological and emotional experience of therapists who engage in psychological therapy with adult survivors of complex trauma. This could have implications for effective training, supervision, management and support for clinicians working in this field. By taking part in this study, you will have the opportunity to directly contribute to the development of a theory, which reflects the lived experience of practitioners working with survivors of complex trauma.

Why have I been asked to take part?
You have been asked to take part as you have a great deal of experience of working with adult survivors of complex trauma.

Do I have to take part?
No. It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

What will happen if I take part?
If you decide to take part, please keep this information sheet and sign the attached consent form and return it to the researcher. The researcher will then contact you by telephone or email to arrange to meet with you at a time that is convenient for you to conduct the interview. A pre-interview participant information questionnaire will be emailed to you. We ask that you complete and send this back to the lead researcher. The interview will be conducted at a venue that is convenient for you. Unfortunately, it will not be possible to reimburse participants for travel or other expenses or costs they may incur as a result of their participation in the study.
During the interview, the researcher will ask you some questions about your experience of conducting psychological therapy with adult survivors of complex trauma. The interview will last about an hour, and will be recorded with two small audio recording devices so that the researcher can listen back to it and examine the information you give in conjunction with interviews from other participants. At the end of this interview process, you will be invited to participate in the evaluation stage of the project where you will be asked for your opinion on the theory produced as a result of the interviews. It is completely your choice whether or not you wish to take part in this later phase of the project and you are under no obligation to do so.

**Will my taking part in this study be kept confidential?**

Yes. Your participation in this study will be kept anonymous and those who read the final report will not have any way of identifying that you took part. Only the lead researcher will have access to the recordings of your interview. This will be transferred onto a secure password protected NHS Lothian computer as soon as possible and deleted from the recording device. All the information we collect during the course of the research will be kept confidential and there are strict laws that safeguard your privacy at every stage. Your name will be removed from the data so that you cannot be recognised from it. Typed interview transcripts will also be fully anonymised, and will be stored securely on NHS premises. Transcripts and recordings will be archived as per NHS Lothian Research & Development Department (Crown Records Management) protocol, and NHS Lothian R&D has a nominated individual who has overall responsibility for archiving within the department. Direct quotes from your interview may be published in the final report, however, these will be fully anonymised and you will not be identifiable.

**What are the possible disadvantages and risks of taking part?**

The focus of the interview is on your experience of working with clients who have experienced complex trauma and I understand that you may feel upset by remembering some of the experiences your clients have shared with you. You will be reminded at the start of the interview that if you feel any distress or get upset to either ask for a break or request to stop the interview altogether. You may also choose to not answer any questions you feel uncomfortable answering. If you are concerned about experiencing distress during or following the interview, then we advise that you do not participate. Should you wish to seek support about the material covered during the interview you can contact Dr. Alison Wells, Clinical Psychologist, in East and Mid Lothian Psychological Therapies Department (Tel: 0131 536 8652). Alison will not be aware of the material covered during the interviews.

**What will happen to the results of the study?**

The study will be written up as a Clinical Psychology Doctoral Thesis, and will be available electronically and manually through the University of Edinburgh library. The final results may also be shared through conferences and peer reviewed scientific journals. Your identification will not be included in any publication.

**Who is organising the research and why?**

This study is being organised and funded by the University of Edinburgh in collaboration with NHS Lothian.

**Who has reviewed the study?**
The study proposal has been reviewed by the lead researcher’s academic supervisor at University of Edinburgh and clinical supervisor in NHS Lothian. The study has also been reviewed by two independent academic staff at the University of Edinburgh.

If you have any further questions about the study please contact Claire Gittoes by email Claire.Gittoes@nhslothian.scot.nhs.uk. Alternatively if you would like to discuss this research with someone independent from the interview process please contact: Dr. Ethel Quayle, Senior Lecturer in Clinical Psychology at the University of Edinburgh, Department of Clinical and Health Psychology by email: Ethel.Quayle@ed.ac.uk.

If you wish to make a complaint about the study please contact NHS Lothian:

NHS Lothian Complaints Team

2nd Floor
Waverley Gate
2-4 Waterloo Place
Edinburgh
EH1 3EG
Tel: 0131 465 5708

*Thank you for taking the time reading this information sheet.*
Name: 
Age: 
Gender: 
Ethnicity: 

Please estimate your current caseload and the total number of clients on your current caseload which meet the criteria of complex trauma, having experience of traumatic stressors that

(1) are repetitive or prolonged
(2) involve direct harm and/or neglect and abandonment by caregivers or ostensibly responsible adults
(3) occur at developmentally vulnerable times in the victim’s life, such as early childhood; and (4) have great potential to compromise severely a child’s development”

Please state your professional status and qualifications:

In what setting/service to you conduct your clinical work?

How would you describe your theoretical orientation e.g. CBT, CAT, Psychodynamic?

How long has it been since you engaged in clinical work with your chosen clinical case?

Do you have a personal history of complex trauma? Please circle as appropriate.

Yes  No

Do you currently receive supervision or personal therapy? (Please state many hours per month?)

Thank you for taking the time to complete this information.
Appendix 5. Participant Consent Form

Participant Consent Form

Project Title: Vicarious post-traumatic changes in practitioners who work with adult survivors of complex trauma.

Name of Chief Investigator: Claire Gittoes

Thank you for reading the information about our research project. If you would like to take part, please read and sign this form.

Participant’s name:__________________ Telephone Number ______________________

__________________________________________________________________________

Please initial box

1. I confirm that I have read and understand the participant information sheet dated 04.11.12 (Version 2) for the above study and have had the opportunity to ask questions.

2. I understand that participation is voluntary and that I am free to withdraw at any time, without giving any reason.

3. I agree that the audio information I provide in the interview can be audiotaped and transcribed. I understand that the audio recording will be deleted at the end of the project.

4. I understand that research data obtained during the study will be fully anonymised so that others could not identify me. This unidentifiable research data may then be stored and used for purposes in the public interest.

5. I agree to take part in the above study and that if the study is published, I understand that all data will be fully anonymised and I will not be identifiable.

__________________________________________________________________________

Name of Participant __________________________ Signature ______________________ Date ____________

__________________________________________________________________________

Chief Investigator __________________________ Signature ______________________ Date ____________

Thank you for agreeing to participate in this research.
### Appendix 6. Example of coding

<table>
<thead>
<tr>
<th>Positive changes</th>
<th>Interviewer</th>
<th>OK um you mentioned there about seeing clients and the growth within them mm what would that looked like?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Participant</td>
<td>Ok I think it's a number of different things I think but um you know first and foremost I think its its not its treating themselves a little better OK and that's really i suppose um not using substances not you know em harming themselves not you know em being in relationships where they are being abused something about um I suppose prioritising themselves enough to seeing themselves as deserving or of being treated in a slightly different way an um that I think is quite a big shift that that you know people need to make quite early on and um so seeing people just making kind of see where decisions for themselves and treating themselves with a little bit of compassion and a little bit of kindness I think this very difficult for a lot of the people that I work with so you know seeing somebody of reward themselves with something nice so it can be quite a sort of behavioural practical thing um that you see its just a change in how people are coping and managing with a day to day life I think there is something about sort of over a period of time um people become a little bit more emotionally contained so I think particularly when I have first start working with a lot of people they are fairly kind of chaotic in terms of their thinking and their feelings it is fairly kind of all over the place I think over a period of time seeing people begin to become a little bit more able to sort of understand their own thoughts and feelings and just kind of regulate that a little bit and to contain it and manage it a bit themselves I think is just just is always a good sign of progress and is something that is kind of rewarding</td>
</tr>
<tr>
<td>Changes in clients</td>
<td>Interviewer</td>
<td>Um mm</td>
</tr>
<tr>
<td></td>
<td>Participant</td>
<td>um I sometimes you do think you know I am encouraging someone else to take good care of themselves and I am not really doing that myself and then other times you do feel you are almost kind of pouring energy into somebody and in a way that they are growing it is very common I still do this often though I try not to but you will get to the end of a session and that person will be feeling much better and you will feel much worse and in a sense of you putting something into them and I think that is slightly the danger is that somebody will feel better and will kind of thrive or grow at your expense if your not careful</td>
</tr>
<tr>
<td>Post-traumatic changes</td>
<td>Interviewer</td>
<td>Levels of growth</td>
</tr>
<tr>
<td></td>
<td>Participant</td>
<td>Self compassion</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“Treating themselves better”</td>
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<tr>
<td></td>
<td></td>
<td>Growth</td>
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<td></td>
<td></td>
<td>Prioritising themselves</td>
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<td>Self worth</td>
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<td>Expectation</td>
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<td>Positive changes</td>
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<td>Compassion/kindness</td>
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<td>Rewards</td>
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<td>Physical rewards</td>
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<td>Positive change</td>
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<td></td>
<td>Change over time</td>
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<tr>
<td></td>
<td></td>
<td>Becoming more emotionally contained</td>
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<td>Clinical presentation/chaos</td>
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<td></td>
<td>Change over time</td>
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<td>Understanding</td>
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<td>Self regulation/containment</td>
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<td>Rewards/progress</td>
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<td></td>
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<td>Progress</td>
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<td></td>
<td></td>
<td>Nurturing self compassion</td>
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<td></td>
<td></td>
<td>Questioning/reflecting</td>
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<td></td>
<td></td>
<td>Growth/‘Pouring energy into somebody’</td>
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<td></td>
<td></td>
<td>Resistance</td>
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<td></td>
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<td>Expense</td>
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<tr>
<td></td>
<td></td>
<td>Growth</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Resentment?</td>
</tr>
</tbody>
</table>
Appendix 7. Researcher diagrams and clustering
Appendix 8. Examples of researchers memos

Development of the research ideas: 12.03.12

I have been working alongside therapists who have a high complex trauma caseload for four months. Before starting my Adult Mental Health placement I had limited experience of working with survivors of trauma. I have been attending group supervision with a variety of clinicians from different background and been amazed at the way range of emotional experiences described by clinicians in relation to their therapeutic interactions with trauma survivors. During a recent group supervision a clinician described being amazed and excited whilst engaging in therapy with a client but also being verbally and emotional abused all within the same session. Again I was thinking to myself what drives this clinician to continue working with survivors of trauma?

After interviewing participant X: 18.12.12

I noticed that she appeared very guarded and defended during the interview. I wonder if perhaps she was anxious? It felt as if she was trying to take control of the interview and had a real sense of anger. It felt like she has had repeated experiences of not being listened to or heard so therefore what’s the point in discussing it with me? How much is she going to invest of herself in the process? The sense of chaos was quite overwhelming jumping from one topic to another. I hadn’t considered the possibility that participants might feel judged or scrutinised during the interviews. Is this influencing how I ask questions and the level of detail I gather during the interviews?

After interviewing participant X: 29.01.13

It strikes me how little time all the participants I have interviewed so far have spent on reflecting on the impact of the work on themselves. It felt as if it was only towards the end of the interview that the participant really felt able to consider the questions in a meaningful way, once he had time to reflect on this during the interview. He commented that he would go away from the interview and wonder about the questions asked, which was in keeping with my sense of how the interview can felt from his perspective. He appeared to be completely stumped by the question of how it makes him feel. He appeared to be completely detached from this as concept.

I felt drawn into normalising his experience, which made me question whether this was first time he had considered these issues. He made reference to the need for safety, which made me wonder about how he had developed his own sense of safety and security—behind models, which don’t have an emotion-focused approach.

What are the conditions which nurture and allow clinicians to reflect on the impact of their work on them?

Following transcribing interviews X and X 26.02.13
“Listening to PX’s interview makes me think about the Bauwens and Tosone (2011) study in which participants reported a greater interest in becoming politically active. This participant seems to be describing a greater interested in becoming more involved in special interest groups and research in relation to complex trauma. This interest appears to be in attempt to cope or perhaps overcompensate for the lack of perceived acknowledgement of complex trauma both on clients and clinicians.”

Neglected vs Neglectful dynamics 27.02.13

From transcribing these two interviews it seems to me that therapists experience mirror that of their clients, in that they don’t feel heard or acknowledged and in fact feel silenced by those placed in the position of protecting them. This leads them to developing strategies for protecting themselves such as becoming defended and detached. It seems that this coping strategy prevents the therapists from giving as much of themselves as you can to the therapeutic relationship and instead develop further strategies, which keeps a distance between them and their clients.

Surviving 22.02.13

How are these clinicians coping with the challenges they face?

“I think for all of us working within the field it is a challenge to be able to protect yourselves”

- Becoming Self sufficient
- Retreating behind models
- Intellectualising
- Avoiding not discussing the emotional impact of their work v sot having the opportunity to share this in supervision

What is the impact of this for clients?

“…innate capacity to listen and that kind of dries up a bit and then you rely a bit more on the model”.

Supervision
- Lack of opportunity for a difference style of supervision
- Supervisor as manager- difficulty being vulnerable
- Supervision as a ‘tick box’ exercise

Following transcribing interview X 29.02.13

The more I compare across interviews, the changes described by participants with the changes participants described witnessing in their clients the fewer differences I see.

“I think our clients or patients give as much back to us you know we are working with the real survivors of life”

Isolation 12.12.13

Appendices 119
I have just finished meeting with my Clinical Supervisor and realised we keep coming back to the sense of isolation experienced from all perspectives. Participants describe the sense of isolation they witness and see within their clients. Clinicians feel isolated with the lack of support from their service and being concerned about sharing their feelings and anxieties with others in case they traumatise or burden others. Equally there is a sense that the organisation is finding its own way of coping by keeping clients are ‘arms length’.

Idealisation? Negative cases 14.01.14

I have just finished meeting with my Clinical Supervisor and I’m struck by the way in the negative cases describe the support from their organisation. It would seem that they have an idealised view of their manager and the support they receive in terms of caseload management. The sense of feeling lucky and grateful that their supervision needs are taken seriously is quite striking. Again expectations seem to play a role here in terms of participants’ experience of their clients and their employers. How does this fit with my expectations? What influence is this having on my interpretation of the data?”
Appendix 9. Interview Schedule

Initial interviews must be guided and directed by the participants themselves. The interviewer must maintain a curious and unbiased stance. The following will be used as a guide and prompt for participants during the initial interviews. In line with grounded theory methodology, future interviews will be guided by the content and analysis of previous interviews.

Wider questions regarding trauma work:

1. What aspects of trauma work do you find most enjoyable?
   
   (Prompt: on what level do you experience enjoyment: cognitive, emotional behaviour, spirituality, relationships?)
   How do you find a sense of meaning and reward from your work?

2. What does it feel like for you listening to your clients’ stories?

3. Have you experienced any positive or negative changes as a result of your work with survivors?
   
   (Prompt: changes in self, life, family etc.)
   What challenges have you witnessed your clients overcoming in the therapeutic process?
   Would you say your clients’ capacity to overcome adversity has affected you in any way?

Opening question regarding the clinical case example (in order to tap into specific autobiographical memories)

1. What was your thinking behind choosing this case?

2. How would you describe the process of therapy with this client?
   
   (Prompt: How would you describe your therapeutic relationship with this client?)
   Did anything in particular help you manage/formulate this case?

3. Did/do you experience any positive or negative changes as a result of working with this particular client?
   
   (Prompt: images, dreams, and memories around what happened to your client?)
   Did the client stimulate anything in you that you wanted to nurture and expand?

Closing Questions

1. How do you feel having spoken about your work with me today?

2. Anything I haven’t asked that you would like to elaborate on?

   - Are you happy for me to contact you in the future to discuss whether my analysis of yours and other participants’ interviews reflects and are in keeping with your experience?
Appendix 10 Systematic Review Protocol

(Based on York’s University Centre for Reviews and Dissemination Guidance for undertaking reviews in health care)

Background

To date the deleterious effects of trauma work have dominated the literature, which has led to a lack of research on its positive outcomes and the factors that might promote these positive experiences in therapists.

There is need to investigate protective factors and what instigates vicarious post-traumatic growth (Linley & Joseph, 2007; Seligman & Csikszentmihayli, 2000), Compassion Satisfaction and Vicarious Resilience. By gaining a better understanding of compassion satisfaction, vicarious resilience and vicarious post traumatic growth modifications can be implemented which facilitate therapists’ potential for positive outcomes.

Debate is on-going as to which type of assessment, quantitative or qualitative, holds the most merit with the theoretical constructs. Others (Tomich & Helgeson, 2004; Tedeschi & Calhoun, 1996) find value in quantitative assessments as they provide allowance for larger-scale studies with a more narrow set of constructs. There are also concerns regarding the unipolar design of many of the quantitative measures and the possibility that qualitative measures are tainted by leading questions or telegraphed expectations that growth “should” occur (Park & Helgeson, 2006).

Previous similar reviews:

The Impact of Trauma Work on Trauma Workers: A Metasynthesis on Vicarious Trauma and Vicarious Post-traumatic Growth (Cohen and Collins, 2012).

No systematic reviews conducted in this area.

Review question

Does engaging in psychological therapy with survivors of trauma lead to compassion satisfaction, vicarious post-traumatic growth and vicarious resilience in trauma therapists?

4. What contextual factors are associated with VR, VPTG and CS in trauma therapists?

5. What positive or negative outcomes (are associated with VPTG, CS and VR in therapists?

6. What personal and demographic factors are related to VR, VPTG and CS in trauma therapists?

7. What psychological processes are associated with VR, VPTG and CS in trauma therapists?
Eligibility criteria

- Studies using a quantitative or mixed methods approach
- Compassion Satisfaction, Vicarious Post-traumatic Growth or Vicarious Resilience are investigated
- Therapists who have not shared directly shared their clients trauma experience (e.g. professionals who were exposed to 9/11).
- All type of study design
- Full-text available
- Studies published in English
- All years considered
- Therapists must have professional status/registration and not be in training.

Population

- Trauma therapists or counsellors working in a psychotherapeutic capacity (primary professional activity is therapeutic work) with survivors of trauma

Outcomes

Positive psychological outcomes for trauma therapists, including:

- Compassion Satisfaction
- Vicarious Post-traumatic Growth
- Vicarious resilience

Planned search strategy

Key searches of online databases (CINAHL Plus, Medline, PsycINFO, Psychological and behavioral sciences, Social Services Abstracts, PILOTS, Sociological Abstracts, Scopus, PsycArticles, ProQuest and EMBASE) using search terms:

“vicarious post-traumatic growth” or “adversarial growth” or “compassion satisfaction” or “Vicarious resilience” or “positive outcome*” or “countertransference” or “positive change*” or “quality of life”

AND

“Trauma Therap*” OR “Trauma counsel?or*”
Manual search for references lists of papers for systematic review

Manual search for key journals identified as prevalent in reference lists of selected papers

**Study selection**

1. Titles screened for relevance
2. Abstracts reviewed to see if meet eligibility criteria
3. Full text of retained studies reviewed to see if meet eligibility criteria
4. Final selection of studies included in methodological appraisal and assessment

**Data extraction**

The following data was extracted regarding each paper:

- Research study question
- Study design
- Sample
- Measures
- Analyses
- Generalisability of findings

**Quality Assessment**

- Specific criteria for each dimension
- Scoring categories of well covered; adequately addressed; poorly addressed; not addressed/not reported; not applicable

**Data synthesis**

- Summary of individual study findings and characteristics (data from standardised data extraction form)
- Overall rating and quality ratings for each of the dimensions identified
- Overall summary of state of the literature in this area
- Limitations of available literature
- Areas identified for future research
Dissemination

- Chapter in doctoral portfolio thesis
- Submit for publication

References


## Appendix 11 Systematic review data extraction form

### General information

Date of data extraction:

Record number (to uniquely identify study):

Author:

Article title:

Citation:

Type of publication (e.g. journal, article, thesis):

Country of origin:

Source of funding (if known):

### Study characteristics

Aim/objectives of the study:

Study design:

Study inclusion criteria:

Study exclusion criteria:

Recruitment procedures used:

### Participant characteristics

Age:

Gender:

Ethnicity:

Socio-economic status:

Occupations/Professional background:

Training orientation:

Qualifications:
Length of time working as a therapist (years);

Hours per week with clients:

Personal therapy:

Personal trauma history:

Supervision (Frequency, orientation):

Number of participants in sample:

**Setting**

Work setting:

**Outcome data/results**

Measures used:

Statistical techniques used:

Results of analysis:

Other notes:
## Quality Criteria for Systematic Review

**Review Question:** What is the relationship between engaging in psychological therapy with survivors of trauma and compassion satisfaction, vicarious post-traumatic growth and vicarious resilience in trauma therapists?

<table>
<thead>
<tr>
<th>Overview of Quality Criteria Domains</th>
<th>Domain</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Research question and objectives</td>
<td></td>
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<tr>
<td>2 Sampling</td>
<td></td>
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<tr>
<td>Sample characteristics</td>
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<td>Response rate</td>
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<td>Characteristics of non-responders</td>
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<tr>
<td>3 Design and method</td>
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<tr>
<td>Operationalisation of variables</td>
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<td>Validity and reliability of measurement variables</td>
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<td>Confounding variables</td>
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<td>4 Statistical analysis</td>
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<td>Appropriately and fully reported</td>
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<td>Sample size and power</td>
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<td>5 Generalisability</td>
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</table>

**Descriptive category**

- **Excellent:** All or the majority of the criteria have been well covered. Limitations of the study are thought to be very unlikely to have been affected by the findings or conclusions.

- **Very Good:** Considerable majority of the criteria have been well covered or adequately addressed. Limitations of the study are thought be unlikely to have been affected by the findings or conclusions.

- **Reasonable:** Majority of the criteria have been well covered or adequately addressed. Limitations of the study may have modestly affected the findings or conclusions.

- **Limited:** Many or most criteria are not well covered or adequately addressed. Limitations of the study are thought likely or very likely to have affected the findings and conclusions.

### Operationalisation of Quality Criteria

1 – Research question and objectives

1.1 The study addresses an appropriate and clear focused question, drawn from theoretical models or previous research.

| Well covered | Contextualised development of the research question drawn from theoretical models and previous research. A clear and well-defined question is specified making reference to outcomes. |
| Adequately addressed | Contextualised development of the research question limited reference to theoretical models or previous research. Lack of clarity regarding research question and objectives. |
| Poorly addressed | No contextualised development of the research question or reference to theoretical models or previous research. Research question OR objectives stated. |
| Not addressed | Research question and objectives not reported. |

Notes

### 2 – Sampling

#### 2.1 The characteristics of the participants are representative of the group being studied.

| Well covered | The sampling method ensures that minimal bias is introduced by ensuring that probability sampling is used. Characteristics of the participants (e.g. gender, age, nationality, practice setting, professional background and/or title, years of experience working with trauma clients, caseload make up, supervision, working hours (Part time/full time) are included and compared to national demographics for the target population. Missing demographic information outlined. Definition of trauma therapist provided. |
| Adequately addressed | The sampling method may introduce an element of bias e.g. self-selected sample. Limited characteristics (4/5 aspects described above) of the participants’ clinical and demographic characteristics are included. |
| Poorly addressed | The sample is highly selected. Minimal characteristics (<4 aspects described) of the participants are included. |
| Not addressed | |

Notes

#### 2.2 The study indicates, how many of the therapists asked to take part did so.

| Well covered | Appropriate and not unduly rigorous inclusion/exclusion criteria applied and between 32%-58% or more of those eligible to participate do so. |
| Adequately addressed | Only between 32%-58% or more of those eligible to participate in study do so or inclusion/exclusion criteria applied limit the generalisability of results. |
| Poorly addressed | Response rate less than 32%. |
| Not addressed | |

Notes
### Notes
- Response rate based on previous research 32% (Pearlman & MaClan, 1995) to 58% (Pope & Feldman-Summers, 1992).

#### 2.3 The study indicates, how many of the therapists asked to take part declined.

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well covered</td>
<td>The number of participants who only completed some measures or those who declined to participate is given.</td>
</tr>
<tr>
<td>Adequately addressed</td>
<td>Sufficient information provided regarding participants who declined to take part.</td>
</tr>
<tr>
<td>Poorly addressed</td>
<td>Limited information provided regarding how many of the therapists who were asked to take part declined.</td>
</tr>
<tr>
<td>Not addressed</td>
<td></td>
</tr>
<tr>
<td>Not reported</td>
<td></td>
</tr>
<tr>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>Notes</td>
<td></td>
</tr>
</tbody>
</table>

#### 3 – Design and method

3.1 The variables (Compassion Satisfaction, Vicarious Post-traumatic Growth and Vicarious Resilience) are clearly defined and operationalised.

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well covered</td>
<td>Clear definition and measurement of the variables is provided. Outcome measures clearly linked to research question. A choice rationale for choice of measure was included.</td>
</tr>
<tr>
<td>Adequately addressed</td>
<td>Variables definition outlined with limited reference to their measurement. Outcome measures are linked to the research question but not as comprehensive or clear as could have been achieved.</td>
</tr>
<tr>
<td>Poorly addressed</td>
<td>Limited reference to variables definition and no reference to the measurement of these variables. Outcome measures are poorly linked to the research question.</td>
</tr>
<tr>
<td>Not addressed</td>
<td></td>
</tr>
<tr>
<td>Not reported</td>
<td></td>
</tr>
<tr>
<td>Not applicable</td>
<td></td>
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<tr>
<td>Notes</td>
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</tbody>
</table>

3.2 Variables measurement method is appropriate and demonstrates validity and reliability

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well covered</td>
<td>Standardised outcome measure(s) used with well-reported psychometric properties (i.e. Cronbach’s alpha and test retest correlation coefficient ≥0.70 and construct validity) in the trauma therapist population or those vicariously exposure to trauma. Psychometric properties are reported in the paper.</td>
</tr>
<tr>
<td>Adequately addressed</td>
<td>Psychometric properties of measurement are adequate and referred to but with few details OR reliability and validity studies are in relation to different population.</td>
</tr>
<tr>
<td>Poorly addressed</td>
<td>Non-standardised outcome measures used with poor psychometric properties (i.e. low validity and reliability). Limited or no information regarding the measures psychometric properties OR the measure has poor concurrent/predictive validity and reliability.</td>
</tr>
<tr>
<td>Not addressed</td>
<td>No reference was made regarding the standardisation, reliability or validity of measures used.</td>
</tr>
<tr>
<td>Not reported</td>
<td></td>
</tr>
<tr>
<td>Not applicable</td>
<td></td>
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<tr>
<td>Notes</td>
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</table>

### 3.3 Confounding variables that may have influenced the results are taken into account

| Well covered | Comprehensive description of potential confounders (e.g. history of trauma) were considered, and allowed for in the analysis. |
| Adequately addressed | Some information regarding potential confounders were considered, and measures used to address confounding were adequate. |
| Poorly addressed | Very limited information about potential confounders were considered, measures used to address confounding were inadequate. |
| Not addressed | |
| Not reported | |
| Not applicable | |
| Notes | |

### 4 – Statistical analysis
#### 4.1 Statistical analyses are fully reported and appropriate

| Well covered | Appropriate statistical analysis conducted (to the key variables and trauma exposure and appropriate for the sample size). Potentially confounding factors were statistically controlled for and parametric assumptions are explored. Explanation for the choice of analysis is provided. Results clearly stated with values (e.g. means, SDs) for outcome variables, test statistic, absolute p values, confidence intervals and effect sizes reported as appropriate. |
| Adequately addressed | Appropriate statistical analysis may have been conducted but this is not clearly reported. Lack of sufficient detail (>3 of the values provided: outcome variables, test statistic, absolute p values, confidence intervals and effect sizes reported as appropriate details provided) to allow for replication. |
| Poorly addressed | Inappropriate analyses. (Not enabling identification of link between outcome and trauma exposure / not appropriate for the sample size). Results presented in described in prose with a lack of numerical data. |
| Not addressed | |
| Not reported | |
| Not applicable | |
| Notes | |
### 4.2 Sample size and power

<table>
<thead>
<tr>
<th>Well covered</th>
<th>Power analysis conducted. Reasonable effect size estimation and sufficient number of participants.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adequately addressed</td>
<td>Acceptable effect size estimation and sufficient number of participants.</td>
</tr>
<tr>
<td>Poorly addressed</td>
<td>Low effect size estimation and sufficient number of participants.</td>
</tr>
<tr>
<td>Not addressed</td>
<td>No power calculations</td>
</tr>
<tr>
<td>Not reported</td>
<td></td>
</tr>
<tr>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>Notes</td>
<td></td>
</tr>
</tbody>
</table>

### 5 – Generalisability

#### 5.1 The findings could be generalised to similar populations.

<table>
<thead>
<tr>
<th>Well covered</th>
<th>Findings are discussed in relation to previous research supporting the external validity of the results to other trauma therapists. Comprehensive account of information is given to determine generalisability.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adequately addressed</td>
<td>Appropriate steps have been taken to ensure external validity. Results are somewhat generalisable.</td>
</tr>
<tr>
<td>Poorly addressed</td>
<td>Inadequate information provided to assess generalisability. No reference is made to previous research supporting the generalisability of the findings.</td>
</tr>
<tr>
<td>Not addressed</td>
<td></td>
</tr>
<tr>
<td>Not reported</td>
<td></td>
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<tr>
<td>Not applicable</td>
<td></td>
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<tr>
<td>Notes</td>
<td></td>
</tr>
</tbody>
</table>

**Other Notes / Possible areas for Revision**