

DUBLIN BUSINESS SCHOOL

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**“UNDERSTANDING HOW VICARIOUS TRAUMA CAN BE EXPERIENCED
BY THERAPISTS WORKING WITH CLIENTS WITH POST TRAUMATIC
STRESS DISORDER”**

**THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE
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ABSTRACT

The purpose of this research project was to gain an understanding of how vicarious trauma can be experienced by therapists working with clients with Post traumatic Stress Disorder (PTSD). The research also explored how therapists resource themselves in order to reduce their risk of vicarious trauma. A sample group of six therapists were interviewed using semi-structured qualitative interviewing procedures, in order to collect in-depth data.

The findings of this research revealed that in working with clients who have experienced severe trauma and subsequently PTSD can impact negatively on the therapist. Their personal outlook, behaviour and thought processes can be altered as a result of the transformative process of vicarious trauma. The findings also recommended the need for awareness of the signs and symptoms of vicarious trauma in conjunction with regular personal reflection.

The majority of the therapists in this study believed that open discussion of therapists' experiences of vicarious trauma allows for a deeper understanding of the risks, provides reassurance of the challenging nature of the work, and reduces a sense of isolation that can be felt in being witness to trauma material. The findings also indicate that the promotion of close knit teams in organisations, engaging in ongoing professional and personal development, and regularly attending supervision are essential strategies in reducing the risk of vicarious trauma.

CHAPTER 1: INTRODUCTION

1.1 Background

Individuals who are experiencing Post Traumatic Stress Disorder (PTSD) seek therapeutic support with a desire to be able manage their emotions and thoughts as opposed to being regularly overwhelmed by emotional flooding from such emotions as fear, anxiety, anger, and depression.

The therapeutic relationship is the context where the coping mechanisms and personal resources which may have be deformed or distorted can be reformed. This working relationship will explore the constricted and habitual behaviour, symptoms and thought patterns which may be impacting on the client's self image and interpersonal relationships. The process of developing this working relationship is gradual, as the person's trust in others and the world has been severely dented as a result of their trauma. (Thorne & Lambers, 2003; Dempsey, 2000)

Working with clients with PTSD, is seen to be challenging work with an intense quality due to clients' level of fragility, general mistrust of others, and a lack of feeling safe in the world. Understanding what is occurring for the client and how this subsequently can impact on the therapist can allow for a better understanding and insight into how to reduce the risk of vicarious trauma.

1.2 Objective and Scope

This research project sets out to explore the experiences of and attitudes of counsellors and psychotherapists who work with clients who present for therapy with Post Traumatic Stress Disorder (PTSD). It aims to investigate whether the impact of post trauma work may increase therapists' vulnerability to experiencing vicarious trauma. It will also examine what self-care strategies therapists can put in place in order to reduce the possible risk of developing vicarious trauma.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

The following section provides a synopsis of research and literature which is relevant to this topic.

2.2 Vulnerability to Trauma

Trauma is a psychological experience when a person's sense of safety is threatened whether or not there is physical harm directly experienced (Dempsey, 2000; Levine, 1997). When a traumatic experience occurs in people's lives, there is an overwhelming sense of fear and helplessness in the face of a threatening event leading individuals to feel disempowered and disconnected from those around them (Lewis Herman, 2001; Rothschild, 2000; Levine, 1997). The experiencing of trauma can occur as a single event or on a continual basis over a period of time. A trauma that occurs as a single (possibly life threatening) event can leave an individual feeling overwhelmed by an inability to avoid or prevent it from occurring (Levine, 1997; Lewis Herman, 2001). Developmental trauma in comparison is rooted in childhood experiences where a person didn't receive adequate developmental support, guidance, and nurturing which has limited the person's resilience and resources in the face of future traumatic experiences (Levine, 1997; Rothschild, 2000; Dempsey, 2000; Miller, 1987). In order to understand how working with a client with PTSD may negatively impact on the therapist, it is necessary to gain an

insight into what occurs for the client as the primary trauma response evokes the secondary response of vicarious trauma (Figley, 1995).

Gerhardt (2004) discusses how our early relationships lay the foundation for our subsequent ability to cope with our emotions and the degree to which they rise and fall as we live in our world. The patterns which subsequently develop are outside our awareness and become the “invisible history of each individual” (Gerhardt, 2004, p.14). In the developmental process, babies who were well cared for, supported and nurtured to deal with both positive and negative emotions are allowed to develop both the resources and resilience to adapt to different life events as they present (Rothschild, 2001; Winnicott, 1990; Miller, 1987; Davis & Wallbridge, 1981). Conversely, unstable foundations in the care provided for the child can limit what can be emotionally held by individuals when faced with a possible traumatic event (Gerhardt, 2004; Winnicott, 1990). Under these circumstances, they can be more vulnerable to becoming trapped in the trauma as they may not have the resources to work through it “leading to lasting changes in physiological arousal, emotional response, cognition and memory” (Dempsey, 2000, p.27). Individuals’ sense of being able to cope or restore a sense of safety is questioned as they are engulfed with a fear of survival whether real or perceived (Lewis Herman, 2001; Rothschild, 2000; Wallin, 2007). Experiencing trauma then can shatter a person’s feeling of safety in a world they once trusted.

During a traumatic experience which is perceived to be threatening, the body responds by activating the ‘fight or flight’ response which causes hormonal secretions to be released to ready the body to deal with this threat (Lewis, 2000; Rothschild, 2000; Driscoll, 2000). These hormonal secretions activate our autonomic nervous system. The autonomic

nervous system is made of two parts; the sympathetic nervous system and the parasympathetic nervous system. These systems exist together but in “a state of dynamic but antagonistic tension” (Rice, 1999, p.138). During a situation which we perceive as dangerous, a signal is sent to the brain which activates the sympathetic nervous system. It signals to make changes in our body such as increasing our heart rate, breathing rate, and blood pressure; to prepare the body to respond to the immediate threat (Rice, 1999; Davis et al., 2000; Driscoll, 2000). The parasympathetic response is activated when the perceived danger is no longer present. We send signals to our brain again to activate this alternate relaxation response. The parasympathetic nervous system restores the body to a relaxed and quiet state. As a consequence a person’s body returns to a regular heart rate, breathing rate, and blood pressure (Rice, 1999; Davis et al., 2000).

A nurturing environment allows for individuals to become securely attached to the primary care giver and to integrate different experiences so that they can be drawn upon as they mature (Cassidy & Shaver, 2008; Sugarman, 2001; Winnicott, 1990). In the case of children who received deficient holding and regulating, their ability to self soothe themselves from an aroused response to the relaxation response may be inhibited. Consequently, it may leave them vulnerable to remaining in a state of hyperarousal for an extended period which may leave them more vulnerable to psychological disturbances, PTSD or emotional flooding when faced by trauma (Cassidy & Shaver, 2008; Gerhardt, 2004; Rothschild, 2000; Mearns & Thorne, 2000; Solomon & Siegel, 2003). They may be then unable to return to a state of homeostasis or emotional equilibrium (Gerhardt, 2004; Solomon & Siegel, 2003). They may not have the resources to integrate the

emotional aspect of an event with the rational verbalisation of the event (Gerhardt, 2004; Solomon & Siegel, 2003; Rothschild 2000). Individuals who experienced trauma may rely on defense mechanisms, habitual patterns, and adapted behaviour. They engage in these strategies to shut out the memory of the trauma or to protect themselves from the risk of future trauma. Gerhardt states simply, “many of the people who find it difficult to recover from a traumatic experience may be those people whose emotional systems are less robustly built” (Gerhardt, 2004, p.135). It is important to be aware that some traumas no matter the resources available to the person leave them vulnerable to its impact.

2.3 Post Traumatic Stress Disorder (PTSD)

PTSD can develop after a traumatic event. Variables such as the supports we have in place, our previous experiences of trauma, whether we were able to successfully engage the ‘fight of flight’ response, and our own internal resources and resilience gained through our early attachment relationships can affect our development of PTSD (Levine, 1997; Rothschild, 2000; Lewis Herman, 2001). For people to be diagnosed with PTSD, a significant impairment in functioning in the different spheres of their lives over an extended period of time is required (DSM-IV-TR, 2000). It is diagnosed based on the DSM-IV-TR (2000) diagnostic criteria. PTSD is characterised by clients vacillating between trying to emotional numb themselves from experiencing reminders of the trauma to the intense fear and anxiety of possibly re-experiencing their trauma (Cassidy & Shaver, 2008). Being engaged in this constricted reality can, as a result, leave clients in a constant state of hypervigilance and avoidance of possible triggers which can reduce their

social interaction (Cassidy & Shaver, 2008). Feeling as though the trauma is perpetually operating in the present without an end, can be the perceived reality of clients with PTSD (Solomon & Siegel, 2003; Herman Lewis, 2001; Dempsey 2000). The individual focuses on one aspect of the trauma resulting in “the experience to be frozen or suspended in the psyche” (Dempsey, 2000, p.28). Traumatic experiences tend to shatter the individual’s inner and world beliefs, values, and insights. Their sense of personal vulnerability, trust, safety, intimacy, and sense of control become distorted and disjointed (Figley, 1995).

2.4 Therapeutic Relationship

Clients may engage in therapy as the trauma can continue to impact on their day to day life long after the event(s) occurred. Engaging in a therapeutic relationship aids the person in gradually creating a narrative of the event which has a beginning, middle, and end. An individual can be stuck in the trauma which can seem perpetual or timeless in character (Solomon & Siegel, 2003; Rothschild, 2000). Becoming aware of how our unconscious past is operating in our constricted present can have an impact on the presenting symptoms such as depression, withdrawal, and aggression (Solomon & Siegel, 2003). As a therapist it is important to create an environment of safety, to work at the client’s pace, and to be aware of the impact of listening to traumatic material within the therapeutic relationship. Accelerating into the trauma before the relationship has been formed could re-traumatise clients, resulting in their fears, anxiety, and mistrust of others to be further compounded (Rothschild, 2000; Herman Lewis, 2001).

Therapists’ most powerful tool is their ability to empathetically engage with a client in order to create an atmosphere where clients can express themselves openly without fear

of judgment or rejection. There is a danger of therapists becoming too empathically involved in the client's world where the boundaries between the therapist and the client may become blurred. Rothschild (2006) describes how emotions can be contagious and in the sphere of therapy this can work to the advantage and disadvantage of the work. Therapists' ability to enter the client's world aids in the process of gaining deeper understanding of their reality which can allow for change to occur. Conversely, therapists who are unable to separate from the client's trauma material leave themselves open to vicarious trauma. Therefore, maintaining clear boundaries in the work allows the therapist to remain empathetic and able to be with them in the work to the mutual benefit of each other (Rothschild, 2006; Pearlman & Saakvitne, 1995).

The therapeutic relationship is one where the deficiencies such as hope, trust, interpersonal connections, and motivation that may not have been experienced during infancy can be (re)built (Lewis Herman, 2001; Rothschild, 2000; Winnicott, 1990). Traumatized clients are as a result not condemned to dysfunction but can develop a healthy attachment with the therapist creating a collaborative partnership for growth (Gerhardt, 2004). This working relationship will explore the constricted and habitual behaviour, symptoms and thought patterns which may be impacting on their self image and their interpersonal relationships. Developing this working relationship is a gradual process. Clients' trust in others and the world has been severely dented as a result of their trauma (Thorne & Lambers, 2003; Dempsey, 2000).

2.4.1 Impact of Trauma on the Client

Clients may not fully have allowed themselves to experience the trauma in its totality in an attempt to protect themselves from its full magnitude. The trauma may seep out in other ways or be triggered by other life events. The life of the individual may as a result become constrictive in order to avoid acknowledging or re-experiencing the trauma (Dempsey, 2000; Rothschild, 2000; Levine, 1997). In response to a trauma, it can be common for individuals to minimise what has occurred so that they can attempt to return to their lives. Trauma can manifest itself by intruding on clients' emotional, cognitive and physical well-being on both a conscious and unconscious level which can deplete their lives of meaning and pleasure (Solomon and Siegel, 2003). Figley (1995) states that trauma can disrupt clients' sense of self and frame of reference which impacts on their identity, their view of themselves, others, and the world around them. These changes can negatively effect their engagement in their interpersonal relationships. Feeling further isolated due to a lacked sense of connection can reinforce clients moving away from supports in their lives.

When a person enters into therapy it is important for a therapist to work with the defense mechanisms and patterns clients already have in place to cope. Working to rebalance and find other ways of coping allows clients to build upon their resources rather than remain in constricted patterns (Rothschild, 2000; Herman Lewis, 2001). Therapists need to be aware that defense mechanisms serve to protect the client from being emotionally overwhelmed. Working with the defenses as opposed to removing them therefore allows for clients' safety to be maintained preventing retraumatisation (Rothschild, 2000). Clients entering therapy may be full of doubt about the therapist being able to help them

but they may also idealise the therapist and place unrealistic expectations on them (Lewis Herman, 2001). Subsequently, therapists continually faced with the despair and helplessness of their clients may begin to question their ability as a result of the overwhelming nature of the work; this can lead to reduced hope in the work (Gold & Faust, 2002).

2.4.2 Challenging Nature of the Work

The therapist may find that in being witness to clients who have experienced trauma that they too begin to question their own safety, vulnerability and faith in the world around them (Lewis, 2000; VanDeusen & Way, 2006). Therapists are most vulnerable to such altered thinking when they are unaware of how their body and mind are assimilating the trauma material (Rothschild, 2006). The focus can remain on the distress of the client without therapists being aware of what discomfort they themselves may be experiencing when empathetically listening. When faced with trauma material from clients on a regular basis, it can confront “everyone with the essence of human suffering, with “man’s inhumanity to man”, and with the essential lack of purity of people’s interactions with each other” (Van Der Kolk et al., 1996, p.43). It is important to be cognisant that working with individuals who are experiencing trauma symptoms is challenging work and it demands “endurance, commitment and perseverance” (Wilson et al., 2001, p.6). Clients cannot resolve their trauma alone and neither can therapists support them if they have insufficient resources in place which can then open them up to vicarious trauma.

2.5 Vicarious Trauma

Vicarious Trauma is a process rather than a single event. In empathetically listening to the traumatic experiences, and graphic descriptions of client's trauma, the therapist's identity, worldview sense of safety, and trust can be open to being negatively altered or transformed (Figley, 1995; Pearlman & Saakvitne, 1995; Pearlman & McCann, 1990; Trippany et al. 2004; Briere & Scott, 2006; Williams & Sommer, 2002; Morrissette, 2004). Vicarious trauma is primarily associated with therapists who engage in work with clients who are survivors of trauma (Dryden & Reeves, 2008; Van Deusen & Way, 2006; Scott & Palmer, 2000). Figley (1995) highlights how, in listening to the traumatic material, the therapist is more vulnerable to experiencing the very symptomatology that their clients experience such as intrusive images, hyper-vigilance, and constrictive behaviour as he or she works to support the client in the integration of their trauma. Through working with traumatised clients, a therapist can develop a heightened awareness of the frequency and dangers of traumatic events occurring which leads them to be increasingly aware of their own individual vulnerability in the world (Trippany et al., 2004).

2.5.1 Impact of Vicarious Trauma

Therapists have been referred to as 'wounded healers' who work with clients in order to facilitate change as a result of their own life experiences. The therapist's personal experience of trauma in conjunction with hearing the trauma material of clients widens the scope of being witness to unbearable aspects of trauma. Consequently, therapists engaging in this work need to be aware of their own internal process and the risks

involved with delving into client's trauma (Wilson et al., 2001). It is also important for therapists to be aware of the signs and symptoms of vicarious trauma as their engagement in the work, their behaviour, and their thinking may be altered as they engage in the process of entering the world of the client (Lewis, 2000; Weiss, 2004). "Vicarious trauma negatively impacts trauma therapists in mind, body and spirit" (Collins & Laughlin, 2005, p.x). For example, a therapist experiencing vicarious trauma may have intrusive symptoms such as continual thoughts and images related to the client's trauma (Gold & Faust, 2002; Lewis, 2000; Rothschild, 2006).

Therapists who are experiencing vicarious trauma may become sceptical and cynical of their client's story, minimise or rationalise their trauma, detach from the trauma material, form judgemental thoughts, and/or feel contempt for the client (Herman Lewis, 2001; Weiss, 2004; Wilson et al., 2001; Scott & Palmer, 2000; Collins & Laughlin, 2005; Saakvitne, 2002). As a result a therapist may try to overcompensate by taking on more responsibility for the client. They may loosen the boundaries of the therapeutic relationship or take on an advocacy role for the client in order to reduce any guilt and/or helplessness they may be experiencing (Herman Lewis, 2001; Wilson et al., 2001; Gold & Faust, 2002). Working with trauma may also result in therapists increasingly feeling anxiety, frustration, and anger which can affect such things as their sleep patterns, ability to concentrate, and their consumption of substances (drugs, alcohol, food, consumer products) (Figley, 1995; Gold & Faust, 2002).

Client work can begin to encroach on the therapist's personal life. They may have difficulty in letting go of clients' trauma material long after the session, as though the clients come home with the therapist (Gold & Faust, 2002; Rothschild, 2006). Therapists

can start seeing the client as fragile with a need to be saved or rescued. Perceptions of the world can be altered in a way that divides the world into victims and perpetrators; the result being the therapist remains in a constant state of alert mirroring the client's experience (Gold & Faust, 2002). The relationships that the therapist has outside of the therapy room with friends, family and partners can also be affected. The high intensity and emotionality of the work can leave therapists less emotionally available to friends and family which can be an indicator of vicarious trauma (Trippany et. al. 2004; Saakvitne & Pearlman, 1996). The nature of a client's trauma may also impact on a therapist's intimacy with their partner "as guilt and intrusive thoughts related to a client's abuse become present when engaging in intimacy" (Trippany et. al. 2004, p.34).

2.5.2 Awareness and Recognition

There is a need for self protection and anticipation when working with trauma survivors which calls for therapists to regularly check in with how they are dealing with the trauma material (Saakvitne, 2002). Therapists do not always ask for help. They may ignore signs, stop taking on new clients, and/or not speak openly in supervision as the therapist may not want to be seen to be having difficulties with the work (Rothschild, 2006; Collins & Laughlin, 2005; Lewis Herman, 2001). These different elements could open the therapist up to vicarious trauma as the stigma associated with speaking openly about what is being experienced can create silence rather than an acceptance of the difficulty of the work.

Pearlman and Saakvitne (1995) propose that key to a therapist addressing vicarious trauma is awareness, and recognition of its symptoms. This highlights the need for therapists to be in tune with how vicarious trauma may be operating in their work and personal lives. Psychological needs can be disrupted as a result of vicarious trauma (Pearlman & Saakvitne, 1995). For example therapists can feel increasingly unsafe in the world because of continually hearing of its dangers and threats from clients. A transformative process can occur when a therapist's sense of control, self belief, and trust in others alters to a very different stance than previously held (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995).

2.5.3 Personal and Professional self-care strategies

Therapists, who no longer believe in the efficacy of their work due to its ambiguous successes, are personally isolated, and who find listening to clients boring are at a high risk of developing vicarious trauma. The draining nature of the work can reduce their ability to remain empathically engaged with their clients (Cooper, 1986; McCann & Pearlman 1990). Strategies to cope with vicarious trauma could include if possible limiting the exposure a therapist has to trauma work by managing a caseload, taking regular breaks and regular peer support (Pearlman & Saakvitne, 1995; Trippany et al. 2004). Proactively engaging in support systems and self monitoring reduces the risk of vicarious trauma developing (Dryden & Reeves, 2008). Having external self-care strategies such as hobbies, activities, and nurturing supportive relationships can help to maintain a work/life balance rather than having the therapeutic role dominating all

spheres their lives (Figley, 1995). Being involved in activities which provide a sense of accomplishment and pleasure allow the therapist to rebalance the cost of bearing witness to a client's trauma (Saakvitne, 2002). Engagement with such activities, provide opportunities to escape from the harsh realities faced as part of the work (Saakvitne, 2002).

Continued engagement in professional education is highlighted as a benefit to therapists, so that they can regularly engage in their own professional development and keep in contact with their peers (Scott & Palmer, 2000). It can support them in periods of feeling helplessness as they face the uncertainty in the work (Pearlman & Saakvitne, 1996; Casement, 2005). Peer supervision or maintaining professional connections allows for the therapist to share experiences of vicarious trauma which in turn offers social support and normalisation of vicarious trauma amongst colleagues (Pearlman & Saakvitne, 1995). Normalisation of vicarious trauma through open discussion allows for the symptoms to be lessened and understood (Trippany et al., 2004). Reducing feelings of helplessness, fear, and anxiety which may have developed through the work allows for more balance to be achieved resulting in increased objectivity in the work (Trippany et al., 2004).

Engaging in professional supervision on a regular basis is also intrinsic to increase awareness of possibly vulnerability to vicarious trauma. Supervision is a space where issues are allowed to be openly discussed; reducing any sense of isolation the therapist may harbour (Trippany et al., 2004). Being mindful of how "the body stores all emotional experiences, both good and bad" opens up the need for therapists to reflect on the impact of their role at regular intervals (Driscoll, 2000, p.18). Personal therapy is also

recommended as the need arises as personal issues can be triggered in providing therapy (Figley, 2002).

2.6 Conclusion

In conclusion, trauma is a psychological experience, when a threat is perceived even if there is no direct physical harm to the individual. The experiencing of trauma can occur as a single event or on a continual basis over a period of time. The ability of an individual to deal with a traumatic event can depend on the supports they have in place, their previous experience of trauma, and their own internal resources and resilience to cope with the situation due to early attachments. Working with PTSD requires for the therapist to enter a client's world which can affect the therapist ability to fully listen without becoming overwhelmed which can impact on a therapist's own sense of helplessness. Empathy is an integral tool of the therapist which allows for wounds of the past to be explored but it can also open them up to experiencing vicarious trauma. Vicarious trauma is the transformative process that can occur when therapists bear witness to their clients' trauma resulting in them mimicking their clients' trauma symptoms. As a result, it is important, for therapists to be aware of the symptoms of vicarious trauma, how this maybe impacting on them, what supports they have in place for themselves and what restorative activities can aid them when working with clients with PTSD.

In the following research, the aim is to examine how therapists may find that in being witness to their client's trauma material, they too may exhibit symptoms of trauma that

mimic their clients. The research also aims to highlight how best a therapist can resource themselves in order to reduce their risk of vicarious trauma when working with clients with PTSD. In the following chapter the methodology used to obtain this information will be discussed.

CHAPTER 3: METHODOLOGY

3.1 Introduction

This chapter will outline the methods employed for carrying out this research. It explains the reasoning for using semi-structured, qualitative analysis, introduces the participants, the materials used, the procedure adopted and ethical considerations which informed the study.

3.2 Research Method

A qualitative approach was chosen for this study as the aim of the research is to examine how therapists may find that in being present to their client's trauma material, they may experience vicarious trauma which can result in them experiencing the symptomatology of their clients.

The process of qualitative research is a method which allows for previously unexplored material to be brought into consciousness "which is partly analysis and partly enabling of the process of analysis" (Meloy, 2002, p.141). This research aims to examine what self-care strategies therapists can engage in to reduce the risk of vicarious trauma. Examining therapists' awareness of vicarious trauma will allow for a deeper understanding of the impact it can have on therapy.

3.2.1 Semi Structured Interview

Semi structured interviews are “a more informal, conversational character, being partly shaped by the interviewer’s pre-existing topic guide and partly by concerns that are emergent in the interview” (Bloor & Wood, 2006, p.104). They allow for a greater degree of flexibility in the exploration of the themes that may emerge during the interview.

The use of open ended and non directional questions allows for a deeper exploration of interviewees experiences. Semi-structured interviews are a process which “enables and encourages interviewees to think out their own positions on complex issues” which provides “an opportunity to reflect on their values and opinions” (Oliver, 2003, p.56).

One to one semi-structured interviews were conducted with the goal of eliciting therapist’s perspectives on the research topic under investigation. The questions were compiled and guided by topics that emerged in composing the literature review and topics which emerged during the interviews.

3.3 Participants

Six participants took part in this research. The participants comprised of four women and two men. All participants were qualified therapists. They had experience of working with clients who had experienced severe trauma and/or had been diagnosed with PTSD.

The participants were contacted by the researcher. They were selected from organisations which have a primary focus on working with trauma survivors. Once contact had been made, the researcher identified herself and explained the nature of the research project and the process of being involved in the research. The participants were informed that they would not be identified in the results of the research and that the information they provided would only be used by the author for this research project.

Scheduled appointment times and dates were arranged at the convenience of the therapist once agreement was obtained to partake in the research. The interviews lasted from 34 to 44 min and took place in each of the therapists' place of work.

All the participants had experience and were familiar with the impact of working with trauma and/or PTSD. The participants ranged in experience from working in the area of trauma from two to eight years. Participants ranged from working towards accreditation to being fully accredited therapists.

3.4 Research Procedure

The interviews took place over a two week period in February 2011. All the interviews were recorded using a digital Dictaphone. All interviews were later transcribed within a week of the interview so that they remained fresh in the mind of the researcher. Each interview followed the same procedure. Each participant was emailed an outline of the research which highlighted the key areas of focus, to allow them time to reflect on the material prior to the interview. The purpose of the research was explained again prior to

beginning each interview. The digital recorder was switched on and off in full view of the therapists.

The questions were compiled by identifying themes in the literature review which would help elicit relevant information based on the aim of the research. Questions were divided into three sections; background and initial impact of trauma work, ongoing impact of trauma work and awareness of vicarious trauma, and strategies for reducing risk of vicarious trauma.

Each interview started with a demographic question enquiring about the therapist's length of time working with this particular client group. The therapists were then asked the questions which had been compiled through the research. Additional questions were asked based on emerging topics during the interview.

3.5 Data Analysis

A qualitative approach was used in conjunction with Interpretative Phenomenological Analysis (IPA) to analyse the data. This approach to psychological qualitative research aims to offer insights into the meanings that interview participants assign to particular events, experiences, and/or states (Smith & Osborne, 2003). The goal is to understand their individual personal perceptions as opposed to arriving at objective statements (Smith & Osborne, 2003). It is also helpful in identifying main and subordinates themes and in highlighting common connections.

3.6 Research Materials

A digital Dictaphone was used for the purpose of recording the interviews. The interviews were then uploaded onto a laptop and the interviews were transcribed, saved, and password protected.

3.7 Ethical Considerations

Participants were provided with detailed information on the research study which outlined the purpose and method of the research prior to being interviewed. They were informed that they would not be identified in this research and that the material provided would not be used in any future research project.

The researcher again took time at the beginning of each interview to outline the purpose of the research. Interview consent forms were signed prior to beginning the interview after questions about the research had been answered.

It was explained to all participants that they had the right to withdraw from the interview at any time up until the submission date of the thesis (15th April 2011).

All participants were informed that recordings and transcripts would be stored safely for a period of 5 years based on the Data Protection Act 1988/2003.

CHAPTER 4: FINDINGS

4.1 Introduction

This chapter outlines the findings from interviews carried out with six therapists in relation to their experiences of and attitudes towards vicarious trauma as a result of working with clients with PTSD. The findings were arranged under various themes, (each with a number of sub themes) which are explored and substantiated by quotes from the six therapists. Interviewees are noted as T1 for therapist 1, T2 for therapist 2, T3 for therapist 3 etc.

One therapist (T4) in the study believed she had experienced vicarious trauma as a result of the work. She said that she had addressed this issue in individual and peer supervision and continue to work with clients.

4.2 Period of time and Reasons for Working with Client Group

The six therapists varied in the length of time they had been working with clients who had experienced trauma and PTSD. The time ranged from a period of eighteen months to eight years.

The reasons for entering into this area of work were predominately opportunistic for five of the six interviewees. This was due to placement and employment opportunities

becoming available in centres where the focus was on post trauma work. T1 said “I suppose in one way it was probably opportunistic, but I had done my undergraduate research on PTSD as well.”

All six therapists had an interest in the field of trauma due to academic study, previous work, and living in post conflict countries. T3 outlined that he had “lived in and worked in lots of post conflict and conflict societies...so I know or have some idea or take on the psychic landscape that a lot of our clients would be navigating.”

4.3 Initial Impact of the Work

Four of the therapists talked about experiencing huge anxiety about working with this client group as they questioned their ability to meet the needs of the clients. This resulted in these therapists feeling overwhelmed and engaging in additional training, reading, or peer support. There was recognition amongst all the therapists about the challenging nature of the work.

T3 for example spoke about the initial impact almost “verging on existential crisis” as it brought him face to face with the “unspeakable” suffering that clients have experienced.

Sadness was an initial emotional response for three of the six therapists. This later developed into anger and frustration when thinking that people could experience such

trauma at the hands of other human beings. T6 expressed sadness at “knowing that some of these people, for them, recovery is not going to be all what it could be.”

In order to reduce feeling overwhelmed, four of the therapists emphasised the importance of establishing clear boundaries. Maintaining a degree of separateness allowed for the therapists to stay present to their client’s story. There was also a process of learning of how to slow down the session for the protection of the client and the therapist. T2 talked about how with one client she could “really picture it, could really imagine and could really feel myself there” and so needed to remain grounded rather than consumed by the client’s experience.

Exploring the initial impact of working with clients who were presenting with post trauma highlighted the range of emotions a therapist may experience when engaging with trauma material.

4.4 Ongoing Impact of the Work

4.4.1 Intensity of the Work

As the therapists continued working with clients who had experienced trauma, there was a divide between therapists who stated that the anxiety had diminished as the work progressed and those who found that the anxiety had intensified the deeper they got into the work.

T1 explained that prior to working with trauma survivors that she had been able to leave the work behind at the end of the day but with this client group it “wasn’t so easy to leave behind”. The work is at a higher intensity so that one therapist described she was left feeling as though “you’d done a huge days work and you may only have seen two clients” (T1). This could result in “a bit of numbing” being experienced after the session (T1).

Some therapists described the physical effects of working with clients with PTSD. For example, T4 found that she was experiencing symptoms similar to having a hangover which lasted “for a couple of months” with such symptoms as nausea, dehydration, headaches, aches and pains, and insomnia. Three of therapists explained that there is a danger in the work of mirroring the chaos of the client. In describing the ongoing impact of the work T2 said that she had experienced “a loss of innocence” as she had seen a side of life that she “couldn’t go back from”. These examples illustrate the depth of suffering that therapists can be witness to and how this can impact on the therapist emotionally, cognitively and physically.

4.4.2 Reason for Hope

T1 was aware that during periods of the work that she would feel emotionally depleted of energy due to a heightened awareness of the despair of her clients. However, seeing growth in the clients fostered a positive belief about the therapeutic process and their

ability to grow. T1 stated that she marveled and felt humbled “to be in the presence of people who have suffered huge trauma and watch them pick themselves up” which “reinforces your own strength then as a practitioner”.

Believing and seeing the resilience of clients who had experienced horrific trauma reinforced the admiration T2 felt for her clients. This allowed T2 to continue to believe in and “have faith in what I was doing” in the face of such trauma. This work was seen by five of the therapists to be satisfying work as one sees the progression of clients even when they were initially reluctant to engage in therapy.

T6 recognised that although the work can involve periods of sadness and frustration, the need for hope rather than pessimism in long term work is essential as clients can lose faith or belief in themselves and “they don’t need you thinking that about them as well” (T6).

4.4.3 Sense of Isolation

In the beginning of the work four of the therapists described how the intensity of the work can leave a therapist immersed in it. It can appear that such trauma is occurring everywhere and this can be reinforced by television, newspapers, radio and film. There is recognition by all therapists that trauma work is something that “nobody wants to hear about it and why would they” (T1). All agreed that supervision is the place to address how the work is impacting on them.

Therapists experience a sense of isolation in the work. T4 explained that “nobody else knows what you’re going through” when working with this client group. Reassurance was found for five of the therapists through training as they became aware of the vulnerability and helplessness of other therapists through open discussions. The interviewees didn’t think these therapists would have had the same difficulties with the work as them due to their level of experience. This helped therapists feel they were not alone in their individual struggles with this client group.

The importance of having a close knit team was highlighted as not always being present. T2 stated that if she had remained in her organisational placement that she may have felt “isolated”. This highlighted that a lack of connection or camaraderie as part of the work place could impact on an individual therapists vulnerability to vicarious trauma.

4.4.4 Change in Thought Process

All six therapists recognised the work could impact on their thought process during and after sessions with clients. For example, T2 felt that the work had caused for her to be a “little more hardened.” T6 explained that things affected her less than in the beginning which she believes allows you to “to do that work long term”. T4 emphasised that although at the time she felt she was able to stay with the emotions, that upon reflection, there was a huge sense of being “steamrolled” and that “it was coming at you all the time”. She felt this limited what she was able to hear and be witness to in the therapeutic

space. On the other hand, both T1 and T5 felt they were able to stay with the emotions of the client, be more empathetic and patient, and have an awareness of their increased sense of vulnerability as a result of working with these clients rather than any numbing occurring.

4.4.5 Behavioural changes

A personal sense of safety was something that two out of the six therapists mentioned as something which impacted on their behaviour. While they may have been safety conscious before, this increased during the course of working with this client group. T4's experienced such behavioural changes as hypervigilance, altered sleep patterns, and paranoia. T4 described the experience of vicarious trauma as having "affected everything in my life". T4 also stated that during this time "I was really struggling" and that it was only through a colleague's intervention that she was able to address her vicarious trauma.

4.4.6 Change in Personal Outlook

All six therapists highlighted that their tolerance for peoples' neurosis and minor problems would be lower due to the intensity of the work. They also became less tolerant of the media representing trauma material and sought more upbeat outlets for themselves such as glossy magazines, comedic films, non related television programmes, and meeting people outside their profession.

Five out six of the therapists have remained hopeful and optimistic but have a heightened awareness of their vulnerability to trauma. For example, T3 explained that it “does effect how you view the world and the human condition”.

T4 who had experienced vicarious trauma remains fearful due to her experience and has become mindful of how “life isn’t valued by others.” This demonstrates the long lasting impact of vicarious trauma if it is allowed to progress. It reinforces the need for self-awareness, engagement with supports and recognition of the symptoms.

When working with the client group T1 found her personal outlook would have mirrored the client group’s “uncertainty about their future” but since finishing in this placement she has become “brighter” in her outlook. She has become aware of this as a result of personal reflection and supervision. This illustrates the need for regular breaks to allow for reflection and insight to be gained.

4.5 Awareness of Vicarious Trauma

All therapists were aware of vicarious trauma being a risk when working with clients who have experienced trauma. They all believed that it was openly discussed amongst colleagues and that there is an awareness of the issue. For example, T1 stated “I would be very mindful of it, but I suppose it’s not something you avoid, if you’re going to go in and do the work”. However, it was highlighted that there is a difference between theoretical knowledge of vicarious trauma and experiential understanding. T3 talked in

relation to how he experienced a near existential crisis in the beginning of the work even though he would “have known the theory.” He believes that “you can only learn through practice” (T3). This is reinforced by T4, who states that one can have the theory but in practice she had a “misconception that I could handle all that.”

4.6 Self-care Strategies

All the therapists had developed different self-care strategies that they employed as part of their professional¹ and their personal² lives to reduce the risk of vicarious trauma. These self-care strategies had become part of their daily lives rather than interventions during times of possible stress. The aim of these strategies was to work to maintain a work/life balance so as to remain present with clients.

Four of the therapists were aware that sometimes there can be a tension for therapists between being strong and being vulnerable which can impact on how regularly these strategies are employed. T3 explains that he doesn't always employ some strategies until

¹ These included; writing up process notes, maintaining boundaries e.g. lunch, breaks, leaving on time, opening windows between clients, emptying bin of tissues, having a cup of tea, leave the room between sessions, reading over clients notes to get into the clients world before each session, awareness of workload, managing caseload, taking regular breaks throughout the day, personal rituals between clients, wearing certain clothing just for work, breathing and grounding exercises, not answering phones during breaks, peer support, peer supervision, individual supervision, reflection, awareness of vicarious trauma rather than ignoring its subtleties

² These included; not having books in view at home, exercise (walking, swimming, dancing), time for yourself, spending time with friends outside of the area, reading light material, eating well, getting enough sleep, massage, energetic therapies, nature, engaging in hobbies (gardening, yoga, horse riding, music, playing sport) trying to stop smoking and drinking coffee,

the burden gets heavy which is “the total opposite of what I talk to my clients about”.

This highlights that what can be helpful is not always used.

4.6.1 Organisational Supports

All therapists worked within organisations and believed there were good supports in place through monthly peer support meetings, in house training, internal supervision, and staff awareness.

4.6.2 Professional Development

All the therapists engage in ongoing training which is either provided by the organisation they attend or sought externally. Choosing what type of training they wish to engage in is based on both personal and professional interest rather than being solely as a result of the work. The therapists in this research also engaged in reading both individually and also through peer led journal meetings.

Two therapists spoke about not always wanting to engage in training or reading groups due to requiring space from the work and also not wanting to be attending their placements outside of when they saw clients.

4.6.3 Supervision

Therapists varied in attendance of supervision from weekly, fortnightly and monthly. Three of the six therapists received internal supervision in the agency they were based in conjunction with external supervision which they personally sourced. Two other therapists were engaged in group supervision as well as their own personal supervision.

It was highlighted that supervisors who have a background experience of working with clients who have experienced trauma were deemed more effective. Their level of experience was considered vital if one is to work directly with trauma. The supervisors who didn't have experience in this area were seen to have provided support but did not guide them in the same way as supervisors who had this experience.

One therapist in this research was not receiving supervision as a result of being employed by a statutory agency which had received funding cuts. She recognised this as being a major limit to her personally and professionally.

4.6.4 Personal Therapy

None of the therapists are currently in personal therapy. Two of the therapists were engaged in personal therapy for a period when they were working with this client group based on a requirement of their training programme.

Each therapist saw that there would be a benefit from being in therapy as the need arose for them but they didn't feel the client work would trigger anything within them to merit entering therapy. It would be a personal choice based on issues which may present in their personal lives.

One therapist is planning on engaging with therapy but this was not work related.

CHAPTER 5: DISCUSSION

5.1 Introduction

The chapter will review the findings from this research into the experience of counsellors and psychotherapists working with PTSD and their risk of vicarious trauma by comparing those findings with the available literature.

5.2 Trauma and Post Traumatic Stress Disorder (PTSD)

The literature defines trauma as a psychological experience when a person's sense of safety is threatened whether or not there is physical harm directly experienced. PTSD can develop subsequent to a traumatic event. It can significantly impair a person's ability to function in the different areas of their lives over an extended period. The research supports the literature, as all the therapists acknowledge how their clients had been living their lives in the shadow of their trauma. T2 spoke of clients being reluctant to come for therapy out of fear of opening up a can of worms but that through therapy they were able to see their trauma as "part of their history...that wasn't defining them" or limiting them in their daily lives.

A sense of fear and helplessness in the face of a traumatic event is also highlighted in the literature whether this is as a result of a once off event or on a continuous basis. All the therapists in this research were working with clients who had experienced trauma on a

continuous basis but not all at the same life stages. In being witness to clients' fear and helplessness, therapists can come to experience the same feelings as their clients. This was consistent with the research. T4 who experienced vicarious trauma stated that like her clients "your world gets closed down". During T1's interview she described a feeling of numbing and fatigue during the session which upon reflection "would be a kind of mirrored response to post trauma" of the client.

5.3 Challenging Work

All the therapists in this research reinforced the literature's acknowledgement of the difficult nature of the work. Bearing witness to clients' traumatic experiences where their personal beliefs, values, and insights have been shattered can severely impact on the therapist (Figley, 1995). During T1's interview she highlighted that the work is anxiety provoking due to the "huge challenge to meet the needs of the clients" in the face of such suffering. In contrast to the anxiety this work can provoke, it was also seen by the therapists to stimulate and accelerate learning which in the longterm benefited in strengthening their confidence and ability.

PTSD literature states that therapists can feel more vulnerable and aware of their own helplessness in the world as they engage with these clients. This was reaffirmed in the research by all the therapists. Metaphorically T3 described how at times "it feels like your climbing a mountain on your hands and knees and the place is covered in fog, and the fog lifts and you look around and you see hundreds of other people climbing the same

mountain on their hands and knees.” Engaging in this work had brought the suffering and deep despair of clients into full view as therapists worked to guide them in their climb. This is reinforced by T2 who believed that this work had caused for her to have a loss of innocence which she couldn’t come back from.

The nature of the work can also hold a sense of isolation for a therapist which can be reinforced if there is limited camaraderie in the workplace. One therapist stated that “everyone had their own way of doing things, there was a lot of autonomy” and she recognised that if she remained on this placement she may have felt isolated (T2). Another example which illustrates this was when T4 explained that “nobody else knows what you’re going through” and they may not want to know which can add to a sense of isolation.

5.4 Therapeutic Relationship

The therapeutic relationship is a place where the deficiencies that may have been present in an individual’s development can be (re)built (Rothschild, 2001; Winnicott, 1990; Miller, 1987; Davis & Wallbridge, 1981). This was reaffirmed in the research as all the therapists had been witness to the growth and resilience of their clients which was fostered by the therapeutic alliance. T3 stated simply that through the work, his clients were able “to get some respite from the mind, some sleep, just slowly to feel like a human being again.” This illustrates the intensity of the trauma material that therapists are witness to.

The literature postulated that such therapeutic relationships require a high degree of “endurance, commitment and perseverance” (Wilson et al., 2001, p.6). This is consistent with the research findings. During an interview, T2 spoke about clients who were “very, very, angry and hostile” and reluctant to attend which made her question how a therapeutic relationship would be formed. T4 spoke of how the work left her “physically, mentally drained and emotionally drained” which led to her to question how they could continue in the work. These examples highlight that maintaining hope in the human ability to be resilient is intrinsic to working with trauma in the face of clients’ suffering.

5.5 Vicarious trauma

Vicarious Trauma is described in the literature as a transformative process that occurs through empathetically listening to the traumatic experiences of clients. This is illustrated by T4’s description of vicarious trauma as being “like the shell of tortoise, so it goes everywhere with you.” All the therapists in this research believed that vicarious trauma was a risk of the work. One therapist described how in any field of work there is collateral cost and that vicarious trauma is a “collateral cost” to therapy (T1). While only one therapist experienced vicarious trauma, all the therapists had experienced the impact the work had on their thought processes, behaviour and personal outlook. This is clearly shown by T2 description of how that she’d “seen a side of life that I couldn’t come back from.”

5.5.1 Dangers of Empathetic Engagement

Being able to empathetically engage with clients is a key tool of therapists creating an atmosphere where clients can express themselves openly without fear of judgment or rejection. The literature indicates that there is a danger of becoming too empathically engaged with clients where an emotional blurring due to transference and countertransference between the therapist and client could occur. The therapists in this study were aware that there is a risk of vicarious trauma if the therapist is unable to separate from the client's trauma material. (Rothschild, 2006) The therapist who believes she experienced vicarious trauma stated that "it is damaging work if you don't have the safety nets and the processes and the supports in place" for yourself (T4).

5.5.2 Boundaries

Being unable to maintain clear and consistent boundaries is highlighted as a risk factor for developing vicarious trauma in the literature (Herman Lewis, 2001; Wilson et al., 2001; Gold & Faust, 2002). The therapists' feedback was consistent with the literature as they also emphasised the need for consistent boundaries. One therapist felt that their boundaries were not sufficient in their early work which opened them up to vicarious trauma. They felt that this process allowed for huge learning but that it was a "rude awakening to the impact this work" when boundaries are not clearly in place (T4).

5.5.3 Self-awareness and Personal Reflection

Pearlman and Saakvitne (1995) suggest that in order to reduce the risk of vicarious trauma that therapists need to be aware of it and be able to recognise the symptoms. All the participants were aware of vicarious trauma and how it can impact on all spheres of their life. One therapist spoke about how it can have an impact physically, emotionally and cognitively and so to “look after yourself as a therapist is absolutely crucial” (T2). Another therapist emphasised there is a danger of vicarious trauma “if one is not aware, so mindfulness and awareness are an important part” of reducing possible risk (T3).

The participants had become aware of vicarious trauma as part of their training, supervision and ongoing personal development. The need for reflection and anticipation when working with trauma is also emphasised in the literature which calls for the therapist to regularly check in with themselves (Saakvitne, 2002). As mentioned previously, one of the therapists had experienced vicarious trauma and she believed that this was due to a lack of awareness and self reflection. This therapist (T4) was left “quite shocked by the subtleties of it” which highlights that somebody can be in the midst of vicarious trauma without recognising it if the focus has been placed on the client as opposed to “caring for yourself first” (T4). This demonstrates that there can be a culture of putting the client’s needs before the needs of the therapist which can lead to negative results.

5.5.4 Impact on Work and Personal Relationships

The literature highlights that therapists may find that in being witness to clients who have experienced trauma that they too begin to experience the clients' symptomatology such as questioning their own safety, having a heightened sense of vulnerability, and loss of faith in the world around them (Lewis, 2000; VanDeusen & Way, 2006). Five of the therapist found that in being present to their clients' despair and fear that they too became more safety conscious, aware of their personal vulnerability and felt at points that trauma was happening all around them. The literature points out that there is a danger as a result of the therapist becoming cynical, sceptical or pessimistic towards the work. This was reinforced by the therapist who experienced vicarious trauma. She became angry, resentful and hated the work as she felt she became a victim of her "client's trauma" (T4). The other therapists in this study maintained their optimism and belief in the work as a result of the progress made by their clients.

Therapists may not always be aware of their own discomfort in being witness to traumatic stories (Rothschild, 2006). In the course of an interview, a therapist said it took time for her to realise she needed to slow down the session for both herself and the client to prevent retraumatisation. (T4) Three of the therapist said at times it was very difficult to stay present and hear all that was being said by the client. This highlights the need for therapists to regularly check in with how they are assimilating the work to reduce the danger of vicarious trauma.

This research also found that the therapist sometimes felt overwhelmed, mirrored their clients' despair, experienced numbing, and anger not only in the session but also after the

session. Leaving the work behind was considered more difficult than with other client groups which led to such symptoms as nightmares, huge fatigue, and a sense of heaviness. These experiences illustrate how such work can encroach into therapists' personal lives if left unchecked. For five of the therapists these symptoms were not permanent but accepted as part of the work.

During the interviews, the therapists didn't feel the work created any distance in their personal relationships which was suggested by the literature as a possible outcome. They believed their friends and family understood their need for time and space based on the nature of the work. However, they did find that their tolerance for people's neurosis and minor problems to be reduced. They tended to avoid such interactions. All agreed their tolerance for the media representing trauma had diminished since engaging in this work and they sought out lighter material.

5.6 Self-care Strategies

There is an emphasis of self-care in the literature. It is believed that therapists cannot support clients to resolve their trauma if they have insufficient resources in place for themselves. Without sufficient supports the therapist could be at risk of vicarious trauma. All the therapists placed an emphasis on the need for having strategies to cope with the work both professionally and personally.

5.6.1 Personal Self-care

Being proactively engaged in activities and support systems which provide pleasure and a sense of accomplishment while also engaging in self monitoring is promoted by the literature to reduce the risk of vicarious trauma (Dryden & Reeves, 2008; Saakvitne, 2002). Therapists engaged in outside interests, hobbies, and nurtured supportive relationships to help maintain a work/life balance which was consistent with the research. (Figley, 1995) The emphasis was on exercise, sleep, nutrition, time alone and engaging in positive outlets. Their self-care strategies have been incorporated into their lives as regular activities rather than one off events in order to achieve a sense of balance.

5.6.2 Open Organisational Discussions

The literature emphasised the need for open discussions about vicarious trauma amongst colleagues in order for symptoms to be lessened, understood, and support to be gained (Trippany et al., 2004). It is also seen to reduce a possible sense of isolation as a result of the work. Four of the therapists believed that there is a culture amongst therapists of being capable which may affect their awareness or realisation of what may be occurring. In contrast to this belief, all the participants believed vicarious trauma is openly discussed amongst colleagues. Discussing it allows everyone to see that other therapists are “grappling with this deep suffering”, resulting in feelings of helplessness and increased vulnerability (T3). Hearing others experiences provides reassurance and a reduced sense of isolation for the therapists which is consistent with the literature. This highlights the

need for camaraderie to be promoted in organisations working with trauma to reduce a sense of isolation being experienced.

5.6.3 Professional Development

Engaging in continued professional development is put forward as a benefit to reducing the risk of vicarious trauma as it allows therapists to develop their skills and keep in contact with their peers. Pearlman and Saakvitne (1996) propose that it can provide support during periods of uncertainty and helplessness. This was corroborated through the research. Therapists talked about the benefit of hearing how other therapist coped, what their anxieties were, and their feelings of hopelessness. They found this to be reassuring, especially if it was coming from an experienced therapist. For example, a therapist who believed that he was verging on an existential crisis at the beginning of the work gained support during a training programme of his peers. He was told the group would help with the weight of the work as he could not carry it alone (T3).

Many of the therapists felt there was a limit to theoretical knowledge and that experiential learning would have benefited them more. This was emphasised by therapists putting forward that it is only through practice that one learn even when you may know all the theory. This highlights a danger of working with this client group if deficiencies in supports, experience and awareness are present.

5.6.4 Supervision

Supervision on a regular basis is seen to be intrinsic to reducing the risk of vicarious trauma according to the literature. All the therapists saw supervision to be vital when engaging in this work. They especially emphasised the need for the supervisor to have a background in trauma work. This allowed them to be understood and supported in the work. One therapist described supervision as the place where they were “hoping to give to my clients...what I was getting in supervision” to facilitate change (T1).

The majority of the therapists felt they could openly discuss their cases without any anxiety of being judged which is highlighted in the research as key to reducing any sense of isolation the therapist may feel which could lead to vicarious trauma. One therapist described how she could bring anything to their supervisor which included all her insecurities and uncertainties in the work (T2). Another therapist talked about feeling supported and understood which provided reassurance (T5).

In contrast, one therapist experienced feeling threatened by her organisational supervisor. She felt she needed to defend her work which was in complete contrast to her external supervisor where she felt guided and supported. This highlights the need to be able to select your supervisor and that there can be limits to organisational supervision.

5.6.5 Peer Supervision

The literature recommends the engagement in peer supervision or maintaining professional connections so that therapists can share experiences of vicarious trauma. This provides social support and a normalisation of vicarious trauma amongst colleagues (Pearlman & Saakvitne, 1995). All of the therapists engage in peer supervision on an ongoing basis. There was recognition of the need for additional supports due to challenging nature of the work. The therapist who experienced vicarious trauma feels that it was through her peer group that she became aware and was able to address what was occurring for them (T4).

5.6.6 Personal Therapy

Regular personal therapy is recommended in the literature as the need arises. The therapists in the study were not currently engaged in therapy but all were open to entering therapy as the need arose. They expressed the belief that entering therapy would not be related or triggered by client work but due to a need in their personal lives. Two therapists felt that the personal work that they had done in preparation for client work had garnered them personal insight and strength to engage more confidently in the work. Supervision was seen as sufficient to support them in their client work without the need for personal therapy.

CHAPTER 6: CONCLUSION

6.1 Strengths and Limitations

This research was based on qualitative research methods which endorse an exploratory inquiry of human perspectives and interpretations, which gave the researcher a greater insight into these participants' experiences. The limits of this study are due to the small sample group of six therapists which cannot be seen to represent all therapists. A larger sample size would elicit more information for the research.

Semi structured interviews were conducted on a one to one basis and although participants were assured that they would not be identified in the research, respondents may not have answered truthfully, due to not wanting to present themselves or the organisations they worked for in a negative light.

The strengths of this research lie in the extensive experience and knowledge of the therapists interviewed, who provided extensive and meaningful data for the research, which both corroborated and conflicted with the literature.

6.2 Recommendations for Future Research

The literature review highlights how early childhood experiences can leave an individual more vulnerable to developing PTSD. Further research could be conducted to ascertain

whether these same early childhood experiences could leave a therapist more susceptible to developing vicarious trauma.

Organisational supports as part of professional self-care strategies were highlighted through the course of this research. A focused piece of research could be conducted on whether the dynamics of the organisation can mirror the dysfunctionality of their clients.

6.3 Research Conclusions

In conclusion, the study examined how vicarious trauma can be experienced by therapists working with clients with PTSD and provided a representation of the experiences and attitudes of counsellor and psychotherapists working with PTSD.

A number of key findings have been highlighted by this research. The first key finding is that there is a danger of therapists putting the needs of their clients before their own needs. This can have negative a negative impact on the clients they are working with. They may ignore their own discomfort, loosen boundaries, and not check in regularly with how they are assimilating the trauma material. This resulted in one therapist experiencing vicarious trauma.

A second key finding was that although only one therapist experienced vicarious trauma, all the therapists had experienced a marked change in their personal outlook, behaviour and thought processes as a result of being witness to their clients' suffering. This

highlights that challenging nature of the work and that through personal reflection and self-awareness that the risk of vicarious trauma can be reduced.

A third key finding was that the need for open discussion of the impact of the work on the therapists, the sharing of experiences, and the need for a close knit team are required to reduce the sense of isolation, helplessness and vulnerability that this work can evoke. Hearing other peoples' experiences provided reassurance to the therapists. This can be facilitated through ongoing training, regular team debriefing, supervision, and peer supervision.

A fourth key finding is the need for regular supervision with a supervisor who has experience in the field of trauma work. The need to speak openly without fear of judgment is essential to provide the support needed to do this work. For therapists to feel their vulnerability and sense of helplessness is accepted provides reassurance which reduces the sense of isolation that can be present in the work.

A fifth key finding is how therapists tolerance for the media and peoples' neurosis is decreased resulting in them avoiding certain material and social interactions. They seek more light hearted or positive outlets in order to have balance in their daily experiences. Engaging in self-care strategies which provide a sense of achievement and pleasure on a regular basis allow for the therapist to continue to engage in work that can have ambiguous successes.

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Appendix 1: Interview Schedule

Section 1: Background and initial impact of trauma work

1. Number of years working with clients who present with PTSD?
2. What drew you towards working with clients with PTSD?
3. What do you feel was the initial impact on you of working with clients with PTSD?
4. What was the ongoing personal impact of working in this area?

Section 2: Ongoing impact of trauma work and awareness of vicarious trauma

5. Did you notice any changes in your thought processes/behaviour/personal outlook?
6. What is your awareness of vicarious trauma?
7. How might it impact on your work?
8. How might it impact on your personal life?
9. How openly is it discussed amongst colleagues and during personal supervision?

Section 3: Strategies for reducing risk of vicarious trauma

10. What self-care strategies do you employ?
11. What organisational supports are in place where you practice?

12. Do you engage in ongoing professional development? What areas?
13. Do you engage in regular supervision? How much? When?
14. Do you enter personal therapy when things come up as a result of providing therapy?

Appendix 2: Interview Consent Form

“Understanding how vicarious trauma can be experienced by therapists working with clients with Post Traumatic Stress Disorder (PTSD).”

This study intends to examine the experiences of counsellors and psychotherapist who work with clients diagnosed with PTSD. This is part of my final year research project (BA Counselling and Psychotherapy) in Dublin Business School and my research supervisor is Mary Bartley.

The process involves an interview which should take no more than 40-50 minutes and will be recorded. The questions are about your experiences and views on the impact of working with clients with PTSD, your understanding of vicarious trauma and what methods you employ for your own self-care.

You will not be identified in the results of this research or in any part of the finished project. The information will only be used by the author for this research project.

Under data protection the author is required to keep the transcripts from the interviews for a period of 5 years and will be stored in a secure location during this time.

Participation in this study is completely voluntary, and you may stop the interview at any time, or withdraw your participation.

The purpose and process of this study has been explained to me, and I agree to Participate.

Participant's Signature: _____ Date: _____

Participant's Name in print: _____

APPENDIX 3: Research Information Sheet

“Understanding how vicarious trauma can be experienced by therapists working with clients with Post Traumatic Stress Disorder (PTSD).”

You are invited to participate in a research project that will form the basis for an undergraduate thesis. Please read the following information before deciding whether or not to participate.

What are the objectives of the study?

This study intends to examine the experiences of counsellors and psychotherapist who work with clients diagnosed with PTSD.

Why have I been asked to participate?

As a therapist working with clients with PTSD, your insight into the impact of the work, your understanding of vicarious trauma, and what strategies may be of benefit to reducing the risk of vicarious trauma will allow for further understanding into the issues faced by therapists working in this area. All data will be confidential and used solely for the purpose of this research.

What does participation involve?

The process involves an interview which should take no more than 40-50 minutes and will be recorded. The questions are related to your experience of working with clients with PTSD and the impact of this work on both your professional and personal life.

You will not be identified in the results of this research or in any part of the finished project. The information will only be used by the author for this research project.

Right to withdraw

Participants have the right to withdraw from the research at any time for whatever reason.

Are there any benefits from my participation?

While there will be no direct benefit from participation, it is envisaged that the results of this study may lead to a deeper understanding of vicarious trauma and effective methods of dealing with it.

Support Services

If you feel that you have been affected by this study, making an appointment with a personal therapist and engaging in supervision would be recommended.

For further contact details for either a therapist or a supervisor you can contact IACP
(Irish Association for Counselling and Psychotherapy) on 01- 2723427.