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MAJOR RESEARCH PROJECT

REBECCA RADFORD MSc

SECTION A: Mental health professionals' responses to clients' trauma: a review of the literature on vicarious trauma.

WORD COUNT: 5498 (199)

SECTION B: Care coordinators' responses to clients' trauma: the role of coping and perceived organisational support.

WORD COUNT: 7971 (389)

SECTION C: Critical Appraisal

WORD COUNT: 1982

Total word count: 15,451 (588)

A thesis submitted in partial fulfilment of the requirements of Canterbury Christ Church University for the degree of Doctor of Clinical Psychology

July 2013

SALOMONS

CANTERBURY CHRIST CHURCH UNIVERSITY

ACKNOWLEDGEMENTS

IF

*If you can keep your head when all about you
Are losing theirs and blaming it on you,
If you can trust yourself when all men doubt you,
But make allowance for their doubting too;
If you can wait and not be tired by waiting,
Or being lied about, don't deal in lies,
Or being hated, don't give way to hating,
And yet don't look too good, nor talk too wise:*

*If you can dream - and not make dreams your master,
If you can think - and not make thoughts your aim;
If you can meet with Triumph and Disaster
And treat those two impostors just the same;
If you can bear to hear the truth you've spoken
Twisted by knaves to make a trap for fools,
Or watch the things you gave your life to, broken,
And stoop and build 'em up with worn-out tools:*

*If you can make one heap of all your winnings
And risk it all on one turn of pitch-and-toss,
And lose, and start again at your beginnings
And never breathe a word about your loss;
If you can force your heart and nerve and sinew
To serve your turn long after they are gone,
And so hold on when there is nothing in you
Except the Will which says to them: "Hold on!"*

*If you can talk with crowds and keep your virtue,
Or walk with kings - nor lose the common touch,
If neither foes nor loving friends can hurt you,
If all men count with you, but none too much;
If you can fill the unforgiving minute
With sixty seconds' worth of distance run,
Yours is the Earth and everything that's in it,
And - which is more - you'll be a Man, my son!*

Rudyard Kipling (1865-1936)

Firstly, I would like to acknowledge the individuals who took part in this study, for giving of their time and sharing their personal experiences thank you so much. I would also like to thank my supervisors Dr Emma Ross and Dr Sue Holttum for their ongoing support and encouragement over the past three years.

I would especially like to thank all my family and friends who have kept me going throughout this Doctorate. In particular my husband, mum and brother - you have been my rock as always. If it was not for your unconditional love, support and belief in me I would not have made it to this point. Thank you for always cheering me on and for helping me to see the bigger picture when things got tough.

This is for you. Thank you.

SUMMARY OF PORTFOLIO

Section A provides a critical review of the extant literature relating to vicarious trauma in mental health professionals. It begins by outlining the prevalence of trauma within mental health services before defining trauma-related concepts such as secondary trauma, vicarious trauma, compassion fatigue and burnout. Vicarious trauma is then explored in relation to its measurement, theoretical underpinnings and impact on professionals. Empirical research into vicarious trauma within mental health professionals is then reviewed, including studies encompassing both individual and organisational factors in the development of VT. The review concludes with an overall discussion and outlines areas for future research.

Section B provides the findings of a qualitative study into the impact of trauma-work on 12 UK care coordinators within two NHS secondary care mental health recovery services. Semi-structured interviews were completed with six psychiatric nurses, four social workers and two occupational therapists. The interview focused on individuals responses to hearing clients' traumatic stories, the role of coping and perceived organisational support. A grounded theory model of care coordinators' experiences is provided. This model is discussed in relation to existing theory and research into trauma work. The study concludes with clinical implications of the findings, methodological limitations and suggestions for future research.

Section C is a critical appraisal of the study's methodology and findings, particularly in relation to the clinical implications and future directions for research.

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MAJOR RESEARCH PROJECT

REBECCA RADFORD MSc

SECTION A:

MENTAL HEALTH PROFESSIONALS' RESPONSES TO CLIENTS' TRAUMA: A
REVIEW OF THE LITERATURE ON VICARIOUS TRAUMA

WORD COUNT: 5,498

A thesis submitted in partial fulfilment of the requirements of Canterbury Christ
Church University for the degree of Doctor of Clinical Psychology

July 2013

SALOMONS

CANTERBURY CHRIST CHURCH UNIVERSITY

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ABSTRACT:

Aim & objectives: The impact on professionals of hearing their client's traumatic experiences has been investigated within the past two decades, with the view that it can have deleterious and long-standing effects on the professionals exposed. One way in which this can occur is through vicarious trauma (VT) – which is the change that occurs to an individual's schemas and outlook on themselves and the world. It is proposed that VT can have a detrimental impact on professionals both in the short and long term, and for this reason it is an important mental health concern for both individuals and organisations. This review aimed to critique the current status and suggest future directions for research into vicarious trauma in mental health professionals.

Method: Cinahl, Ovid Medline, PsychInfo, the British Nursing Index and Archive and Google scholar were searched using a range of search terms: 'vicarious trauma', 'vicarious traumatisation', 'secondary traumatic stress' and 'compassion fatigue'.

Results and conclusion: Twenty seven articles relevant to VT were reviewed. Findings suggested some discrepancy in the literature regarding whether VT occurs in a range of professionals and how to measure it. Mixed results were found regarding the importance of individual factors (such as a personal history of abuse) and organisational resources (such as supervision) within VT. The majority of studies investigated VT within professionals providing therapy and a dearth of UK studies was highlighted. Future research should continue to investigate the differences between vicarious trauma and related concepts and to elucidate its mechanisms and how it might be prevented. Additionally, studies should establish whether the risk of VT is restricted to specialist trauma workers or can also apply to generic mental health professionals.

1. **INTRODUCTION:**

1.1 Working with trauma

A large proportion of health-care professionals work with individuals that have experienced some degree of trauma (either physical or psychological), and subsequently have psychological difficulties (Sabin-Farrell & Turpin, 2003). Working with individuals who have experienced trauma is termed 'trauma work' and can involve being exposed to clients' descriptions and responses to their traumatic experiences. The experience of trauma is thought to be relatively common in the general population (Yule, Williams & Joseph, 1999) and is often the central issue for people with mental health problems. Indeed, estimates suggest that, at any time, 47% of mental health workers will be working with survivors of childhood sexual abuse (Sabin-Farrell & Turpin, 2003). Considering this and other traumatic experiences, mental health professionals have a high chance of engaging empathically with trauma survivors in their work.

1.2 The impact of working with trauma:

In the last two decades research has suggested that being exposed to another's traumatic experience can lead to indirect traumatising and stress in the professional (Blair & Ramones, 1996). McCann and Pearlman (1990) proposed the term 'vicarious trauma' (VT) to describe the negative and long-standing impact that working with trauma victims may have on the therapist. They provided a conceptual framework for understanding VT - the 'self-constructionist self-development theory' (CSDT). The CSDT theory suggests that the way that we make sense of the world

(our cognitive schemas) can become altered when new information does not correspond with our own beliefs. It has been suggested that VT has far-reaching effects leading to changes in both self-and professional identity, one's view of the world, spirituality, self-capacities and psychological beliefs, particularly relating to safety, trust and control (Saakvitne & Pearlman, 1996).

The CSDT framework also proposes that exposure to clients' trauma can lead to sensory changes including imagery intrusions and other bodily reactions (Pearlman & Saakvitne, 1995). Indeed, some theorists suggest that these responses can lead to posttraumatic stress disorder (Blair & Ramones, 1996). Importantly, professionals can attempt to cope with the knowledge of others' trauma through defensive reactions such as psychological numbing or denial. This can diminish professionals' ability to provide care to others and thus both individuals and organisations are compromised through the experience of VT (Dunkley & Whelan, 2006).

More recently, theorists have suggested that some individuals can also experience positive outcomes in response to trauma work which has been termed vicarious post-traumatic growth (Brockhouse, Msetfi, Cohen & Joseph, 2011). Although this is an emergent area of research with relatively few studies, (Brockhouse, Msetfi, Cohen & Joseph, 2011) the CSDT framework is also proposed to account for such changes – as individuals gain a more positive view of the world through a change in their cognitive schemas (Tedeschi, Park, & Calhoun, 1998). This area has attracted interest alongside research into VT.

1.3 Defining vicarious trauma:

Although the term 'vicarious trauma' was coined by Mc Cann and Pearlman (1990) there are a number of related concepts that also describe the impact of trauma-work. Terms such as secondary trauma, compassion fatigue and burnout have also been found within the VT literature (Tabor, 2011). Although confusion and overlap between the terms has been acknowledged, authors have tried to distinguish between the concepts (Jenkins & Baird, 2002). Burnout is thought to be best described as a 'psychological syndrome in response to chronic interpersonal stressors on the job' (Maslach, Schaufeli & Leiter, 2001). It is thought to encompass being depleted of one's 'emotional and physical resources' and may arise from a range of caring roles (Deville, Wright & Varker, 2009). Compassion fatigue (CF) and secondary traumatic stress (STS) are terms that are thought to be interchangeable as Figley (1995) states 'compassion fatigue is a more user friendly term for secondary stress disorder'. Importantly, STS and CF are not thought to encompass the cognitive and schematic changes outlined in VT. Although this distinction is helpful, the historical overlap in terminology has made research findings difficult to interpret (Sabin-Farrell & Turpin, 2003).

1.4 The measurement of vicarious trauma

The majority of research studies into VT have employed questionnaires to provide quantitative data. The most widely used measures of trauma symptoms are the impact of events scale (IES) (Horowitz, Wilner, & Alvarez, 1979) and the Trauma Symptom Checklist-40 (Elliott & Briere, 1992). Specific measures of VT have also been developed including the traumatic stress institute belief scale (TSI-BS) which measures an individual's disrupted beliefs (Pearlman, Maclan, Johnson, & Mas, 1992). Other scales include the compassion fatigue self-test for practitioners (CFST)

and the secondary traumatic stress scale (STSS) (Motta, Kefer, Hertz, & Hafeez, 1999). Although these measures are widely used in trauma research, those that do not identify changes in beliefs have been criticised for not measuring VT specifically. In addition to quantitative studies, qualitative research has also explored experiences of VT, employing a range of methodologies.

1.5 Individual and organisational factors in vicarious trauma:

A number of authors have highlighted the importance of assessing how VT may be influenced by individual and organisational factors (Dunkley & Whelan, 2006). For example, some studies have found a link between VT and personal trauma history, negative coping strategies, levels of stress, psychiatric history and intellectual functioning (Brewin, Andrews & Valentines, 2000; Halligan & Yehuda, 2000; Pearlman & Maclan, 1995). In terms of work characteristics, organisational culture, supervision, group support, self-care, work environment and education are hypothesised to alleviate the impact of VT on individuals (Bell, Kulkarni & Dalton, 2003). However, studies in this area have produced inconsistent results and uncertainty remains about the contribution of individual and organisational factors in VT (Sabin-Farrell & Turpin, 2003).

1.6 Rationale for this review:

The aim of this review is to critique the extant literature relating to VT in mental health professionals. The review will focus on VT specifically, as opposed to related concepts such as secondary trauma. Therefore, for this review, VT will be classified as a change or alteration in beliefs/views of the world, in addition to symptomatic distress where reported. The review will exclude individuals who are not primarily

engaged in therapeutic work with trauma survivors such as emergency workers or judicial personnel. In this way, the review builds upon findings from the most recent review in this area (Sabin-Farrell & Turpin, 2003) which encompassed vicarious trauma within health care professionals more broadly. This is important as VT research has been carried out with a range of individuals, posing a challenge to the synthesis of findings relating to mental health professionals specifically.

2 **METHOD:**

2.1 Literature search:

The following databases were searched: Cinahl (1981-March 2013), Ovid Medline (1946-March 2013), PsychInfo (1806-March 2013), the British Nursing Index and Archive (1993-March 2013) and Google scholar. Due to the historic overlap in conceptual terms, a range of search terms were employed including 'vicarious trauma', 'vicarious traumatisation', 'secondary traumatic stress', and 'compassion fatigue'. A number of results were produced (please see appendix 1) and each study was reviewed against the inclusion/exclusion criteria. Reference lists of articles were also reviewed for further studies.

2.2 Inclusion/Exclusion criteria:

Inclusion criteria: Studies that encompass VT as defined by a change or alteration in outlook or beliefs/views of the world, in addition to symptomatic distress where reported. Also, studies including mental health professionals/therapists; psychiatric nurses, social workers, psychologists, counsellors, psychotherapists, psychiatrists, child welfare officers and other

professionals who engage therapeutically with traumatised individuals. Articles published in English and from peer reviewed journals were also included.

Exclusion criteria: Articles involving non-professionals and professionals not primarily engaged in therapeutic work. Also, studies not pertaining to a change in beliefs or schemas and unpublished dissertations were excluded.

3 LITERATURE REVIEW:

3.1 Quantitative and mixed-methodology studies

The literature search produced a total of 15 quantitative and mixed-methodology articles. Furthermore, two review papers and three conceptual reviews were identified. The main findings of each article are discussed under key themes. Please see Appendix 2 for a summary of each article.

Existence of VT:

One of the key debates within the area of VT is whether it is a separate concept from secondary trauma/compassion fatigue and burnout, and how prevalent it is. Two of the earliest studies into VT found it to be present in trauma therapists and counsellors (Schauben & Frazier, 1995; Pearlman & Mac Ian, 1995). Schauben and Frazier (1995) found that counsellors with higher numbers of sexual violence survivors on their caseloads had higher levels of symptoms of PTSD and VT (as measured by the TSI Belief Scale and a self-report measure). However, the correlations between caseload and VT were weak and the authors used non-standardised measures, rendering it difficult to be conclusive about the findings. The second study by Pearlman and Mac Ian, (1995) investigated the impact of trauma-

work on 188 trauma therapists in America and found that less experienced therapists had more altered beliefs about self-trust, self-intimacy and self-esteem and experienced higher levels of anxiety, intrusions and avoidance. However, the correlations in this study were also weak which undermines the reliability of the results. Also, the finding that a higher proportion of sexual violence survivors on one's caseload were associated with less disruption in beliefs was not fully explored by the authors. The findings of these earliest studies therefore raised discussion about whether VT exists and whether certain variables (such as years of experience) are potential risk factors for VT.

More recent studies have contradicted the findings of the two studies discussed (Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995). For example, Devilly, Wright and Varker, (2009) investigated VT, STS and burnout in a sample of 152 mental health professionals in Australia. They found relatively low levels of all three variables within the sample and found that exposure to patients' traumatic material was not correlated with any of the variables. Although this study appeared to contradict the previous studies and the CSDT framework, the response rate for the study was relatively low (32%), and the average age of the sample was over 38. This suggests that younger professionals who may have left the field due to difficulties in coping were not represented in the sample.

Other studies have also called into question the existence of VT as Dunkley and Whelan (2006) found generally low levels of traumatisation (i.e. disruption in beliefs and PTSD symptoms) in 62 Australian telephone counsellors. However, although the return rate of surveys was comparable to previous studies, the sample size was small and comprised mainly women which may have influenced the findings.

Importantly however, the study highlighted that VT is possible in telephone counsellors as five participants fell within the 'high' or 'very high' range for disruptions in cognitive beliefs. Therefore although early studies concluded that VT occurred in trauma therapists and counsellors, more recent studies have not replicated these findings, calling into question the existence of VT.

The impact of working with different types of trauma:

Another key issue within the literature is whether working with different client groups predisposes an individual to VT. A recent mixed-methodology study looked into positive and negative changes in 143 Israeli social workers from the field of family violence and 71 general social workers (Ben-Porat & Itzhaky, 2009). The results suggested that the two groups did not differ significantly in levels of VT. However, significantly more general positive and negative changes were experienced by family violence social workers. This suggested that social workers exposed to clients with experiences of family violence were not at a greater risk of VT than social workers from other fields. However, the authors acknowledged that clinicians not working in the field of family violence may have been exposed to trauma from previous roles, making comparisons between types of trauma exposure a challenge.

In contrast to previous findings, Cunningham (2003) found that the type of trauma social workers encountered did impact upon the experience of VT. In this study, social workers in the areas of sexual abuse and cancer completed measures of VT. Clinicians in the sexual abuse field reported more disruptions in cognitive schemas than clinicians in the cancer field. However, due to the cross-sectional nature of the study causation could not be implied and the study used self-report measures of

level of exposure to clients' trauma which is subject to error. Therefore the studies reviewed indicate contradictory findings as to whether the type of trauma exposed to influences the experience of VT.

History of childhood trauma:

Some studies suggest that a personal history of childhood trauma predisposes an individual to VT. One of the first studies to investigate this was by Baird & Jenkins (2003). In this study, 99 sexual assault and domestic violence counsellors with interpersonal trauma histories completed the TSI Belief Scale (a measure of VT) and the compassion fatigue self-test. Counsellors with interpersonal trauma histories scored higher on the compassion fatigue self-test but not on VT or burnout, suggesting that a personal trauma history does not impact upon experience of VT. However, the study acknowledged a lack of information on response rate and no information regarding non-responders who the authors suggest could have been more distressed than responders. Another early study by Adams Matto and Harrington (2001) found that TSI scores were not associated with social workers' personal trauma history, their reported weekly amount of face-to-face client contact, or self-reported levels of intrusions of clients' material. However the authors acknowledge that TSI scores appear to be measuring perceptions about self and work that, like burnout, may relate to social workers' general outlook rather than trauma work per se. Furthermore, a significant overlap was found between the TSI and burnout scores suggesting a lack of distinction between the concepts.

Two other studies were found to negate a link between VT and a personal trauma history. No association was found between the two variables in telephone counsellors (Dunkley & Whelan, 2006) and clinicians who treat sexual abuse

survivors (Van Deusen & Way, 2006). However, there was a low response rate (33%) in the Van Deusen and Way (2006) study, and perhaps individuals who left the field due to VT were not represented in the sample. Furthermore, the study did not include a non-sexual abuse control group making it difficult to generalise findings to other clinicians. The Dunkley and Whelan (2006) study also acknowledged that the measurement of VT was problematic as the TABS and IES-R relate to 'first hand' trauma and were not correlated suggesting that they measure different constructs.

Other studies have found a link between childhood trauma and the experience of VT. Way, VanDeusen and Cottrell (2007) found that childhood emotional neglect and younger age predicted greater disrupted cognitions about self-intimacy. However, this study was also affected by a low response rate and only assessed clinicians providing sexual abuse treatment. Furthermore, an American study (Michalopoulos, 2012) found that social workers with a trauma history were more likely to experience VT, and that social support was a protective factor for those without a trauma history but not those with one. These studies therefore suggest that a personal history of childhood trauma can increase the likelihood of developing VT.

Two other studies have also found a positive association between the experience of childhood trauma and VT in domestic violence counsellors (Jenkins, Mitchell, Baird, Whitfield & Meyer, 2011) and therapists (Williams, Helm & Clemans, 2012). However, causal conclusions between childhood trauma and VT cannot be made due to the cross-sectional design, and a larger more heterogenous sample would assist in understanding the relationships between variables such as motivation for working within the area, VT and related concepts. Interestingly, Williams, Helm and Clemans (2012) found that therapists who engaged in more self-care activities

benefited from the partial mediating effect of self-care on VT when they had experienced childhood trauma. Although the sample size was acceptable for the path analytic procedures employed, larger samples are generally preferable. These studies suggest a link between childhood trauma and VT, which may be mediated by self-care.

Other Individual factors:

Individual differences have also been proposed to influence the development of VT. Key factors investigated include social support, experience level, age, spirituality and gender amongst other things. An early study by Brady, Guy, Polestra and Brokaw (1999) looked at VT in the context of spirituality. They completed a national survey in America with 1000 female psychotherapists. Interestingly, the study found that therapists with higher levels of exposure to sexual abuse material reported significantly more trauma symptoms but no significant disruption of cognitive schemas. Spiritual well-being which has been thought to be a key area damaged in VT was found to be higher in therapists who saw a higher number of sexual abuse survivors. The study employed a large sample size which added credibility to the findings, and they concluded that being exposed to suffering may enhance spiritual well-being. The finding however is contrary to the CSDT framework.

Another study by Dunkley and Whelan (2006) investigated the impact of coping styles on VT and found that a non-productive coping style was related to disruptions in cognitive beliefs, while an active problem-solving approach was not. Another study into counsellors of trauma victims found that time spent counselling victims was the best predictor of trauma scores (Bober & Regehr, 2006). Although participants generally believed in the usefulness of recommended coping strategies including

leisure activities, self-care and supervision, these beliefs did not translate into participation in the activities. Importantly, there was no association between time devoted to coping strategies and traumatic stress scores. Importantly, this study had a relatively high response rate (45%), suggesting that the sample was more representative of the population than other studies in the area.

Way, VanDeusen and Cottrell (2007) investigated age and gender in relation to VT and found that being male and being younger predicted greater disrupted cognitions about self-esteem and self-intimacy which is the ability to be attuned to one's emotional experiences. The study by Michalopoulos (2012) found that an increase in social support and in experience level of social workers predicted less severe VT. These studies therefore suggest that younger individuals and men are more disposed to the experience of VT and those with greater social support and experience are less likely to develop it.

Organisational factors:

Studies have also suggested that organisational factors can impact upon VT. Dunkley and Whelan (2006) found that supervisory working alliance was associated with lower levels of disruption in beliefs. However, the authors concluded that simply receiving supervision was not sufficient and that a positive relationship with supervisors was needed in order to reduce VT. However, it is important to acknowledge that the study utilised a small sample size, most of whom were women. Also, Devilly Wright and Varkers (2009) found that work-related stressors best predicted therapist distress. However, as discussed, their study acknowledged a low response rate, as well as a largely female sample.

A key study which has challenged the view that organisational strategies reduce VT is by Williams, Helm and Clemans, (2012). This study found that supervisory working alliance did not mediate the effect on VT. However, clinicians who experienced an inadequate relationship with supervisors were not represented in the model. Importantly, the study was the first to examine the effect of organizational factors on VT, finding that organizational culture and workload did not significantly affect development of symptoms of VT. Thus, the results of this study did not align with CSDT, or the notion that organizational culture and workload directly influence therapists' vulnerability to VT.

3.2 Critique:

The studies reviewed suggest that uncertainty remains over whether VT occurs in response to trauma work. Although studies have provided evidence to both support and refute the existence of VT, the limitations discussed make it difficult to be conclusive about the findings. The studies also highlight inconsistent findings relating to the importance of gender, experience, caseload and supervision in VT. However, this may in part be linked to the different ways in which VT is measured, making comparisons between studies difficult. In addition, the studies reviewed encompassed diverse samples in terms of professional background, caseloads and type of trauma exposed to which further complicates the synthesis of findings.

Most of the studies reviewed were completed in America or Australia, suggesting the need for UK studies. In addition, many studies highlight the need for research into more generic mental health clinicians and those with a mixed caseload of clients.

Furthermore, many studies acknowledged the apparent response bias inherent within VT research due to the sensitive nature of the topic. This may result in individuals taking part because of a personal experience of VT and thus not representing a range of views. Importantly, many of the studies utilised relatively small sample sizes, or found weak correlations between variables suggesting that some findings are less robust. Lastly, many studies had a homogenous sample in terms of gender and ethnicity making the findings less generalisable.

3.3 Qualitative studies

Twelve qualitative articles were identified which focused specifically on the experience of VT and studies are explored according to key themes. Please see Appendix 3 for a summary of each article.

Experiences of working with trauma:

One of the earliest qualitative studies to investigate the impact of trauma work was by Steed and Downing (1998). In their Australian study, four female counsellors and eight female psychologists working with sexual abuse survivors completed interviews which were analysed using thematic content analysis (Steed & Downing, 1998). The study found that therapists commonly reported affective responses to their client's material and that outside of therapy counsellors reported negative effects physiologically, emotionally and cognitively which adversely affected their personal and professional lives. However, positive responses were also noted, and thus it was suggested that the current conceptualisation of VT may be limited. Although this was one of the first qualitative studies to identify positive responses, the study did not provide information on the thematic analysis or on how

inter-rater reliability or quality was established, making the quality of the findings difficult to ascertain.

A second qualitative study was completed by Iliffe & Steed, (2000). In this study, 18 Australian counsellors (thirteen women and five men) were interviewed about how they cope with working with victims of domestic violence which were analysed using interpretative phenomenological analysis (IPA). Participants described classic symptoms of VT including changes in cognitive schemas and also reported burnout. Some of the coping strategies included monitoring caseload, debriefing, peer support, self care and political involvement. Importantly, this study did not identify positive effects of trauma-work for participants. Furthermore, including five males in the sample made a comparison of gender differences difficult.

Other studies have explored VT in psychological practitioners and therapists (O'Neill, 2010; Smith, Kleijn, Trijsburg & Hutschemachers, 2007). O'Neil, (2010) interviewed eight Canadian practitioners working with traumatized clients in isolated communities. A narrative analysis found profound changes in beliefs, expectations, assumptions of self and the world, levels of compassion and strength, and identity. Importantly the participants had also experienced posttraumatic growth. The authors acknowledged however that the boundaries between researcher and practitioner were not always clear throughout the research. Furthermore, participants were not given a guiding definition of VT; rather, the research questions focused on general experience. This may have inadvertently led participants to share more general aspects of their experience rather than specific experiences of VT (O'Neill, 2010).

In contrast to the previous studies, Smith, Kleijn, Trijsburg and Hutschemachers (2007) completed interviews in the Netherlands with 11 trauma therapists about how they cope with client's traumatic experiences. Grounded theory was employed and the findings highlighted 20 categories of reaction types which included shock, anxiety, helplessness and intrusions amongst other things. However, the study did not identify any changes in cognitive schema or general outlook suggesting that VT was not identified in this sample.

Importantly, three relatively recent qualitative studies have found positive responses to trauma work alongside the more negative aspects. A Sri Lankan study by Satkunanayagam, Tunariu & Tribe (2010) used IPA to explore the impact of trauma-work for 12 counsellors, psychologists and psychiatrists. The study found an accumulated negative emotional impact as well as invaluable opportunities for positive growth when participants rebuilt their assumptions of the world in light of their clients' trauma. Another study of 21 American psychotherapists reported both negative and positive consequences of trauma work (Arnold, Calhoun, Tedeschi & Cann, 2005). Negative consequences included changes in therapist's view of the world, basic beliefs about human nature and in the degree of optimism about the future. Positive aspects included increased levels of sensitivity, compassion, insight, tolerance, and empathy. The study employed a respectable sample size and also used a member-check and inter-rater reliability which increased the validity of the findings, although the constant comparison method was poorly outlined.

Another US study by Lonergan, O'Halloran and Crane (2004) also identified positive aspects of trauma work. Eight therapists working with traumatized children completed semi-structured interviews which were analysed using Interpretivist

paradigm. The negative symptoms of trauma work included sadness, grief and a growing awareness of secondary stress. Importantly, positive experiences included being able to interpret some of their own negative experiences as positive. In contrast, Clemans (2004) found that 21 American women employees of a rape crises programme reported a host of emotional and existential challenges such as increased feelings of vulnerability as women, diminished trust in others, and questioning the overall goodness of society.

Coping

Four qualitative studies investigated coping strategies for trauma-work. Firstly, Harrison and Westwood (2009) analysed interviews with six Canadian therapists working with traumatized clients using narrative analysis. A number of protective practices were identified including countering isolation; developing mindful self-awareness; expanding perspective to embrace complexity; active optimism; self-care; maintaining boundaries; empathy; professional satisfaction; and creating meaning. However, the sample size was relatively small and they identified the need to study individuals who are coping and not coping in order to broaden perspectives. In another study, Hunter and Schofield (2006) completed interviews with eight Australian counsellors in order to explore how they cope with clients' traumatic experiences. They employed grounded theory and found that counsellors developed their own personal and professional strategies for coping with the challenge of traumatic stories and also utilised support provided by the organisation.

One qualitative study explored the relevance of supervision in VT (Sommer & Cox, 2005). This involved semi-structured interviews with sexual violence counsellors (one man and eight women). The interpretive analysis revealed four

themes: talking about the effects of the work, addressing VT in supervision, supervision encompassing a collaborative rather than expert-model approach and tensions regarding supervisors also being managers. Lastly, Lonergan, O'Halloran and Crane (2004) also identified coping strategies that trauma therapists employed to manage the effects of trauma-work and VT. They included consultation, exercise, vacations, developing hobbies, setting limits around discussing work, limiting the number of difficult cases and working as part of a team.

History of trauma and VT

Qualitative studies have addressed other factors that are thought to influence the development of VT. In a US sample, Benatar (2000) explored the effects of working with survivors of sexual abuse for experienced therapists with/without a history of childhood sexual trauma. Twelve trauma social workers and psychologists completed interviews which were analysed using thematic analysis. The study found that experience with trauma work and similarities between patients and therapists trauma histories were important factors in evaluating the impact of the work. In this way, experienced therapists with a childhood sexual abuse history did not appear to be more vulnerable to VT than their counterparts.

3.4 Critique:

Qualitative methods have become an increasingly popular means of investigating experiences of VT. However, it is clear that quantitative studies of VT which encompass measures appear to dominate. Overall, the qualitative studies reviewed suggest that VT exists in a range of professionals and that there are positive aspects of working with trauma as well as negative ones – further supporting the idea that current conceptualisations of VT may be too narrow. The qualitative studies also

appear to provide more detailed accounts of individuals' experiences of VT which have not necessarily been captured in standardised measures. As with the quantitative studies, most of the qualitative studies have been completed in Australia or America, and with individuals directly involved in therapy with traumatised individuals.

4 SUMMARY OF THE REVIEW AND RESEARCH IMPLICATIONS:

This review has aimed to critique the extant literature relating to VT in mental health professionals. A total of 27 articles were reviewed; a summary of the findings is explored:

Existence and prevalence of VT

Overall, research studies have produced some inconsistent findings regarding the evidence base for the existence of VT. However, the findings do suggest that, for some individuals, working with trauma has a detrimental effect on their mental health and that this appears to go beyond just work-related stress. Although larger scale quantitative studies have found VT to be present in some professionals (Schauben & Frazier, 1995; Pearlman & Mac Ian, 1995), the methodological limitations such as small sample sizes have undermined the findings. Importantly, the qualitative studies reviewed have also provided valuable evidence on the experience of trauma-work and VT. Generally qualitative studies have provided more consistent support for VT although a key limitation is that these studies may have recruited individuals who consider themselves adversely affected by their exposure to trauma work. What remains unclear is the extent to which findings from qualitative studies and

quantitative studies have been integrated– in terms of areas of discrepancy and commonality.

None of the studies reviewed have addressed the way in which VT develops in professionals. This is in part due to the lack of clarity regarding the concept, as well as the emphasis on cross-sectional studies which prevent causative models from being tested. However, qualitative studies are amenable to exploring developmental processes, and some of the studies reviewed highlighted the evolution of particular symptoms or strategies in VT.

Measurement of VT

One of the most important issues relates to how VT is measured. Studies have employed a range of measurement tools, but there is yet to be one VT questionnaire which is consistently used in research. In addition, another common criticism in this area is that certain measures such as the IES asks participants about their own responses to trauma rather than responses to clients' trauma. Therefore the call for a widely-accepted measure for VT remains. The qualitative studies reviewed have however helpfully increased understanding of how individuals can be affected by trauma – suggesting a broader repertoire of responses than measures encompass. Although the issue of measurement of VT is ongoing, some authors in the area acknowledge that our “strongest assessment tool is our ability to reflect on our own experience” (Figley, 1995).

In addition, a closely related issue within the VT literature relates to the interchangeable use of the terms VT, ST and CF which has posed a challenge to

defining and measuring VT. Furthermore, certain studies (Devilley, Wright & Varker, 2009; Adams, Matto & Harrington, 2001) have found a high correlation between VT and related concepts such as burnout. Therefore further investigation into the differences between these related concepts should continue (Jenkins & Baird, 2002). Importantly, the review suggests that some mental health professionals also experience positive benefits from being exposed to trauma– namely posttraumatic growth. This leaves researchers questioning whether studies which treat them as separate phenomena are in some ways restricting our understanding of them. Therefore future work should be more cohesive in addressing the impact of trauma work rather than investigating either VT or vicarious posttraumatic growth, and should investigate these concepts over time.

Factors associated with VT

Another key area which warrants further investigation is the extent to which individual and organisational factors can reduce VT. The studies reviewed produced mixed findings regarding helpful strategies. However, some of the factors thought to predispose a person to VT include being younger, less experienced, being male and having a history of abuse. Organisational factors that may protect individuals from VT include a good supervisory relationship and appropriate workload. Qualitative studies identified extensive coping strategies used by participants but have not shown whether such strategies can lead to a reduction in VT. Therefore the factors associated with VT and its management warrants further investigation.

Sample

Another common issue is the relatively low response rate which makes it difficult to ascertain whether participants were similar to those who declined to participate. Furthermore, most of the participants were from professional groups (such as therapists) who are engaged in formal therapeutic work with trauma survivors. Many studies recommended that future research should broaden the sample to more generic mental health workers to establish whether the risk of VT is restricted to only specialist trauma workers. This is particularly important in light of the responsibility to assess and address risk in the workplace (Health & safety executive, 2001). Lastly, most studies included Australian and American professionals, with little known about UK populations.

Clinical Implications

This review suggests that despite the inconsistent findings, some mental health professionals may be at risk of vicarious trauma through their exposure to traumatic stories. However, the impact of VT on clinicians' ability to fulfil their professional roles and on the organisation more generally remains unknown. Furthermore, the evidence remains unclear as to what can sustain or protect mental health professionals from VT in practice. For example, a number of organisational factors have been investigated in relation to VT including supervision style, working alliance with supervisors and organisational culture; the results of which are inconclusive. Therefore understanding organisational influences on VT is important, in addition to whether specific training or other preventative interventions would helpfully reduce the experience of VT. This is particularly important in light of the responsibility that organisations have to protect staff from the harm that certain jobs may bring (Health & safety executive, 2001).

Future research

In summary, the review suggests that future research should continue to discriminate between VT and related concepts and appropriate measurement tools. This is also important given the more positive aspects of trauma-work that studies have identified – emphasising that the current conceptualisations of VT may be too narrow. Future research should consider how to integrate findings from different methodologies and should address the impact of trauma work on a broader range of professionals such as generic mental health workers and clinicians within the UK. Further qualitative research might helpfully map how individuals' responses to clients' trauma are managed over time and to explore why some individuals report positive experiences indicative of personal growth.

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MAJOR RESEARCH PROJECT

REBECCA RADFORD MSc

SECTION B

CARE COORDINATORS' RESPONSES TO CLIENTS' TRAUMA: THE ROLE OF
COPING AND PERCEIVED ORGANISATIONAL SUPPORT

WORD COUNT: 7971

A thesis submitted in partial fulfilment of the requirements of Canterbury Christ
Church University for the degree of Doctor of Clinical Psychology

July 2013

SALOMONS

CANTERBURY CHRIST CHURCH UNIVERSITY

ABSTRACT

Aim and Objectives: Research suggests that working with trauma survivors can result in a range of negative effects including ‘vicarious trauma’, ‘secondary trauma’, ‘compassion fatigue’ and ‘burnout’ amongst other things. Although the impact of being exposed to traumatic stories has been investigated in a range of professionals no studies to date have explored the impact of this on UK mental health workers known as care coordinators. The aim of this study was to explore a sample of care coordinators responses to client’s traumatic stories and the role of coping and perceived organisational support.

Method: Twelve UK care coordinators (community psychiatric nurses, occupational therapists and social workers) from two NHS mental health recovery teams completed interviews about their experiences of hearing clients’ traumatic experiences. Grounded theory was employed to analyse the interviews.

Main findings: The care coordinators heard traumatic stories in their role and were ‘active participants’ in these disclosures. They also experienced short and long-term levels of distress which included a range of negative emotions, a mixture of positive and negative responses and a broadening of their perspectives on themselves, their clients and the world. Care coordinators also developed a range of individual coping strategies, experienced individual and organisational barriers to seeking support and experienced limited organisational support for hearing traumatic stories.

Implications and future research: This is the first UK study to investigate care coordinators’ responses to clients’ traumatic experiences. Therefore further exploratory studies are required in addition to studies with larger sample sizes and measures of trauma related symptoms.

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1. INTRODUCTION

1.1 The prevalence of trauma in mental health

A traumatic experience is an aversive event which is physically or psychologically damaging for an individual and leads to subsequent psychological difficulties (Sabin-Farrell & Turpin, 2003). The experience of trauma is thought to be relatively common in the general population, as estimates suggest that between 40% and 70% of people have experienced a traumatic event (Yule, Williams & Joseph, 1999). Furthermore, the experience of trauma is often common for people with mental health difficulties with estimates suggesting that over 95% of mental health service users have experienced a traumatic event (Switzer et al, 1999). Furthermore, nearly half of all mental health service users are thought to have experienced symptoms of posttraumatic stress disorder (PTSD) (Sabin-Farrell & Turpin, 2003). Therefore estimates suggest that mental health professionals are likely to engage with trauma survivors in their professional roles.

1.2 The impact of trauma-work on professionals

'Trauma-work' relates to the empathic engagement with individuals who have experienced traumatic events. Over the past 20 years there has been an interest in the impact of trauma-work on professionals (Cohen & Collins, 2012) and this has led to a growing body of research into concepts such as 'secondary trauma', 'compassion fatigue', 'vicarious trauma' and 'burnout' amongst others. The view that trauma-work could have a negative impact upon professionals first derived from literature on 'secondary traumatic stress' (STS) (Figley, 1995a). STS related to symptoms and emotional responses similar to posttraumatic stress disorder (PTSD) which individuals working with trauma survivors can exhibit (Figley, 1995a). The term

'compassion fatigue' (CF) also relates to the emotional reactions specific to trauma-work but authors have more recently suggested that CF and STS are terms that can be used interchangeably (Sabin-Farrell & Turpin, 2003). In contrast, burnout can be defined as the 'cost of caring' which occurs when individuals become emotionally depleted through a prolonged caring role (Figley, 1995b).

The term vicarious trauma (VT) was first coined by McCann and Pearlman (1990) and relates to the specific cognitive changes in individuals that can arise from trauma-work. McCann and Pearlman (1990) proposed a theoretical framework for understanding VT – the constructivist self-development theory (CSDT) which proposes that individuals construct their own realities through cognitive structures or schemas (Cohen & Collens, 2012). VT is thought to occur as new information challenges current schemas leaving individuals' view of themselves, other people and the world around them altered. They argued that change in schemas distinguished VT from other concepts and that these changes were pervasive, cumulative, and permanent (Baird & Jenkins, 2003). McCann and Pearlman (1990) suggested that five key areas are affected in VT including safety, trust, esteem, intimacy and control (Pearlman & Saakvitne, 1995). Importantly, VT was also thought to encompass changes in the sensory system such as symptoms of PTSD (Blair & Ramones, 1996).

1.3 Research into Vicarious trauma

In the last two decades VT has been investigated in sexual violence counsellors (Schauben & Frazier, 1995), trauma therapists (Pearlman & Maclan, 1995), mental health professionals (Follette et al, 1994), psychotherapists (Brady, Guy, Poelstra & Brokaw, 1999) and child protection workers (Cornille & Meyers, 1999) amongst

others. Although a mounting evidence base for VT has arisen, some studies have found low levels of traumatisation in trauma-workers (Dunkley & Whelan, 2006; Devilly, Wright & Varker, 2009) which challenges the intuitive sense that trauma-work adversely affects individuals. Importantly, the inconsistent findings within the literature may be accounted for by the range of ways in which VT is measured, as well as the historical overlap between related concepts. However, despite the inconsistency within VT literature, a plethora of studies suggest that, for some individuals, trauma-work has a negative and long-standing impact (Sabin-Farrell & Turpin, 2003).

Research into VT has also investigated the relevance of individual differences such as gender, age, type of trauma exposed to, professional background, years of experience, personal history of trauma and coping strategies. Two systematic reviews in the area of VT have considered the relevance of these factors (Beck, 2011; Sabin-Farrell & Turpin, 2003). It is thought that negative coping strategies, individuals' stress levels, being a woman and having a personal history of trauma are associated with VT (Beck, 2011). Furthermore, coping strategies have been highlighted including self-care and work/life balance (Baum, 2004), social support (Bober & Regehr, 2006) and qualities such as humour and optimism (Sexton, 1999). Importantly, organisations have also been thought to influence the experience of VT and organisational culture, supervision, group support and self-care can all alleviate the impact of this work on individuals (Bell et al, 2003).

1.4 Care coordinators and trauma-work

Most VT research to date has focussed on professionals who are in formal therapeutic roles with trauma survivors -such as counsellors or therapists (Iliffe,

2000; Johnson & Hunter, 1997). However, many studies have highlighted the need to investigate the impact of trauma-work in a range of professional groups such as generic mental health workers (Dunkley & Whelan, 2006). This is relevant for the UK which has not produced any studies in this area. This is important as VT may not be restricted to those who specialize in treating trauma survivors and may pose a risk to any professionals engaging empathically with traumatised individuals (Sabin & Farrel & Turpin, 2003).

In the UK, generic mental health professionals in the NHS are known as “care coordinators”, and all have a primary mental health profession such as psychiatric nursing, social work or occupational therapy. They work within mental health services in the UK and coordinate the care of individuals with severe and enduring mental health problems in line with the care programme approach (CPA) (Department of Health, 1990). A care coordinator’s role is varied but they commonly provide emotional support alongside practical support and many clients see their care coordinator on a weekly basis. Importantly, this can be the main source of support that some clients receive from services.

1.5 The impact of trauma-work on care coordinators

The impact of trauma-work on care coordinators has not been investigated to date. Previous research has highlighted the need to investigate the impact of trauma-work in generic mental health workers, particularly in the UK (Sabin-Farrell & Turpin, 2003). The negative consequences of trauma-work are relevant not only for individuals but also for organisations as they have a responsibility to ensure staff are safe from the harm that their work may bring (Sexton, 1999). The Government has also prioritised the health of health workers (Department of Health, 1998) suggesting

that professionals should be 'protected from the harm to their health that certain jobs cause'.

The impact of professionals' health on the care of patients is also relevant. The Department of Health (1999) stated that good-quality working lives of NHS staff should be a priority in order that they can provide good quality care. This is important as levels of stress in health-care staff are thought to be higher than other occupational groups in the UK (Borrill et al., 1998). Therefore knowing what risks certain jobs carry, as well as what can sustain and protect professionals is of benefit to individuals, organisations and service users.

1.6 Rationale for research and research questions:

To date, the impact of trauma-work on UK care coordinators has not been explored. In light of what is known about the impact of trauma-work, there is a responsibility to understand risks within the work place for clinicians. Therefore this study aimed to understand how care coordinators respond to clients' traumatic stories, how they cope with such experiences and how the organisation impacts upon their experience of disclosures and build a grounded theory model of these processes. For this study, the terms 'disclosure' and 'stories' are used interchangeably.

The three research questions were:

- How does a sample of care coordinators respond to hearing clients' traumatic stories?
- How do care coordinators cope with hearing clients' traumatic stories?

- What are participants' perceptions of how the organisation impacts upon their experience of hearing client's traumatic stories?

2. METHOD

2.1 Participants:

Twelve care coordinators (ten women and two men) from two NHS secondary care mental health recovery services participated in the study. The sample comprised six community psychiatric nurses, four social workers and two occupational therapists. Participants mean age was 43.9 years and the average time working as a care coordinator was 7.9 years. Participants' ethnic backgrounds included white British, white Irish, black British, black African and black Caribbean (please see appendix 4 for demographic information).

2.2 Ethical considerations:

The study initially gained approval by Canterbury Christ Church University (CCCU) (please see appendix 5), followed by the NHS Research Ethics Committee (NREC) (please see appendix 6). Local R&D (research and development) approval was also gained from both NHS Trusts (please see appendix 7 and 8). The study adhered to the British Psychological Society (BPS) code of conduct and the Health and Care Professions Council (HPC) code of conduct (BPS, 2006; HPC, 2009).

2.3 Design:

This study adopted a qualitative design, using semi-structured interviews to elicit care coordinators' responses to clients' traumatic stories. The interviews were

analysed using grounded theory (GT) (Charmaz, 2006). GT aims to construct a theory on the basis of subjective human experience and refrains from imposing a priori theoretical interpretations on the data (Charmaz, 2006).

Interview:

The semi-structured interview guide included standard questions which specifically related to the three research questions (see appendix 9). However, it also remained flexible so that questions could arise from responses during interviews, which is in line with the GT methodology (Charmaz, 2006). Each interview began by asking participants to think of a time that they had experienced a disclosure. The remaining questions were composed in accordance with guidance for GT interviews and from the pilot interview feedback.

2.4 Procedure:

The principal investigator (PI) attended each mental health services' team meeting in order to invite care coordinators to participate in the study. At this meeting, the PI briefly outlined the study and distributed information sheets (please see appendix 10) for interested parties. In addition, all care coordinators in the service were invited to participate by email which included a copy of the participant information sheet. Clinicians who expressed an interest in the study but who did not meet the inclusion criteria were asked to pass the information on to their colleagues. This reflected a snow-ball strategy commonly used in qualitative research (Coolican, 2000).

An initial pilot interview was completed with a mental health professional and feedback was provided on the style of the questions and language used. Interviews

with participants were then completed at their place of work where they were provided with a further copy of the information sheet and the opportunity to ask questions. Issues of confidentiality were outlined in the information sheet and participants signed the consent form before taking part (please see appendix 11). Interviews lasted between 37 and 55 minutes and at the end of the interview, participants were provided with a debriefing form and the opportunity to ask any questions (please see appendix 12). Each interview was audio recorded and transcribed by the PI.

2.5 Data analysis:

The interviews were analysed using a constructivist grounded theory methodology (Charmaz, 2006). This acknowledges the co-construction of reality between researcher and participant (Strauss & Corbin, 1998). In line with the grounded theory method, initial line-by-line coding of each interview facilitated immersion in the data. Next, focused coding occurred whereby the initial salient codes were developed into higher order themes (Charmaz, 2006). Theoretical coding then allowed related themes to be drawn together into the core categories which form the basis of the grounded theory. The constant comparison method was employed which allows new meanings to arise as each new piece of information is compared to existing data (Boeije, 2002). Theoretical memos (please see appendix 13) and diagrammatic clustering (please see appendix 14) were also used to develop the core categories (Charmaz, 2006).

Throughout the analysis, data storage software was used (Nvivo 9) (QSR International, 2009-2010) which affords the systematic coding and organisation of

codes. This has been recommended as a means of ensuring rigour and quality in qualitative analysis (Bazeley, 2007).

2.6 Quality assurances:

Quality assurances are standards that help ensure the validity of findings produced in qualitative research.

Firstly, the process of 'bracketing' took place whereby the PI reflected on existing opinions and views on the research topic (please see appendix 15). Secondly, the PI kept and maintained a research diary throughout the study (please see appendix 16). This allows the researcher to detail their thoughts and ideas throughout the data collection, analysis and theory generation stages. The diary can then be analysed alongside the data in order to identify researcher biases which may have influenced the analysis. Thirdly, extensive quotes have been used throughout the results to evidence the development of categories and the audit trail includes excerpts from a range of interviews (please see appendix 17). Fourthly, research supervisors were consulted throughout the study and an independent colleague coded an interview excerpt and no discrepancies were noted.

3. RESULTS

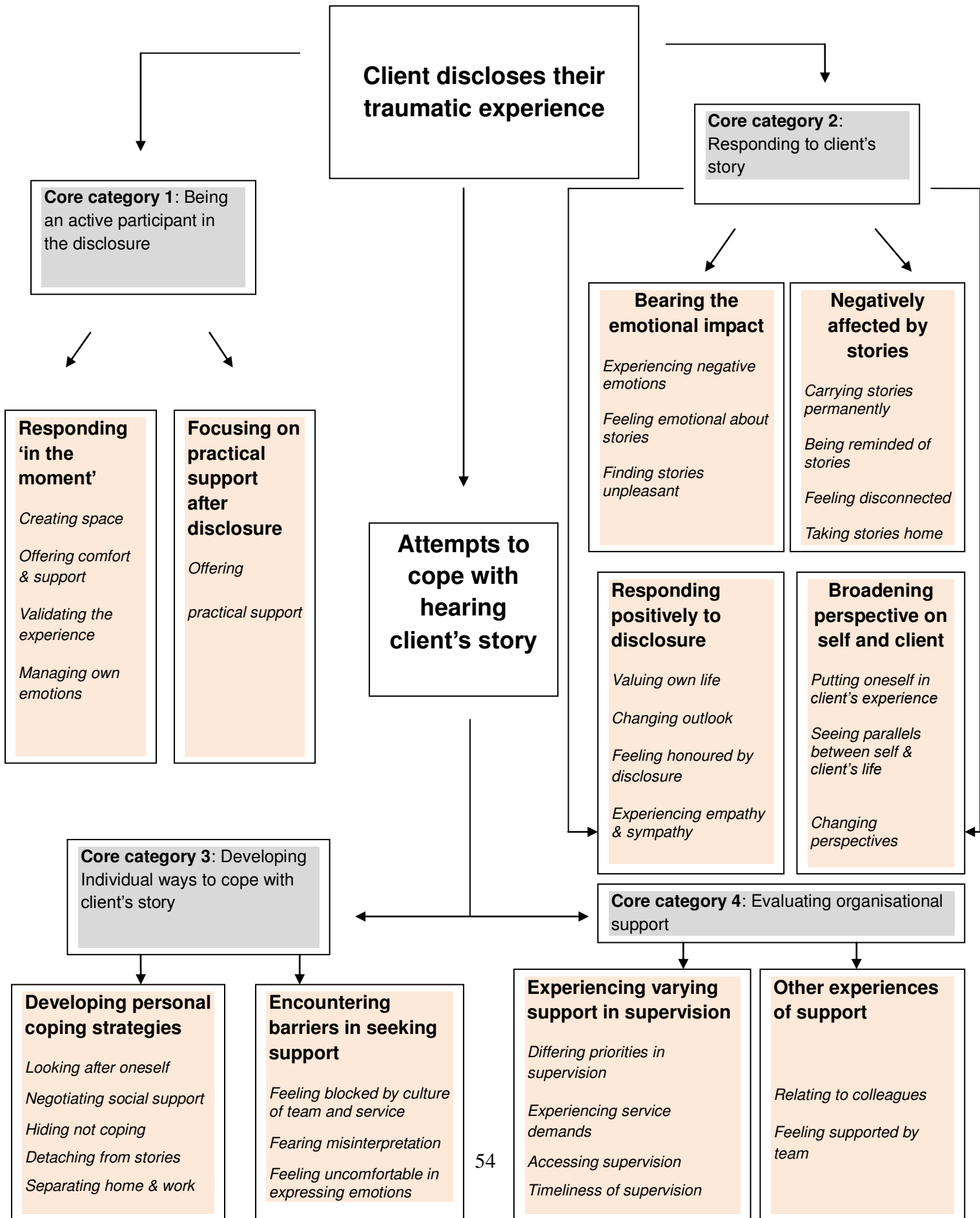
The study produced a grounded theory model which reflects how care coordinators respond to hearing clients' traumatic stories. The model, with both core categories and sub-categories is shown below (figure 1). Each category is

demonstrated with quotes (please see appendix 18 for a full audit trail of developed categories).

Summary of model

The model suggests that participants respond to clients' traumatic experiences by being 'active participants in the disclosure' (core category 1) which reflects how participants respond 'in the moment' to facilitate their clients' disclosure based on what they view as helpful, and supportive. Later participants 'focus on practical aspects of disclosure' which includes offering practical support and moving the client on. The model also shows that participants experience a personal response to clients' stories (core category 2) which includes an emotional impact, some distinctly positive and negative responses and a broadening of their outlook on themselves, their clients and the world. Participants then develop their own coping strategies for managing the negative response to their clients' stories (core category 3) and experience some personal barriers in seeking support for hearing stories. Lastly, the model reflects participants' perceptions of organisational support for disclosures (core category 4), which includes experiences of supervision and other sources of support.

Figure 1: Grounded theory model: the impact of traumatic stories on care coordinators.



Core category 1: Being an active participant in the disclosure

Every participant recounted the experience of a traumatic disclosure. The first core category 'being an active participant in the disclosure' emerged early in the analysis, as care coordinators demonstrated *how* their own responses supported the experience of the disclosure. Importantly, participants held differing views about how to respond 'in the moment' and in managing 'practical responses after the disclosure'.

Sub-category 1: Responding in the moment

Participants responded by 'creating space for the disclosure', 'validating the experience', 'providing comfort and support', and 'managing one's own emotions'.

Creating space

Participants attempted to create 'space' through being with the client, recognising the disclosure as 'their time' and giving the client time to disclose:

'I was there with her for some time it must have been an hour and a half which was a long time to really give her, it was sort of the first time she had actually disclosed it to me and I wanted to sort of give her that time to contain it'

Participant 10, lines 65-68.

Creating space also occurred through participants not having a particular response:

'..yeah she was so distressed and I just gave her space really just to talk about you know her experiences and the way she was feeling, I didn't sort of have any particular response it just, just there for her to talk about it'

Participant 8, lines 33-35.

Validating the experience

Some participants validated their client's emotional experience. In this way, an understanding of the client's experience was expressed:

'.. just to say that I knew what she was going through even though I didn't, I felt something, and of course I suppose that there might have been a level of me saying you know that's really awful.'

Participant 1, lines 19-21.

Acknowledging the difficulty of having 'carried' the story was also highlighted:

' I acknowledged how traumatic that must have been for her and how she's carried it all these years and had not been able to tell anyone about it and how hard that must have been for her'.

Participant 4, lines 61-63.

Offering Comfort and support

Care coordinators expressed the importance of comfort and support during the disclosure. Comfort was shown by attempting to console the client:

"..I said I wanted to try and see him more and to console him"

Participant 3, line 93.

The desire to offer encouragement and physical comfort was also acknowledged:

“I actually felt on that day that I wanted to cuddle her I didn’t but that’s how I don’t know I just wanted to let her know that I was there for her in some way”

Participant 8, lines 81-82.

Managing own emotions

Participants expressed different views about the role of their own emotional responses in disclosures. Some participants normalised emotional expression:

“I think she was very upset and I probably did show some upset with them and shared you know we’re not completely robotic”

Participant 5, lines 100-101.

In contrast, other participants suggested a need to withhold their emotions:

“I mean I think you know, not to burst into tears or (...) you know to just break down and not be able to speak or anything like that”

Participant 11, lines 337-338.

Sub-category 2: Focusing on support after the disclosure

For some participants, their response to the disclosure went beyond responding ‘in the moment’ to ‘offering practical support’:

Offering practical support

Practical support encompassed tools for emotional regulation and contacting other support agencies:

“you can deal with something if they say that its happening now cos then you kind of go through the things that they need me to help with... is there anyone that I can contact at the health centre, look at going to [name of third sector organisation] to get yourself checked out”

Participant 9, lines 43-45.

Practical support was also a medium for helping clients to ‘move on’:

“..and getting them to start thinking about that how we can help them to start moving on”

Participant 12, lines 72-73.

Core category 2: Responding to client’s story

Participants’ personal responses to disclosures included emotional responses, negative and positive responses to disclosures and participant’s broadening perspectives on themselves, their client and the world which was not experienced as either wholly positive or negative.

Sub-category 1: Bearing the emotional impact

Participants reported a range of 'negative emotions' and described disclosures as an 'emotional experience' and as 'unpleasant'. For some, the emotional impact remained after the disclosure.

Experiencing negative emotions

Participants' negative emotional responses included sadness, helplessness, shock and anger. Sadness appeared to arise from what the client had been through:

"..and sadness for her that she'd been through so much and thinking that you know no one should really go through that go through that"

Participant 10, lines 82-84.

Participants spoke about being moved to tears by their clients' experience:

"I've never ever felt like that again that I've wanted to cry about what a person had been through"

Participant 4, lines 46-48.

Participants were also experienced anger:

"Probably a bit of anger, so it was a bit of anger as well that someone can put a child through that"

Participant 9, lines 57-58.

Shock was also common, which for some reduced with repeated exposure to stories.

For others it was a reason for remembering the story:

“For me that was quite a shock. Probably why I have never really forgotten it”

Participant 4, lines 32-33.

Feeling emotional about stories

Many participants reported feeling ‘emotional’ during and after disclosures. The frequency of exposure to traumatic stories was also acknowledged:

“I hear it every day and I find it unpleasant. I still manage my life around it you know it is difficult and it’s not nice emotionally”

Participant 2, lines 150-152.

A number of participants were emotional when recounting the disclosure:

“I’m quite a hard natured person I couldn’t help I found myself emotional with her at the time if you know what I mean I feel myself getting emotional now”

Participant 1, lines 196-198.

Findings stories unpleasant

Participants often recounted their clients’ experiences, describing them as ‘difficult’, ‘uncomfortable’, and ‘disturbing’:

“Honestly it was very disturbing you know it made me feel that our job is very very hard sometimes when you hear certain things, it’s depressing you as well”

Participant 2, lines 109-110.

Another participant described disclosures as ‘too much:

“..so it’s something that sometimes you feel wow this yeah and it is I don’t wanna hear it it’s too much’

Participant 4, lines 54-55.

Sub-category 2: Experiencing a negative effect of stories

The negative responses to stories included ‘carrying stories permanently’, ‘experiencing reminders of stories’ as well as disclosures ‘impacting on home life’ and leaving individuals ‘feeling disconnected’.

Carrying stories permanently

Participants suggested that traumatic stories could remain with them for different reasons – including the ‘visceral response’ of the client and just in a ‘general sense’:

“I think just in a general sense, I think that you carry that around with you all the time”

Participant 12, lines 134-135.

Carrying stories ‘unconsciously’ was also acknowledged:

“..that has like a ripple effect on your own personal life as well because I mean unconsciously you carry it over to your house or home really”

Participant 3, lines 158-159.

Being reminded of stories

Participants could also experience reminders of clients' stories through day-to-day functioning and also the media:

“..especially when you watch the news and you hear about anything related to that issue it gives you kind of a flashback you know and you just remember”

Participant 2, lines 112-114.

Visiting the client's house could also act as a reminder:

“.. occasionally it'll pop in my head and if I go past the area where she lives”

Participant 4, lines 94-95.

Feeling disconnected

Some participants reported being 'disconnected', 'hardened' and 'detached' from stories:

“so in a way I felt that I couldn't fully access my own feelings around that and I was a bit disconnected from it in a way”

Participant 12, lines 37-38.

Detaching oneself was a form of protection:

“..and then trying to stay emotionally detached as much as possible from that, from their experience”

Participant 11, lines 329-330.

Taking stories home

Participants also thought about clients' stories at home:

“It was really upsetting...I definitely went home thinking about how horrendous that must have been for her”

Participant 8, lines 40-41.

This often stemmed from thinking about the clients' experience of the trauma:

“..even after work you're thinking wow it must have been very difficult to even be brought up in such a situation”

Participant 3, lines 111-112.

Sub-category 3: Responding positively to stories:

Participants also identified positive responses to hearing disclosures including 'valuing own life' and experiencing a 'change in outlook' which was constructive.

Some participants viewed the 'disclosure as an honour' and others experienced 'empathy and sympathy' as a response.

Valuing own life

Participants reported feeling 'thankful', 'appreciative', 'cherishing' what they have and valuing their lives:

"I mean (...) you can't help but value your own life"

Participant 1, line 348.

Changing outlook

Some participants reported that disclosures left them 'appreciating the complexity of social beings', believing that people can change, appreciating the 'fragility of human beings' and with a 'wider perspective':

"I think it gives me a wider perspective when I work with clients about what they've been through and so for me I think it's just I appreciate the complexity of human beings more"

Participant 10, lines 130-132.

Feeling honoured by disclosure

Participants spoke about the honour and 'privilege' of a client being able to disclose which reflected on their relationship:

“In a weird way sort of privileged to although that might sound weird but because it was the first time that my client had openly spoken about it with me it just made me think well she must feel enough trust and that must be quite a big thing for her”

Participant 5, lines 554-557.

The sense of ‘honour’ was also highlighted:

“..how not blessed but honoured I suppose I was that she was able to disclose”

Participant 4, lines 62-63.

Experiencing empathy and sympathy

Another positive response to clients’ disclosures included experiencing empathy and sympathy:

“Yes, I think it really makes you (...) empathise and understand people’s suffering and I think unless you’re in this kind of profession I think that’s really hard”

Participant 6, lines 411-413.

Sub-category 4: Broadening perspective on self, client and the world

Disclosures had also broadened participants’ perspectives on themselves, their clients and the world. This occurred through ‘putting oneself in client’s experience’,

through considering the 'parallels between self and client's life' and through the disclosure 'changing world view'.

Putting oneself in client's experience

Participants tried to understand their clients experience through considering themselves in their situation:

"I always have most of the time tried to understand that the personal experience from their point of view so I think ok how would I be so if I was in that situation"

Participant 3, lines 114-116.

Trying to understand how the client felt was clear:

"I suppose I was putting myself in her shoes and thought how you know it felt for her"

Participant 8, line 95.

Seeing parallels between self and client's life

The connections between clients' and care coordinators' lives was highlighted as the reason for some participants remembering the story:

"Something about the relationship and you know how I am you know with my family and that that's another reason it's stayed with me and I really cared"

Participant 5, lines 132-133.

These 'parallels' could also help care coordinators manage personal challenges as well as to induce fear:

" I was just petrified throughout the whole of it that something was gonna happen and I don't know if that was me thinking too much about that case"

Participant 1, lines 285-287.

Changing world view

Disclosures had also changed participants' world-view. Many participants saw the world in a more negative light and as a less safe or fair place:

"What I would say what I've actually achieved from some of the stories is I've become more aware of life so to speak so what can actually happen"

Participant 3, lines 190-192.

Another participant spoke about trust:

"It's made me really wary with my own children about who I trust them with and probably being over-protective of them"

Participant 6, lines 139-140.

Core category 3: Developing individual ways of coping with client's story

Participants all coped with repeated exposure to traumatic disclosures by developing coping strategies to manage their negative responses. In addition to this, participants also encountered barriers to seeking support for their experiences.

Sub-category 1: Developing personal coping strategies

Personal coping assisted in managing the general demands of participants' roles as well as their responses to traumatic stories. The strategies developed included 'looking after oneself' 'negotiating social support', 'hiding the not coping', 'detaching from stories' and 'separating work from home'.

Looking after oneself

Participants coped by employing a range of self-care activities including drinking alcohol, enjoying relaxing activities, sleeping, having 'treats' and exercising:

"..only yoga which has saved my life it's been a brilliant way to manage my stress"

Participant 5, line 346.

Negotiating social support

Coping also occurred through seeking out and limiting social support and by finding meaning in family relationships:

"As long as I can do my job well, do what I'm here for, earn a wage, then [name of family member] is my priority you know out of everything [name of family member] is my main focus and my main reason for being now so that's helped because as soon as I go in that door that's what's important"

Participant 12, lines 430-433.

Hiding the not coping

Some participants reported 'hiding' signs of not coping, and being seen to be 'coping' appeared to be synonymous with managing one's job:

"Having to present yourself as being strong, is I guess what I'm saying, and coping you know even if a manager says are you ok with that? Sometimes saying yes just because you want to give that view of yourself that you're coping, you're managing that you can do your job well"

Participant 12, lines 249-252.

One person acknowledged a long history of hiding the 'not coping':

"I've had [number] years of being sneaky (laughs) and you can hide it"

Participant 4, line 485.

Detaching from stories

Detaching from stories was a result of disclosures but was also developed as a protective response as some participants would intentionally avoid stories or detach from stories:

"I think as health professionals we're taught (...) trained to detach ourselves and look at the look at the facts as much as possible so that that's a (...) that's a protection"

Participant 11, line 54-56.

Becoming detached to the point of being 'un-shockable' was also highlighted:

"I think you had to be un-shockable to some level at some point because you wouldn't cope"

Participant 7, lines 161-162.

Switching off from work

Participants also attempted to cope by switching off from work:

"sometimes because I try to switch off yeah I forget things as well"

Participant 2, line 211.

For some this would occur at specific points such as arriving home. The difficulty of trying to switch off was also acknowledged:

"it's a case of kinda (...) trying to keep work as work and but it doesn't always happen"

Participant 9, lines 379-380.

Sub-category 2: Encountering barriers in seeking support

Participants' experienced barriers to seeking support including 'feeling blocked by the culture of the team', 'fear of self being misinterpreted' and 'feeling wary of expressing emotions'.

Feeling blocked by culture of team and service

Participants felt that emotional experiences were not expressed due to 'institutional attitudes' and a focus on documentation:

"institutional sort of attitudes really, I don't think people are very although we work in mental health I don't think we are psychologically minded, it's more about function (...) as long as you put the right words in the right places and document as you should have done then the other part of it is just your job"
Participant 12, lines 218-224.

Participants also reported not being asked about their emotional responses:

"..it's all about the work that's going on, no one's ever said to me how do you feel, what does it make you feel like when she says something like that or he says no one's ever asked me that"
Participant 4, lines 460-463.

A 'macho bravado' and 'stiff upper lip' culture acted as a barrier to emotional expression:

" I think there's generally a general sort of, unspoken rule (...) you should be able to have a stiff upper lip, don't get upset, things are not meant to affect us, I think people just think we're robots and just get on with it"
Participant 8, lines 294-296.

Fearing misinterpretation

Participants also feared that their emotional expression would be misinterpreted as not coping:

“..there’s a number of my own paranoia as to how that person will respond in terms of and then taking the actual information and the context that I want to discuss how to process or they will take it in the context of can she manage her workload”

Participant 10, lines 198-201.

A fear of being seen to not be functioning was apparent:

“I suppose what I’m thinking is that if I know it’s silly but if I disclose how it makes me feel then I’m not functioning well”

Participant 4, lines 471-472.

Feeling uncomfortable in expressing emotions

Participants discomfort in expressing their emotions stemmed from feeling a ‘burden’, ‘vulnerable’ and as judging themselves:

“I liked that I was able to do that and on the other hand I didn’t because I felt very vulnerable and I felt very as I said like a service user like you know I needed the service”

Participant 9, lines 216-218.

Core category 4: Evaluating organisational support

Participants explored their experiences of organisational support which included 'experiences of support in supervision' and also 'experiencing other forms of organisational support'.

Sub-category 1: Experiencing varying support in supervision

Experiences of supervision included 'differing priorities', 'being part of the supervision culture', 'accessing supervision' and the 'timeliness of supervision'.

Differing priorities in supervision

Participants spoke about cases in supervision and were less familiar with discussing their feelings:

"We tend to talk about cases and tend to talk about what you're doing with the person we tend not to talk about how it makes me feel"

Participant 4, lines 457-458.

Negotiating the 'agenda' in supervision was also viewed as a struggle for some:

"I think it's something that I struggle with, that if [supervisor's name] cancelled or they may come with their own agenda to supervision and may not really prepare for what I want to bring myself"

Participant 10, lines 347-349.

Experiencing service demands

Participants experienced the supervision culture as a pressure to discuss service priorities and workload:

“Time is limited and there’s not the time to think about, it’s just getting things done”

Participant 10, line 366.

Importantly, service demands influenced participants’ experience of supervision:

“..so you might be dealing with really difficult stuff and then yet again it’s just you know any number of audits and gaps there are where things haven’t been done and can you go away and make sure you find the time to do that please thanks very much”

Participant 5, lines 227-230.

Accessing supervision

Participants spoke about a general lack of supervision which could often go unmonitored:

“I was without a clinical supervisor for a while and it wasn’t sort of chased up”

Participant 8, lines 258-259.

Timeliness of supervision

The timeliness of supervision would be another important factor in discussing the

emotional impact of disclosures:

“ I have a supervisor every 6 weeks so you know you wait 6 weeks to discuss it and you know by that time I may have found someone else that I can process that information with and not want to share it with that person anyway because for me that can be too late you know”

Participant 10, lines 332-335.

Sub-category 2: Experiencing other forms of organisational support

Some participants would also seek support for disclosures from colleagues and the team:

Relating to colleagues

Colleagues were seen as a valuable source of support:

“That’s a really important function to have colleagues sitting around you that you can just say this was particularly tough or I’ve had a tough day and at other times it would be their time to you know voice those concerns”

Participant 12, lines 183-185.

Importantly, support from colleagues could be sought when it was needed:

“I think if I find someone a colleague who I can say if they have time or they can make time to go through ones that have been emotionally difficult or draining then (...) I can do that with them”

Participant 10, lines 303-305.

Feeling supported by team

Some participants also experienced the team as supportive:

“..the team as I said are very very supportive and they’re all aware and they’re very very supportive”

Participant 4, lines 182-183.

4. DISCUSSION

This research aimed to explore care coordinators’ responses to clients’ traumatic experiences and the role of coping and organisational support; each research question in turn is discussed.

4.1 Care coordinators’ responses to clients’ traumatic stories

All of the participants had at some point experienced a traumatic disclosure in their role. Furthermore, a number of participants commented on the relative frequency of traumatic disclosures. This initial finding is perhaps *not* unexpected given the prevalence of trauma experienced by mental health service users (Switzer, Dew, Thompson, Goycoolea, Derricott & Mullins, 1999). What remains only partly understood is whether care coordinators appraise disclosures as an important part of their role. Disclosures were described as a ‘privilege’, ‘unpleasant’ and as an ‘emotional experience’ amongst other things which may account for the various ways in which participants ‘actively responded’ to disclosures. Therefore, acknowledging that care coordinators experience disclosures, in addition to a deeper analysis of their appraisal of disclosures and what shapes their responses would be important. Understanding this is valuable as professionals’ responses to disclosures can

determine whether clients' feel cared for (Nelson & Phillips, 2001) and able to discuss their experience again (Nelson & Hampson, 2008).

The findings suggest that disclosures had a personal impact on participants, including a range of emotional responses, positive and negative changes and a broadening of their outlook more generally. Participants' emotional responses have been found in other studies including shock (Splevins et al, 2010; Smith, Kleijn, Trijsburg & Hutschemaekers, 2007), anger (Iliffe & Steed, 2000; Satkunanayagam et al, 2010) and sadness (Shamai & Ron, 2009; Schauben & Frazier, 1995). Some participants reported feeling 'emotionally drained' and other studies have also found that negative emotions can linger beyond the initial disclosure (Shamai & Ron, 2009). This finding can be understood within the framework of secondary traumatic stress (Figley, 1995) which encompasses the sudden and aversive reactions that trauma-workers can have. This raises concerns about the emotional demands involved in being a care coordinator, a concern which has been expressed for trauma workers more recently (Cohen & Collens, 2012).

The findings suggest that participants experienced a longer-term impact of hearing stories including 'Carrying stories permanently', although details of exactly how they stayed with individuals were not expressed or perhaps known by participants. Possible theoretical explanations include VT (and the alteration of schemas) as well as through 'emotional contagion' which is the unconscious experience of another's distress (Figley, 1995a). Other longer-term effects included experiencing 'reminders of stories' which could also be understood within the framework of secondary traumatic stress (Figley, 1995a). This occurs as individuals re-experience the survivor's trauma and encounter reminders of it (Jenkins & Baird, 2002). A related theme arose from participants' experiences of 'taking stories home'

which care coordinators may be at risk from, as well as the challenge of 'switching off' from work. Another negative response to disclosures related to 'feeling disconnected' and previous studies have also found that trauma-work becomes less overwhelming over time (Hunter & Schofield, 2006; Lonergan et al, 2004; Shamai, Kimhi & Enosh, 2007). However, although becoming 'unshockable' is a possible outcome of repeated exposure to disclosures, this emotional disconnection could be communicated to clients and prevent them from disclosing their experiences.

Other long-term changes identified included 'positive responses to disclosures' which encompassed valuing own life, change in outlook and disclosure as an honour. Indeed, some studies acknowledge that people who experience disclosures cope well (Brady et al, 1999) or report positive responses (Eidelson et al, 2003). Such responses include having an overall appreciation of life (Bell, 2003; Ben-Porat & Itzhaky, 2009) feeling lucky (Pistorius et al, 2008), and more compassionate (Splevins, et al, 2010; Ben-Porat & Itzhaky, 2009). Importantly, this study suggests that care coordinators can experience positive responses alongside negative responses to disclosures in line with emerging literature on posttraumatic growth literature (Brockhouse, Msetfi, Cohen & Joseph, 2011). This suggests that further research into positive and negative responses which does not conceptualise VT and vicarious posttraumatic growth as separate would be beneficial (Cohen & Collens, 2012).

Another long-term impact of hearing traumatic stories was the broadening of participants' perspectives on their life, their client's life and their view of the world. 'Changing outlook' related to participants' views on the world which were altered as a result of hearing disclosures. Some participants saw the world as a more dangerous place, they trusted people less and felt more vulnerable which previous studies have

also found (Bell, 2003; Benatar, 2000; Clemans, 2004; Pistorius, 2008; Clemans, 2004). Other participants reported being more protective of their family and more cautious about people which previous findings have also reported (Clemans, 2004; Iliffe & Steed, 2000).

The change in outlook that participants reported is in line with McCann and Pearlman's (1990) CSDT framework as participants' view of the world had been seemingly altered through information that challenged their cognitive schemas. This is in line with areas thought to be affected in VT including one's outlook on life and views relating to safety, trust and control (Saakvitne & Pearlman, 1996). Furthermore, the VT literature suggests that these changes can be permanent which reflects participants' experiences. Importantly, this suggests that it is not only specialist trauma workers who are at risk of VT, and secondary trauma, but that front-line secondary care mental health staff are also at risk. Lastly, although care coordinators did not disclose a personal trauma history, the 'parallels between self and client' suggest that care coordinators' own experiences may make disclosures more pertinent which should be considered.

4.2 Coping with traumatic stories:

Care coordinators developed a range of coping strategies in response to repeated experiences of traumatic stories which could be facilitated or obstructed by individual and organisational factors. Individuals' coping strategies included social support, hiding the not coping, detaching from stories and attempting to separate work and home. The importance of social support has been found in previous studies (Benatar, 2000). However, some participants felt less emotionally available for their

own family and friends which other studies have also identified (Harrison & Westwood, 2009; Splevins et al, 2010). Self-care activities were also a key way in which individuals regulated the emotional impact of the work. Previous studies have also found that exercising (Hunter & Schofield, 2006) and hobbies can alleviate the stress of trauma-work (Harrison & Westwood, 2009). Another key coping strategy found in previous studies is attempting to 'tune out' from work (Iliffe & Steed, 2000) which participants also employed but with varying success. Therefore the ability of care coordinators to implement self-care strategies and the effectiveness of such strategies, particularly in light of the organisational culture experienced requires further consideration.

Individual barriers to seeking support included a fear of misinterpretation and feeling wary about expressing emotions. These barriers lead to 'hiding the not coping' which may arise from fears around emotional expression. Organisational barriers to seeking support included feeling blocked by the team and service. Some participants also experienced a 'stiff upper lip' or 'macho bravado' culture. The culture may serve to help the organisation fulfil its primary task of completing documentation rather than supporting staff to care. However, a recent report outlined the damaging effect on patient care when staff become overwhelmed with targets and regulatory requirements (Francis, 2013). Organisational theories also suggest that teams can defend against the anxiety which is aroused through completing the primary task of the organisation (Bain, 1998). Social defences are thus created 'unconsciously' by members of the organisation (Bion, 1961; Lyth, 1960) and can include denying or suppressing feelings which may reflect participants' experiences.

4.3 Perceived organisational support for traumatic stories:

Some participants experienced supervision as a supportive process. Previous studies suggest that supervision can reduce disruptions in cognitive beliefs if supervisors and supervisees have a good relationship (Dunkley & Whelan, 2006). However, supervision should be timely and accessible and should actively explore the emotional impact of disclosures. Other aspects of supervision which impacted upon support available for participants included differing priorities and the supervision culture. Other research has highlighted the need for organisations to foster a culture that acknowledges the impact of trauma work on individuals and to provide support systems to help employees manage the effects (Cohen & Collins, 2012). To achieve this, support may be needed in the service-line or from more influential sources within the organisation.

The finding that colleagues are a source of support for traumatic stories has been found in previous studies (Clemans, 2004; Iliffe & Steed, 2000; Lonergan et al, 2004; Pistorius et al, 2008; Smith et al, 2007). Colleagues are thought to assist in managing feelings of isolation and to provide a space for sharing emotions and debriefing (Hunter & Schofield, 2006). Therefore teams that foster good working relationships are helpful. However, it is important to acknowledge that participants perceived colleagues as a source of support alongside fears that emotional expression could be 'misinterpreted' by others. It may be that individuals hold conflicting views about seeking support from colleagues, which may require further consideration.

4.4 Clinical implications

This study suggests that care coordinators may be at risk of symptoms of VT, ST and burnout more generally. This highlights the importance of individuals and organisations understanding the range of ways in which disclosures can affect care coordinators. Acknowledging both individual and organisational influences also removes the individualisation of the issue and ensures that individual coping strategies are encouraged and promoted within an overall systemic organisational approach (Cohen & Collens, 2012). The findings also suggest that the Department of health may need to further consider the occupational health risks for generic mental health workers. This is particularly relevant given increasing pressure on service provision including payment by results (Department of Health, 2006) which may reduce care coordinators capacity to manage disclosures.

Practical strategies to support care coordinators include ensuring that supervision is regular and timely and that it can encompass supervision styles which provide a 'holding space' (Kaner & Prelinger, 2005) for care coordinators to increase their capacity to contain and reflect on experiences over time. Care coordinators may also benefit from specific training on disclosures as well as a professional organisation to support them in trauma work. Clinical psychologists may also assist in fostering a culture of emotional expression in relation to traumatic stories and where possible assist care coordinators in sharing their responses.

4.5 Limitations and quality assurances:

A response-bias may have occurred within the study as only individuals comfortable to discuss the research topic offered to participate. This could infer that

individuals less able to speak about the issues were not represented in the sample. Indeed, more affected individuals may have left their position as a care coordinator; a limitation that has also been highlighted by previous research. Another possible limitation is that the level of exposure to traumatic stories and the types of traumatic stories disclosed were not recorded which previous research suggests may be relevant in the development of VT and related concepts.

Importantly, the principal investigator's own position within the research process should also be acknowledged. Previous experience as a care coordinator had led to the formation of some strong assumptions and beliefs about the impact of trauma-work on individuals. In this way it was important to acknowledge that there was some expectation that there would be a negative response to trauma work, based on personal experience and knowledge of other care coordinators from previous contexts. Therefore although every effort was made to be aware of the interface between such views and the importance of not biasing the process of data collection or interpretation, it is important to acknowledge that the author held strong opinions on the topic which could be considered a limitation.

Finally, a general critique of the model should also be considered. Although the model illustrates how care coordinators responded to clients stories, there are parallels between some of the codes and the questions asked in the interview. This is in part due to a focus on the specific areas of interest within the interview, as linked to the research aims. It is therefore important to emphasise that such themes have not arisen spontaneously from the data and have been clearly linked to the line of enquiry which the interview has followed. Therefore a different style of interview that asked about experiences of traumatic stories in a much less structured way may have produced a model with a different set of categories.

4.6 Future research

To the author's knowledge this is the first UK study addressing care coordinators' responses to clients' traumatic stories. Therefore further studies investigating the impact of trauma-work would be important, particularly given the number of care coordinators employed within UK mental health services. Certain professionals such as occupational therapists were less representative in the sample, which future studies could address. Future qualitative studies may be complemented by quantitative data regarding care coordinators' degree of exposure to trauma. Furthermore, specific measures of VT may helpfully quantify symptoms and allow a larger sample to be investigated.

4.7 Conclusion

This research aimed to explore how care coordinators respond to clients' traumatic experiences and the role of coping and perceived organisational support. Twelve care coordinators were interviewed and grounded theory was used to analyse the data. The findings suggested that care coordinators hear traumatic stories in their role and are 'active participants' in these disclosures. They also experienced short and long-term levels of distress which included negative emotions, a mixture of positive and negative responses and a broadening of their perspectives on themselves, their clients and the world. Care coordinators also developed a range of coping strategies, experienced barriers to support and evaluated organisational support for hearing disclosures. Further research into care coordinators experiences is required and suggestions for future research have been outlined.

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MAJOR RESEARCH PROJECT

REBECCA RADFORD MSc

SECTION C

CRITICAL APPRAISAL

WORD COUNT: 1982

A thesis submitted in partial fulfilment of the requirements of Canterbury Christ
Church University for the degree of Doctor of Clinical Psychology

July 2013

SALOMONS

CANTERBURY CHRIST CHURCH UNIVERSITY

- 1. What research skills have you learned and what research abilities have you developed from undertaking this project and what do you think you need to learn further?*

The major research project (MRP) has provided me with experience of every stage of planning and carrying out a research study. A key skill that I have developed is the ability to carry out a comprehensive review of the existent literature base and plan a study that corresponds to my own analysis of gaps in the literature and areas for future research. I have therefore learnt how to synthesise the existent findings and plan research based upon this analysis. Within this I have also developed the ability to consider the size of the project, time restraints, practicalities and ethical approval procedures which I will take forward to future studies.

I have learnt about the value of constructivist grounded theory (GT) as a qualitative methodology and the types of research questions that it lends itself to. I chose this method because it acknowledges the co-construction of reality between researchers and participants and takes a 'bottom-up' approach to theory generation which is particularly appropriate for topics which are relatively under-researched such as care coordinators experiences (Charmaz, 2006). However, I would like to learn more about similar forms of qualitative analysis such as interpretative phenomenological analysis (IPA) (Smith, Jarman, & Osborne, 1999). IPA is also a strongly idiographic approach that focuses on the 'lived experience' of individuals and it would be helpful to know how this more detailed analysis of individual cases could contribute to understanding the impact of trauma work for care coordinators.

Lastly, undertaking a qualitative study has helped to consolidate my understanding of what quantitative methods can also offer.

I have also learnt to reflect upon how my own beliefs and opinions can impact on the research and I actually found that the research diary was crucial in this process. However, the importance of acknowledging my personal biases whilst conducting the interviews was apparent and I have firmly developed the skill of asking non-leading or unbiased questions. This is an important part of the research process (Breakwell, 2006) and a skill I would use in future studies. An area that I found particularly challenging during the analytic process was the use of the constant comparison method. I encountered more conceptual than practical literature on this method but found the use of metaphor extremely helpful as an interpretative tool in the process (Dye, Schatz, Rosenberg, & Coleman, 2000). Importantly, the constant comparison method is used in other qualitative methodologies and is therefore something that I can confidently take forward to further research.

Importantly, I have developed the ability to become more autonomous within the research process. In this way, I gained a growing awareness of when to ask for assistance from supervisors and when to be assured in my own decision-making. I was surprised by the level of autonomy required for this study and I have developed more of an ability to tolerate the uncertainty inherent in research and the continual questioning during the analysis of whether I am 'doing it right'. On reflection, I had initially underestimated the complexity of qualitative analysis and how being 'comfortable with uncertainty' is a key part of this (Schram, 2006). Therefore, the ability to manage uncertainty whilst working constructively is a crucial skill that I have gained from completing this study.

2. If you were able to do this project again, what would you do differently and why?

If I were to complete this project again I would have collected information on the frequency and type of traumatic stories that care coordinators are reportedly exposed to as this would have been relatively easy to collect, alongside the demographic information. The frequency of traumatic stories that care coordinators experience is at present unknown. However this is important information when considering the potential risks of working in such a role (Health and safety executive 2001). The type of trauma experienced is also important as although 'traumatic experiences' were defined by what participants deemed to be traumatic, there may be certain disclosures (such as abuse) which care coordinators could benefit from specific training or support in managing. This is important not only for care coordinators but also for the experience of service users. However, collecting information on the frequency and type of traumatic stories exposed to would have required some consideration as participants would be providing a retrospective account of their exposure to disclosures which may be not be accurate.

In completing this study again, I would have also considered the challenge of care coordinators recounting their client's narratives in such detail during the interviews. This made it difficult to 'steer' the conversation back and at times I wondered whether an initial discussion or strategy for managing this from the outset would have been helpful. I could have reflected more before the interviews on challenges such as this which might be inherent in such sensitive topics. An important point I would consider in completing this project again is that of triangulation. 'Triangulation'

(to combine two or more sources) can occur in a number of ways within GT, one of which is to triangulate sources of data (Patton, 2002). Given more time it could have been helpful to interview managers and supervisors about their experience of organisational support for care coordinators responses to traumatic stories. This would have provided rich data from a second source, which is an important way of reducing bias and increasing the credibility and quality of investigative findings (Patton, 2002).

In planning this project again I would probably try to increase the data collection period so that participants had more opportunity to participate. It became evident that if I had been more flexible with the dates offered for interviews then care coordinators who worked part-time or were less available would have participated. I could have also tried to recruit across other secondary care mental health teams to increase the likelihood of recruiting more participants such as occupational therapists who were less represented in the sample. This would have also been helpful as the experience of reconfiguration and change that services were experiencing may have reduced the number of participants who felt able to participate.

3. *Clinically, as a consequence of doing this study, would you do anything differently and why?*

Clinically I will be aware of the possible impact of trauma work on care coordinators and other generic mental health workers. In a clinical role I will also pay attention to how care coordinators are managing more generally - with the appreciation that their capacity to hear difficult stories is linked to their ability to manage all of the other aspects of their role. In this way, appreciating the demands of

a care coordinator in the broadest sense would be important as well as promoting individual and organisational ways of coping where possible. Leading by example may be important within this and a willingness to explore my own experiences of the impact of trauma work, when appropriate, may also be important. This may help to normalise the emotional experiences involved in this type of work and to break-down barriers around being seen as 'coping' or 'not coping'.

This study has made me reflect on the role of clinical psychology within mental health teams and how to support care coordinators against the negative impact of trauma work. Importantly I would pay more attention to the culture of the team and the impact this has on individuals as a result of this study. The importance of challenging unhelpful cultures that dominate and damage individuals where possible is also something I would consider in practice. Part of achieving this may be to offer teams a psychological understanding or a formulation of what they are experiencing. However, I am aware of not underestimating the difficulty in trying to influence organisational culture. Indeed, this has prompted me to reflect upon these issues more deeply, and to return to some relevant literature relating to tensions of trying to be a 'hero innovator' and implement organisational change independently (Georgiades & Phillimore, 1975). In practical terms however I will try in my role as a clinical psychologist to create a reflective space for clinicians to discuss the emotional impact of the work for them. I would also like to continue carrying out research in this area and it may be helpful to actively communicate my ongoing commitment to the area to colleagues.

In terms of clients, this study has made me more mindful of their experiences of disclosures. I am more aware that they may have disclosed their traumatic

experiences a number of times and that I may be one person in a long line of professionals to hear a client's story. It has made me reflect on how I personally respond to disclosures in clinical practice and has led to a deeper analysis within me of what I think is helpful for clients. I have also reflected on my own experiences of supervision for discussing personal responses to disclosures, alongside barriers that I was not aware of prior to this research. In this way I have gained an insight into my own assumptions about what helps manage the impact of trauma work and how to ensure that I can access support for such experiences in the future.

4. If you were to undertake further research in this area what would that research project seek to answer and how would you go about doing it?

To my knowledge this is the first UK study in this area. Therefore knowing how the findings from this study apply to other care coordinators' experiences would be important. It would also be helpful for future research to explore views that began to emerge from this study about how care coordinators feel about managing disclosures and what would help them manage these experiences. Asking care coordinators about this is a different research question to the impact of disclosures but one that is nevertheless important. It is important because it supports staff and ultimately influences how service users experience the process of disclosures, which is important (Nelson & Hampson, 2008). A qualitative method would lend itself to exploring these types of research questions.

I am also aware that standardised measures have not been used to investigate the impact of traumatic stories on care coordinators. One of the challenges within this area is the overlap of terms and concepts relating to the impact of trauma work. However, that should not prevent a larger scale study investigating symptoms

experienced by care coordinators to be completed. Indeed previous studies have taken a large sample of mental health workers and investigated burnout, vicarious trauma, and secondary trauma using questionnaire data (Deville, Wright & Varker, 2009). Therefore a similar study encompassing questionnaire data on these concepts would provide helpful information on the experiences of care coordinators. Importantly, it may also assist in distinguishing between the similarities and differences between the concepts based on their measurement tools (Jenkins & Baird, 2002).

Importantly, I am aware that a response bias may have occurred in the study whereby individuals who were particularly affected or unaffected by the issues explored may have been more likely to take part. Therefore there may be other views that went unheard during the research process. It would therefore be useful to try to elicit a greater range of views on the research topic, and questionnaires may be a more discreet way of achieving this. Furthermore, questionnaires can usefully investigate the relevance of other variables found in previous studies of vicarious trauma such as gender, age and years of experience amongst other things.

This study has been able to uncover aspects of individual's experience in coping and seeking help (including barriers) that questionnaire data may not adequately capture. Therefore further qualitative studies that explore experience in detail will continue to be beneficial. This may be particularly helpful with care coordinators who do not report any negative consequences of trauma work; to understand what sustains and protects them. Lastly, I would want to investigate care coordinators experiences beyond secondary care mental health services. There are also generic mental health workers in psychosis services, access services (which are teams undertaking shorter-term work with individuals), children's services, older adults

services and a plethora of other NHS services. Therefore research that looks at other UK services with generic mental health workers would be an important avenue for future research.

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MAJOR RESEARCH PROJECT

REBECCA RADFORD MSc

SECTION D

APPENDIX

A thesis submitted in partial fulfilment of the requirements of
Canterbury Christ Church University for the degree of

Doctor of Clinical Psychology

July 2013

SALOMONS

CANTERBURY CHRIST CHURCH UNIVERSITY

APPENDIX 1: Search terms for literature review

- Databases: Cinahl (1981-March 2013), Ovid Medline (1946-March 2013), PsychInfo (1806-March 2013), the British Nursing Index and Archive (1993-March 2013) and Google scholar.
- Search terms employed: Trauma, vicarious trauma, vicarious traumatisation, vicarious traumatisation, secondary traumatic stress, secondary trauma, compassion fatigue, posttraumatic stress disorder.

Table 1: Number of articles produced from literature search

Search term searched (under 'all fields')	Total number of articles	Number of relevant articles	Further relevant articles identified from reference list of relevant articles
1. Trauma	240	1	0
2. Vicarious trauma	164	12	1
3. Vicarious traumatisation	29	1	0
4. Vicarious traumatisation	131	2	0
5. Secondary traumatic stress	189	5	0
6. Secondary trauma	196	0	0
7. Compassion fatigue	181	4	1

Table 2: Number of review articles produced from literature search:

Search term searched (under 'all fields')	Total number of systematic or literature reviews	Number of relevant articles identified from reference list
1. Trauma	0	0
2. Vicarious trauma	2	0
3. Vicarious traumatisation	3	0
4. Vicarious traumatisation	0	0
5. Secondary traumatic stress	0	0
6. Secondary trauma	0	0
7. Compassion fatigue	0	0

APPENDIX 2: Summary of quantitative and mixed methodology studies

Articles/D ate	Method	Sample	Measures	Main Findings
Schauben & Frazier (1995)	Mixed methodology	148 (118 psychologists , 30 sexual violence counsellors) from the USA	Victimisation history TSI BS (5 subscales) PTSD symptom checklist Brief symptom inventory Maslach Burnout Inventory COPE inventory Qualitative: Questions about difficult & enjoyable aspects of work	Counsellors with a higher percentage of survivors in their caseload reported more disrupted beliefs, (particularly about the goodness of other people) more symptoms of post-traumatic stress disorder, and more self-reported vicarious trauma. Symptomatology was not related to counsellor's own history of victimization. Qualitative data regarding difficult and enjoyable aspects of working with survivors also were gathered along with data on the strategies used by counsellors to cope with work-related stress.
Pearlman & Mclan (1995)	Questionnaire	188 American trauma therapists	TSI BS Symptom checklist -90 revised	Those newest to the work were experiencing the most psychological difficulties. Those with a personal trauma history showed more negative effects from the work than those without a personal history. Trauma work appeared to affect those without a personal trauma history in the area of 'other-esteem'.
Deville, Wright & Varker (2009)	Questionnaire	152 mental health professionals in Australia	Interpersonal support evaluation list Self-report victimisation history Depression, anxiety & stress scale Copenhagen burnout inventory STSS TSI-BSL Interpersonal reactivity index	Exposure to patient's traumatic material did not affect STS, VT or burnout, contradicting the theory or the originators of STS & VT. Rather it was found that work-related stressors best predicted therapist distress.
Dunkley & Whelan (2006)	Questionnaire	62 Australian telephone counsellors	TABS IES-T Coping scale for adults (short form) Supervisee scale from the supervisory working alliance inventory (SWAI)	Generally levels of traumatisation (PTSD & disruption in beliefs) were low. 5 participants had 'high' or 'very high' levels of disruption in beliefs. Also 15 respondents spoke of at least 2 PTSD symptoms. Non-productive coping was related to disruptions in cognitive beliefs, whilst dealing with the problem was not. Having a strong supervisory working alliance was associated with lower levels of disruption in beliefs. No significant predictors of PTSD symptoms despite a positive correlation with personal trauma history.
Ben-Porat <zhaky	Mixed methods –	143 Israeli Social	STSS Post traumatic growth	Average levels of trauma in both groups. No significant difference in levels of traumatisation between groups. Level of growth higher in those not in family violence field. Family violence

(2009)	Questionnaire & thematic analysis	workers, 71 working in family violence, 72 general social workers	inventory Qualitative: Asked participants to list positive and negative changes that occurred in themselves, in their lives, and their families as a results of their work	therapist reported more negative changes in spousal relations and views of work and more positive changes of increased assertiveness and control of anger.
Cunningham (2003)	Questionnaire	182 American social work clinicians	TSI-BS	Clinicians who worked primarily with clients who were sexually abused reported more disruptions in cognitive schemas than clinicians who worked with those who had cancer
Way, VanDeusen & Cottrell (2007)	Questionnaire	383 sexual abuse clinicians from USA	TSI-BS Childhood trauma questionnaire	Respondents reported high rates of childhood maltreatment. Male gender predicted greater disrupted cognitions about self-esteem and self-intimacy. Clinician age and childhood emotional neglect predicted greater disrupted cognitions about self-intimacy.
Michalopoulos (2012)	Questionnaire	160 American social workers		Increase in social support and in experience level of social workers predicted less severe vicarious trauma. An interaction effect between trauma history and social support trending on significance indicated higher levels of social support might help those without a trauma history but not those with a trauma history against vicarious trauma
Jenkins, Mitchell, Baird, Whitfield & Meyer (2011)	Questionnaire	101 sexual assault and domestic violence counsellors from USA	Demographic and counselling experience questionnaire Motivation & changes – open ended questions TSI life event questionnaire CFST for psychotherapists TSI-BS Maslach burnout inventory Symptom checklist -90 revised	Counsellors motivated by interpersonal trauma report both more symptoms and positive changes (including dealing with their own trauma). Those seeking personal meaning report becoming more hypervigilant and self isolating. Those saying they learned from client's rate symptoms lower, suggesting stress inoculation. Supervision of trauma counsellors should facilitate learning from client's separately from processing counsellor's trauma
Williams, Helm & Clemens (2012)	Questionnaire	131 clinical social workers from USA	Childhood trauma questionnaire The five factor wellness inventory Supervisory working alliance inventory	Personal wellness partially mediated the relationship between childhood trauma and VT. No significant effect of organisational culture on VT. No significant effect of workload on VT.
Baird & Jenkins (2011)	Questionnaire	99 sexual assault and domestic violence counsellors in USA	TSI-BSL CFST	Results showed concurrent validity between TSI-BSL and CFST, moderate convergence with burnout but useful discrimination and strong convergence with general distress, but adequate independent shared variance. Counsellors with interpersonal trauma histories scored higher on CFST but not on TSI-BSL or burnout, consistent with the CFST's emphasis on trauma symptoms

Adams, Matto & Harrington (2001)	Questionnaire	185 social workers from USA	TSI-BS Personal trauma history Maslach burnout inventory Perceived social support – friends Somatic symptoms –likert scale	TSI score associated with younger age, more reported somatic symptoms, lower salary, lower social support and great burnout. TSI scores not associated with personal trauma history, amount of client contact or self report of level of intrusiveness of client material into social workers lives
Van Deusen & Way (2006)	Questionnaire	Clinicians who treat sexual abuse survivors (111) and sexual abuse offenders (272) in USA	TSI-BS Childhood trauma questionnaire & author generated questions	Respondents reported high rates or multiple forms of childhood maltreatment however there was no relationship between history of child sexual abuse and vicarious trauma effects. Scores for self-reported disruption in cognitions about intimacy with others exceeds norms for mental health problems.
Brady & Guy (1999)	Questionnaire	1000 women psychotherapists USA	IES TSI-BS	Therapists with higher levels of exposure to sexual abuse material reported significantly more trauma symptoms but no significant disruption of cognitive schemas. Spiritual well-being was thought to be higher for those clinicians who saw more sexual abuse survivors.
Bober & Regehr (2006)	Questionnaire	259 therapists who counselled trauma victims from USA	IES TSI-BS Coping strategies inventory	Time spent with counselling trauma victims was the best predictor of trauma scores. Although participants generally believed in the usefulness of recommended coping strategies including leisure activities self-care

APPENDIX 3: Summary of qualitative studies

Author/Date	Method	Sample	Main findings
Steed & Downing (1998)	Thematic content analysis	4 female Australian counsellors and 8 female Australian psychologists working with sexual abuse survivors	All therapists reported negative effects of working with traumatized clients. Findings indicated that therapists experience affective responses in relation to hearing their client's traumatic disclosures. Outside of the therapeutic session, negative physiological, emotional and cognitive effects were reported. However, positive sequelae were also noted.
Iliffe & Steed (2000)	IPA	13 female and 5 male Australian domestic violence counsellors	Described classic symptoms of vicarious trauma and reported changes in cognitive schemas particularly with regard to safety, world view and gender power issues. Specific challenges to domestic violence work include changes in counselling practice to meet unique needs of DV clients, difficulties with confidentiality, fear for client's safety, feelings of isolation and powerlessness. The majority reported symptoms of burnout but used a range of strategies for dealing with the adverse effects including monitoring client's caseload, debriefing, peer support, self-care and political involvement.
O'Neill (2010)	Narrative analysis	8 Canadian practitioners	10 categories provided a structure for arranging the themes generated from 8 narratives. 6 meta-themes were interpreted from the data: helping takes over life, humanity, respectful engagement, invested and embedded, profoundly affected and belief. Protective factors found in elements of embeddedness and connectiveness of practitioners and their motivation for doing the work they do.
Smith (2007)	Mixed method Quantitative & Grounded theory	5 expert trauma therapists & 6 therapists from Netherlands	63 specialised trauma therapists: assessed how they cope with client's traumatic experiences. The results on trauma-related reactions were inconclusive. Qualitative study of 11 expert therapists - results indicated a specific reaction pattern to trauma there are valuable opportunities for personal and professional growth.

Satkunanayagam (2010)	IPA	12 counsellors, psychologists, psychiatrists and medical officers from Sri Lanka	Accumulated negative emotional impact and the work can also have positive growth-promoting, satisfying factors when mental health professionals rebuild their assumptions of the world in light of their experiences of working with survivors of trauma there are invaluable opportunities for personal and professional growth
Arnold (2005)	Constant comparison method	21 American psychotherapists	In addition to reporting several negative consequences, all the clinicians in this sample described positive outcomes. The descriptions of positive sequelae are strikingly similar to reports of growth following directly experienced trauma and suggests that the potential benefits of working with trauma may be significantly more powerful and far-reaching than the existing literatures scant focus on positive sequelae would indicate.
Lonergan et al (2004)	Interpretivist paradigm	8 US therapists working with traumatised children	Therapists perceive common issues related to treatment, impact of the therapeutic work and the importance of making personal meaning of their work. Becoming a trauma specialist is a developmental process requesting careful examination, willingness to be changed and a programme of self-care.
Harrison & Westwood (2009)	Narrative analysis	6 Canadian therapists working with traumatised clients	9 major themes salient across clinician's narratives of protective practices; countering isolation in professional, personal and spiritual realms, developing mindful self-awareness, consciously expanding perspectives to embrace complexity, active optimism, holistic self-care, maintaining clear boundaries, exquisite empathy, professional satisfaction and creating meaning.
Hunter & Schofield (2009)	Grounded theory	8 Australian counsellors	Counsellors develop their own personal and professional strategies for coping with challenge and the supportive structures and coping strategies provided by agencies.
Sommer (2005)	Basic interpretative analysis	1 man & 8 women sexual violence counsellors from USA	The study revealed 4 themes related to trauma work: counsellor feelings, vicarious traumatisation, helpful qualities of supervision and organisational considerations.
Benatar (2000)	Thematic	12 trauma social	Therapist experience with trauma work and similarities between patients and therapists trauma histories appears to be

	analysis	workers and psychologists from USA	important factors in evaluating the impact of the work. Experienced therapists with a childhood sexual abuse history do not appear to be more vulnerable to VT than their counterparts.
Clemans (2004)	Grounded theory	21 employees of a rape crises centre from USA	The findings suggest that the role presented workers with a host of emotional and existential challenges, such as increased feelings of vulnerability as women, diminished trust in others and questioning the overall goodness of society.

APPENDIX 4: Participants' demographic information

Total number of participants	12
Gender	10 women, 2 men
Mean age	43.9 years (range 34-48)
Ethnicity	Black African: 2 White British: 6 White Irish: 1 Black Caribbean: 1 Black British: 2
Profession	2 OT's 4 SW's 6 CPN's
Mean number of years qualified as mental health worker	12.9 years (range 4.5 – 20 years)
Mean number of years working as a care coordinator	7.9 years (range 0.5 – 25 years)

Key: CPN: Community Psychiatric nurse; OT: Occupational therapist; SW: Social worker.

APPENDIX 5: Canterbury Christ Church University approval

30th August 2011

Direct line 01892 507773
Direct fax 01892 507660
E-mail paul.camic@canterbury.ac.uk
Our Ref PC/dc/083/dissertations

TO WHOM IT MAY CONCERN

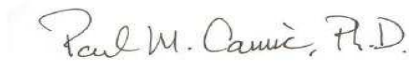
I am writing to inform you that funding has been secured for the doctoral-level research project of Rebecca Radford who is a clinical psychology trainee at our institution. This research project is in partial fulfilment of the Doctor of Clinical Psychology degree awarded by Canterbury Christ Church University. Each trainee is assigned a Lead and Second Supervisor who will closely monitor the scientific and ethical components of this research project.

All research in the clinical psychology doctoral programme at Canterbury Christ Church University is carried out in accordance with the Research Governance Framework for Health and Social Care 2005. The University provides insurance coverage, against negligent harm, for our postgraduate students while undertaking research. A copy of our insurance letter is attached and this is automatically renewed each year.

All doctoral dissertation proposals are independently vetted by two members of the clinical psychology programme faculty before being given approval. Only those research projects that are deemed to be of significant clinical and scientific merit are approved.

The above mentioned clinical psychology trainee is employed full-time by Surrey and Borders Partnership NHS Trust and is bound by the requirements of the Research Governance Framework (RGF). They are also required to adhere to the *Code of Ethics and Conduct* of the British Psychological Society.

Yours sincerely,



Prof Paul M. Camic, Ph.D.
Reader in Clinical & Health Psychology,
Research Director
Department of Applied Psychology
Canterbury Christ Church University

APPENDIX 5 CONTINUED: Canterbury Christ Church University approval.



Salomons Campus at Tunbridge Wells

30th August 2011

Miss R Radford
26D Pepys Road
New Cross
LONDON
SE14 5SB

Direct line 01892 507773
Direct fax 01892 507660
E-mail paul.camic@canterbury.ac.uk
Our Ref PC/083/dissertations08

Dear Rebecca

I am writing to inform you that the Independent Research Review Panel has approved your Independent Research Project proposal. Congratulations!

As soon as you have obtained full R&D and ethics approval for your project you should provide a copy of the approval letter/s to the department Research Administrator (Viv Cousins).

I wish you well with your study and hope that you enjoy carrying it out.

Yours sincerely,

A handwritten signature in black ink that reads "Paul M. Camic, Ph.D.".

Prof Paul M. Camic
Research Director
Clinical Psychology Training Programme

Faculty of Social and Applied Sciences

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Broomhill Road Southborough Tunbridge Wells Kent TN3 0TG (UK)
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Professor Robin Baker CMG, Vice Chancellor and Principa

Registered Company No: 4793659
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Registered Charity No: 1098136

APPENDIX 6: NRES Ethical approval letter.

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APPENDIX 6: NRES Ethical approval continued.

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APPENDIX 6: NRES Ethical approval continued.

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INTERVIEW GUIDE

Project Title: Care co-ordinators' responses to clients' trauma: A grounded theory study.

Interview questions below are given as examples of the types of questions that will be asked in the interview.

Introduction:

Hello and welcome to this interview today.

This interview will last for approximately one hour and will involve me asking you a number of questions about your responses to working with clients who have at some point told you about their traumatic experiences. It is important that you do not mention any names or other client identifiable information during the course of the interview; should this happen, the recording will be stopped and the information deleted immediately.

I will begin by asking you to cast your mind back to a time when you have worked with a client who has shared their traumatic experience with you and the questions will progress from there. Nearing the end of the interview, I will make sure that you have the opportunity to add or say anything that you would like to before it ends. Do you have any questions?

Interview:

We are going to take five minutes now to think about a time when you have worked with a client who has told you about their traumatic experience. Feel free to close your eyes at this point if it will help to aid your memory.

I would like you to try and remember a time when a person that you work with has disclosed to you the events of a traumatic experience. It can be anyone that comes to mind, and it can be the first time that you remember hearing their experience or someone who you have heard discuss their experience a number of times. The experience can be anything that one could deem to be traumatic, so think broadly about the term traumatic.

- Before answering the first questions, please remember not to disclose any names or other identifiable information during the interview. Ok, could you describe the situation and how the client told you about the traumatic experience? What was the situation when they recounted their experience?

APPENDIX 9: Interview guide continued.

- Do you remember the way the client talked – whether they seemed distressed or calm, or how they carried themselves?
- How did you feel when you heard your client's experience?
- How did you respond to hearing your client's story? What did you say or do?
- Has there been a personal impact on you of hearing this client's experiences?
- How have you coped with hearing this client's experiences?
- What has been helpful in supporting you to manage these experiences?

Now I would like you to think about other client's, or other occasions where clients have told you about traumatic things that they have experienced.

- In relation to the one you have just talked about, how typical is this of the kind of things that happen in your work? Does it happen a lot, or not very much?
- How do you usually cope?
- Are there ways in which your organisation has supported you with managing these experiences?
- What has been particularly helpful in supporting you with this experience?

There are a couple of minutes left of this interview. Is there anything that you would like to say or add before the end?

Debriefing (recorder switched off). The interview has now finished. Is there anything that has been raised that has left you feeling uncomfortable or that is difficult that you want to talk about while I'm still here – or any further questions you have for me about the research of what happens to the data.

Many thanks for taking the time to complete this interview.

APPENDIX 10: Participant information sheet



PARTICIPANT INFORMATION SHEET:

Dear Colleagues,

Project Title: Care co-ordinators' responses to clients' trauma: A grounded theory study.

As you are aware my name is Rebecca Radford and I am a trainee Clinical psychologist completing my doctorate in clinical psychology at Canterbury Christ Church University. I am conducting this study as part of my training and I am asking care coordinators to take part.

This research is a study into the experiences of care coordinators when working with clients who have experienced traumatic events.

I am asking care co-ordinators about their responses to hearing about clients' traumatic experiences. I am therefore recruiting individuals who:

- Currently work as care coordinators in an adult mental health service within the NHS
- Are from a range of professional backgrounds
- Have worked with clients who have experienced traumatic events.
- Have experience of hearing client's talking about their traumatic experiences.

I have enclosed an information sheet with this letter which informs you of the study in more detail and may answer any questions that you have about participating in this study. It would be really appreciated if you could read through this information and consider whether you would like to take part. If you agree to take part, please complete the consent form attached with this letter in the freepost envelope provided within one month of receiving this letter. If you are not interested in taking part then please discard this information.

If you have any concerns or queries regarding this project or anything in this letter then please do not hesitate to contact me. Contact information is provided at the end of this letter,

Many thanks for your time,

Rebecca Radford
Trainee Clinical Psychologist
Email: rr139@canterbury.ac.uk
Tel: 07921454994

APPENDIX 10: Participant information sheet continued.

Care co-ordinators' responses to clients' trauma: A grounded theory study.

Many thanks for taking the time to read this information sheet.

I would like to invite you to participate in a research project about care coordinators responses to hearing the traumatic experiences of their clients. Before you decide whether to take part in the project I would like to give you some more detailed information on it. If you still have any unanswered questions after reading the information then please do not hesitate to contact me. Once you have read through the information and had any of your questions answered, please consider whether you would like to take part. If you would, please complete the consent form attached and return it in the free-post envelope. If you would not like to take part then please feel free to discard the information sheet.

Reason for this study:

Research suggests that caring professionals can be vulnerable to the negative effects of psychotherapeutic work with trauma victims. It is thought that changes can take place within the caring professional as a result of empathic engagement with the client. Importantly, research to date has mainly focussed on individuals carrying out psychological therapy with clients and there is a lack of acknowledgement that care coordinators may also listen to clients' stories as part of their roles.

This study therefore aims to look at how care co-ordinators manage the experience of hearing clients' accounts of trauma. Therefore the aim of this study is to gain an understanding of how care coordinators view these experiences and also what their responses are and how they cope.

Who has approved this study?

This study has been approved by Canterbury Christ Church University, an NHS Research Ethics Committee and an NHS Research and Development department. Their role is to scrutinise all research proposals to ensure that participants are adequately protected and that the research is properly conducted and that the interests of those taking part are adequately protected.

What does participation in this study involve?

Participation in this study will involve completing a one hour interview. This will involve being asked to think about times when you have heard clients traumatic stories and then to answer some questions regarding your experience of this. Questions will not ask you to recall any personal experiences or memories of trauma or to disclose any details of clients' traumas. The focus will be on your response to hearing others experiences and not the details of the event itself. However, it may possibly involve you talking about a time when you felt distressed because of something specific you heard from a client.

What happens if I become distressed during the interview?

At any point during the interview we can take a break, stop or even come back to a question a little later. If you continue to feel distressed as a result of the interview you

APPENDIX 10: Participant information sheet continued.

may wish to consider some extra support such as counselling, of which details will be provided.

Do I have to take part?

You are under no obligation to take part in this study. Participation is entirely voluntary and you may withdraw from the study at any point. This will not impact on your rights in any way or your role and responsibilities within the workplace.

What happens if I want to discontinue with the study once it has begun?

You may withdraw from the study at any point and will not need to justify or explain your decision to do so.

What will happen to my responses from the interview?

Your responses from this interview will be digitally recorded and stored in a locked cabinet on Canterbury Christ church University premises for approximately one year to give enough time for writing my thesis. They will then be destroyed. They will be stored on a password protected memory stick so that the original version (on the audio recorder) can be destroyed immediately after the interview. Only I will have access to the interview responses. The interview will be anonymously transcribed and the anonymous transcription will be stored securely at Canterbury Christ Church University Department of psychology for a period ten years after which it will also be destroyed.

What are the potential risks or consequences of taking part?

This interview will focus on your responses to hearing the traumatic experiences of others. Therefore this may be a sensitive topic that may be emotive to discuss. If at any point during the interview you feel that you would not like to continue because of these reasons, then you are entitled to discontinue. At any point in the interview you can take a break or even stop or come back to a question. Furthermore, if you would like support with these concerns after the interview you will be given the contact details for counselling services (both within the NHS and in other sectors).

Is what I say in the interview confidential?

Whatever you say in the interview will be kept confidential. The only exception to this is if you disclose any issues of professional misconduct where a client or service user has been, or continues to be, at risk of harm in any way. I am bound under my professional code of conduct to follow NHS protocol for reporting issues of malpractice.

Do I need to inform anyone that I am taking part?

All participants are encouraged to inform their supervisors or managers that they are considering taking part in this research. This is because the interviews may raise issues relating to work for which further support/discussion would be helpful. It is also important for managers/supervisors to know about time taken for research purposes.

Can I have access to the report once completed?

APPENDIX 10: Participant information sheet continued.

If you would like a copy of the overall results once the study is completed then you are welcome to obtain a copy. You can do this by using the details below.

How shall I proceed if I am happy to take part?

If you have read this information sheet and are satisfied that all of your questions have been answered then please complete the consent form and send it back in the envelope supplied. If you would not like to take part, please feel free to destroy this letter.

Many thanks for taking the time to read this information sheet and consider this study,

Yours Sincerely

Rebecca Radford
Trainee Clinical Psychologist

My contact details should you have any questions:

Rebecca Radford: r.radford139@canterbury.ac.uk

Tel: 07921454884 (Mobile, Monday – Friday 9-5pm)

APPENDIX 11: Participant consent form



PARTICIPANT CONSENT FORM:

Dear Colleagues,

Project Title: Care co-ordinators' responses to clients' trauma: A grounded theory study.

Name of Researcher:

Miss Rebecca A Radford

Please read the information below and initial the box where you give your consent:

1. I confirm that I have read and understood the information sheet entitled 'Participant Information sheet for the study entitled above. I have been able to consider the information, and have any questions answered satisfactorily.
2. I understand that my participation in this research is entirely voluntary and that I am free to withdraw at any time without giving any reason.
3. **All data will be anonymised.** I understand that anonymous sections of my data collected during the study may be looked at by two examiners from Canterbury Christ Church University Clinical psychology programme and from regulatory authorities where it is relevant to the research. The chief investigator (Rebecca Radford), Lead supervisor (Dr Sue Holttum, Canterbury Christ Church University) and Clinical Supervisor (Dr Emma Ross) will have access to the anonymised transcript and the final write-up will contain short anonymous quotes which will be seen by a wider audience. I give permission for these individuals to access this data.
4. I have been made aware that direct quotes may be used in the write up of the research. These quotes will be anonymised. I agree to the use of direct quotes.
5. I agree to my interview being digitally recorded. I understand that this recording will be destroyed once the interview has been transcribed.

Name of Participant

Date

Signature

Rebecca Radford

Date

Signature

APPENDIX 12: Debrief handout.



DEBRIEF HANDOUT

Dear colleague,

Many thanks for taking part in this research today. As you are aware, the aim of the research was to investigate how care coordinators respond to their clients' traumatic experiences. It is hoped that this research will provide a better understanding of how care coordinators cope with these experiences and how the organisation supports them in this.

If after completing the interview you would like to have some one-to-one support to discuss any of the issues raised in the interview or other issues that have been raised for you then you can contact some supportive services below:

- *NHS staff counselling service:****details removed to protect trust confidentiality******
- *Samaritans helpline:* the Samaritans is a charity-based helpline that offers free support to anyone in distress who would like the opportunity to talk through their difficulties. Support is available 24 hours per day, 365 days per year. The number for UK calls is **08457 909090** (local rates apply) or email **jo@samaritans.org**.

If you have any questions or queries regarding the research project or your participation in today's interview then please do not hesitate to contact me by email or telephone:

- Email:
- Telephone:

Once again, many thanks for your time and participation in the study.

Rebecca Radford
Trainee Clinical Psychologist
Canterbury Christ Church University
Salomons Campus Tunbridge Wells
Southborough
Tunbridge Wells, TN3 0TG

APPENDIX 13: Theoretical memos.

Early memo:

Core category 1: Responding to disclosure

One of the first core categories which is emerging from the data relates to the way in which participants are 'responding to disclosures'. Participants are responding to participants with comfort, support, encouragement, optimism and in some cases physical comfort. This appears to occur alongside other responses to the disclosure which includes the emotional reactions and changes in outlook that relate to the other core categories. This category suggests that participants are 'responding' to disclosures with a range of responses. Although this is occurring alongside the other experiences emerging (such as emotional responses) this is one of the first ways in which care coordinators respond to traumatic stories – by actually responding to the disclosure itself.

Later memo:

Core category 1: Being an active participant in disclosures

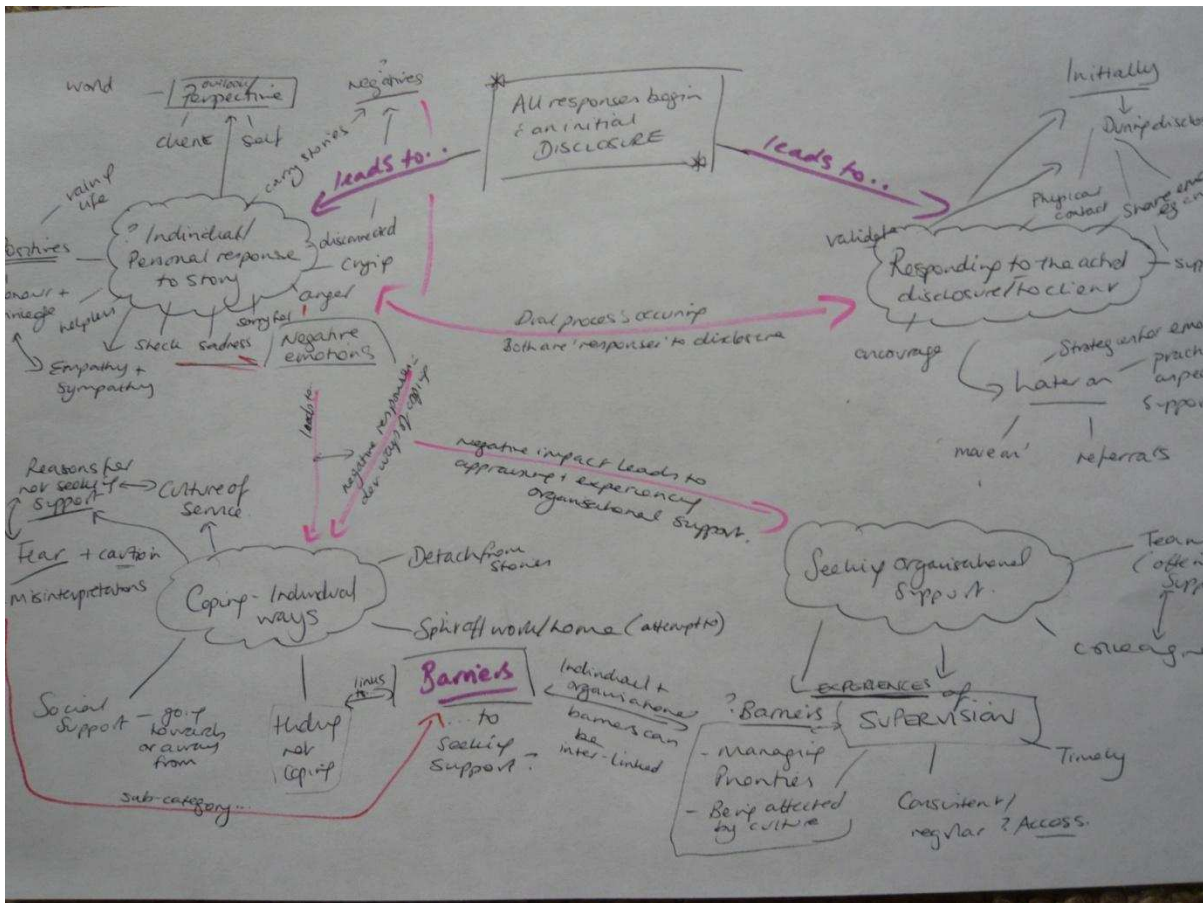
It is clear from the interviews that participants are responding to their client's stories although further analysis suggests that 'responding' is too broad and generic and does not capture the participants' response in the moment to what the client is disclosing. Perhaps this category should be renamed to something like 'managing the disclosure' or 'being an active participant in the disclosure'. It is as though participants are saying that these stories are not just didactically delivered onto some passive recipient (who happens to be a care coordinator). It seems as though an enormous range of responses to the disclosure itself arise, suggesting that participants respond in way that they think is best, they respond on an individual basis and hold different beliefs about what is helpful during the disclosure. Participants have given their clients' time, space to share their experiences in this way they are considering how to respond on an individual basis. This suggests that this category relates to more of an 'active' sharing in the disclosure than a passive or recipient role.

Core category 3 and 4: Developing individual ways of coping and evaluating organisational support

It has been unclear whether to have two separate categories that reflect individual and organisational ways of coping. This is because it is not always helpful to collate coping strategies as either individual or organisational as this underplays the inter-dependency between the two concepts. For example, 'feeling blocked by culture of team and service' shows how the culture of the organisation can influence individual experiences. Furthermore, other focused codes (such as barriers to discussing clients or emotions and experiences of supervision) have been further categorised into either individual or organisational categories because within both of those focused codes there are both organisational and individual barriers to coping or gaining support and

thus the 'individual versus organisational' distinction appears to be helpful here. Therefore, the interdependent relationship between the two categories needs to be outlined. This is important so that the terms do not create a polarised view of experiences being located either in the individual or in the organisation.

APPENDIX 14: Example of diagrammatic clustering.



APPENDIX 15: Bracketing interview questions.

BRACKETING INTERVIEW

1. What motivated you to do this research?
2. Why do you think you are interested in this particular area?
3. Are there any events in your personal history that are relevant to this research?
4. What do you hope to achieve with this research?
5. What findings are you hoping for?

Excerpt from bracketing interview.

Interview facilitated by a colleague of the PI (mental health professional). Interview transcribed by the PI.

Question 1

PI: Well (..) erm, I guess I very first became interested in the role of generic mental health working when I worked as a care coordinator which was a few years ago now, before I got on to clinical training and I remember thinking back then that the role was so much erm (...) I guess broader than it was given credit for and erm yeah one of the aspects I really encountered was hearing about often quite tragic or say quite difficult experiences that left me erm on occasions really quite moved. I mean it didn't happen all the time but when it did I thought oh gosh how significant this moment was for the client and that you felt like it was kind of like their life in your hands so to speak for that period of time and erm (...) yes I suppose it did feel quite daunting. So yeah I guess I've always been aware of how much support care coordinators provide and how little we actually know of their experiences really. The other piece of it which I guess got me thinking about a project with care coordinators was around the topic of vicarious trauma which wasn't something I had come across before doing this course but erm, but erm yeah it was what I started to know and learn about from starting clinical training and thinking about why trainees were encouraged to think about the impact of what they hear and yet I had not encountered this in my previous role.

APPENDIX 16: Research diary.

EXCERPTS FROM RESEARCH DIARY

February 2011

I met with my external supervisor for the second time today in order to discuss my project and the next steps in terms of defining what the exact focus of the study will be. We spoke about the literature regarding vicarious trauma, burnout and secondary trauma and some of the influences regarding coping and organisational support. I had completed a number of literature searches around the topic and was able to briefly touch upon the main findings. We discussed at length the challenge of measuring vicarious trauma due to the lack of consensus regarding the concept and related terms, as well as the multitude of ways in which it is measured. This has made the existing literature difficult to interpret. We spoke about my motivation for completing this study and for focusing on care coordinators in particular for this. This allowed me to speak about my own experiences as a care coordinator, which led to my initial interest in the area. We discussed a 'bracketing interview' which I need to look into as I have not completed this for qualitative pieces of work before. I think it will aid me in reflecting on my own motivation for the research and views on the topic, which is important to know. I feel more informed regarding grounded theory and how this can may be a helpful methodology for eliciting views on this area. We did explore the merits of employing a qualitative methodology over a quantitative one which has helped me to focus more on what my research questions will be. Emma has lent me a book on grounded theory which I will begin to read. We will meet again in a month and I let her know that in the interim I will be looking for an internal supervisor for the project at Uni.

June 2011

I had the proposal review at Salomons today which lasted for approximately an hour. It was a helpful process actually and I have one week now to submit the minutes of the meeting, which are the conditional points on which the project has been agreed. Some of the points discussed I had not thought of previously. Helpfully I need to consider more 'why' and 'how' questions in my interview guide as opposed to too many 'what' questions, which may lead to responses which are more descriptive rather than those that are explanatory. We also thought about recruitment of participants and that it will be better to also recruit from a second NHS trust in order to increase the likelihood of accessing care coordinators. This is particularly important with regard to certain professionals (such as social workers and occupational therapists) of which there are fewer in mental health teams. This means that I need to consider finding a professional from within this second trust who will be happy to act as research coordinator for me. This could prove challenging as I am

uncertain of any contacts that I have in that trust. Other helpful issues that were raised included confidentiality (for both participants and service users), as well as increasing the number of participants to recruit from 8 to 14. I have also been recommended to read a paper by Yardley on quality assurance which I will try and take into account whilst planning the study.

March 2012

I had the NREC ethics panel today which was daunting although relatively helpful. Although the review was brief, they raised a number of points to consider. As with my Salomons review they are concerned about protecting the confidentiality of participants and service user and so I need to amend my interview guide in order to be clearer about the implications of breaching confidentiality. They also highlighted a few discrepancies on the IRAS form which will be quick to amend. The panel were insistent that care coordinators are advised to inform their managers that they are taking part in the research. I have mixed feelings about this for a number of reasons but will agree to this suggestion and make the amendments in order to the project approved. Other than that the panel only raised very minor amendments and I hope that the 'letter of favourable opinion' will follow soon after I submit the changes.

November 2012

I completed my pilot interview today with a mental health colleague in preparation for the first interview which I have scheduled for next week. The pilot interview was extremely valuable. It has helped me to hone some of the questions that I want to ask. Importantly, the participant went into great detail about the participant's actual trauma as opposed to their response which means that I may need to be aware of too much time in interviews being given to client's actual stories rather than the care coordinator's responses. Importantly however, the 5 minute reflective task at the beginning seems to work really well and my colleague gave positive feedback on this. I am glad that this has been included at the start of the interview guide – it should give every participant some space to think about a story or disclosure they have heard; probably a helpful introduction to quite a sensitive topic.

March 2013

I met with my Emma today, the main purpose of which was to discuss the interviews and data analysis to date and plans for the remainder of the study. I explained my progress in terms of completing line by line and focused coding for 7 of the interviews to date. I was able to explore the emerging core categories and how that was impacting upon the remaining interviews in terms of focus and thinking about theoretical saturation. We spoke about some of the challenges I have experienced in the interview (such as keeping people on topic) and some of the strategies that I

have tried to employ to manage this. Lastly, we made a plan for support and supervision input for the remainder of the project.

May 2013

I met with Sue today and outlined my data analysis to date which appeared to make sense and fit with the research questions. I spoke about the emerging core categories and how they had developed from the focused codes. I was able to ask some more technical questions regarding the analysis around the construction of core categories and ensuring that the model is representative of the data. We decided upon a deadline for the last aspect of the coding, in order to ensure that both supervisors are able to look at my grounded theory before writing my results and discussion.

APPENDIX 17: Interview excerpts

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APPENDIX 18: Audit trail: Quotes, focussed codes, sub-categories& categories.

Quote	Focussed codes	Sub-categories	Categories
<p><i>'..yeah she was so distressed and I just gave her space really just to talk about you know her experiences and the way she was feeling, I didn't sort of have any particular response it just, just there for her to talk about it'</i></p> <p><i>" I was there with her for some time it must have been an hour and a half just which was a long time to really give her time it was sort of the first time she had actually disclosed it to me and I wanted to sort of give her that time to contain it"</i></p> <p><i>" so they can tell it their own way and I think she just needed space to say that, erm, as my sort of going back to it it's just about letting them have that moment to say that I don't, always particularly, not in that instance actually say anything"</i></p> <p><i>"and that's you're very next thought but I do have to try and clear my head and let that just be the space for that to be said and recognised"</i></p>	<p>Creating space</p>	<p>Responding in the moment</p>	<p>Being an active participant in the disclosure</p>
<p><i>"..my response was to say to acknowledge that you are you do understand what they're saying if you share with the client in their experiences and do understand"</i></p> <p><i>" just to say that I knew what she was going through even though I didn't I felt something (previously under care and support)"</i></p> <p><i>"yeah I acknowledged how traumatic that must have been for her and how she's carried it all these years and"</i></p>	<p>Validating experience</p>		

<p><i>not been able to tell anyone about it and that with me and how hard that must have been for her."</i></p>			
<p><i>"said I wanted to try and see him and to console him so this is how has it was"</i></p> <p><i>"I didn't(cuddle her) but that's how I don't know I just wanted to let her know that I was there for her in some way"</i></p> <p><i>'..I think I asked her if it was ok to put my arm around her and stuff because what can you do in those certain circumstances.'</i></p> <p><i>'But you know there are people that can help you, there are things that we can support you with'</i></p> <p><i>"you know and I said I remember just trying to encourage about the fact that she had come through or was working through that to an extent"</i></p> <p><i>"you've got to be there to support that person through that disclosure and to hear and to be there as somebody who's actively listening"</i></p> <p><i>"and that's not my role anyway to try and get justice for someone it's just to support them in that sense "</i></p>	<p>Offering comfort & support</p>		
<p><i>"I think they need to be a bit more supported with this issue and you need to try and be empathetic but not end up crying with them really"</i></p> <p><i>"now erm obviously there was a level of being you know horrified by the what had happened to this woman"</i></p>	<p>Managing own emotions</p>		

<p><i>erm but the you don't show that"</i></p> <p><i>"I mean I think you know, not to burst into tears or (...) you know to just break down and not be able to speak or anything like that"</i></p> <p><i>"because they're the client and I think it's very unprofessional if you become distressed in that situation"</i></p> <p><i>"I think she was very upset and I I probably did show some upset with shared you know not completely robotic"</i></p> <p><i>"thought it was natural I think to cry in front of her as well and I just cuddled her"</i></p> <p><i>"I would not start crying with them because no that's not useful to them I think they need to be a bit more supported with this issue and you need to try and be empathetic but not end up crying with them really"</i></p>			
<p><i>"sometimes in my head is sometimes thinking let's get on to more practical things what can I do about this or how can I help"</i></p> <p><i>"times is very helpful I think giving that person a set of tools to cope when you're not in session is very helpful so you know the techniques such as put it all behind locked doors, you know only opening those doors when we're in a session together you know that's when it comes out that's when you talk about it, having difficulty in between time you shut that all away and lock all your doors and I think that really helps with people giving them a set of strategies to cope between sessions"</i></p>	<p>Offering practical support</p>	<p>Focusing on support after disclosure</p>	

<p><i>“I think it’s not easier but you can deal with something if they say that its happening now cos then you kind of go through the things that do you need me to help you with those but please is there anyone that I can contact at the health centre, look at going to [name of third sector organisation] to get yourself checked and something like”</i></p> <p><i>“and that yes those things have happened and they’re really awful but where do we work from now and getting them to start thinking about that how we can help them to start moving on”</i></p> <p><i>“ It made me made me want to start to do more for them”</i></p>			
<p><i>“yeah yea it was just I mean when you hear about things like that you hear about things in the news but to experience that kind of trauma and sadness and grief you know firsthand and erm..... I keep wanting to cry”.</i></p> <p><i>“when I first started out they really did bother me (did they) yeah it was really quite upsetting at times and shocking”</i></p> <p><i>“I think it’s the kind of shock that the reality against the fantasy if you like” and sadness sadness for her that she’d been through so much and thinking that you know no one should really go through that go through that at all”</i></p> <p><i>“in the sense of it’s very sad and it’s really awful, but, the more you work in this field (...) the more it seems commonplace that these things have happened to people”</i></p> <p><i>“this happen to a fellow human being</i></p>	<p>Experiencing negative emotions</p>	<p>Bearing the emotional impact</p>	<p>Responding to client’s story</p>

<p><i>so first felt sad”</i></p> <p><i>“I think I felt that I wanted to cry because it was it was just so traumatic”</i></p> <p><i>“I think, I think if you’re hearing them for the first time its definitely more upsetting you might think oh gosh the more you hear them they’re not so shocking, its still upsetting but its not shocking”</i></p> <p><i>“and shock erm sadness anger, anger at what she had been through in that sense you know in what she had experienced you you know”</i></p> <p><i>“She said the whole thing and I think for me that was quite a shock. Probably why I have never really forgotten it”</i></p> <p><i>“I didn’t feel traumatised by it I just felt I don’t know I just (...) emotional I suppose”</i></p>			
<p><i>“I know it would have been the same back then with this kind of case I’ll go in and I just feel so emotionally spent and exhausted”</i></p> <p><i>“I’m quite a hard natured person I couldn’t help I found myself emotional with her at the time if you know what I mean I feel myself getting emotional now”</i></p> <p><i>“so yeah it was I remember being emotionally drained coming back from the appointment”</i></p> <p><i>“they hear it they can’t cope with it I hear it every day I find it unpleasant I still manage my life around it you know it is difficult it’s not nice it emotionally”</i></p>	<p>Feeling emotional about stories</p>		
<p><i>“know she actually disclosed that, and as I said very very difficult when</i></p>	<p>Findings stories unpleasant</p>		

<p><i>somebody's disclosing that somebody's seen you know [content of disclosure],</i></p> <p><i>"honest it was very disturbing you know it made me feel that our job is very very hard sometime when you hear certain things you hear it depressing you as well"</i></p> <p><i>" so it's something that sometimes you feel wow this is too much, yea yea and it is I don't wanna hear it it's too much"</i></p> <p><i>"it was uncomfortable to hear it was really quite uncomfortable to hear"</i></p> <p><i>"No, no no it's not a nice kind of thing to think about"</i></p>			
<p><i>"I have. I mean it's probably one of the stories that's always stayed with me"</i></p> <p><i>"that kind of visceral response that they're having so that that's affecting that you know that stays in your memory"</i></p> <p><i>"Definitely, I think just in a general sense erm, I think that you carry that around with you all the time"</i></p> <p><i>"that has like a ripple effect on your own personal life as well because you tend to get I mean unconsciously you carry it over to your house or home really"</i></p>	<p>Carrying stories permanently</p>	<p>Experiencing a negative effect of stories</p>	
<p><i>"whereby even just driving down the road you can look at someone and start analysing them because I think of some of the things that you have heard then"</i></p> <p><i>" In terms of her case as well especially when you watch the news and you hear about disaster things or</i></p>	<p>Remembering stories</p>		

<p><i>anything related to that issue it gives you kind of a flashback you know and you just remember oh"</i></p> <p><i>"yeah occasionally it'll pop in my head and if I go past the area where she lives"</i></p>			
<p><i>"I think it's taught me for my own protection to not get too involved and to stay slightly distant"</i></p> <p><i>"and then trying to stay emotionally detached as much as possible from from that, from their experience"</i></p> <p><i>"Well for some that I've been working with erm, I suppose some I get a sense that they're more detached from the emotion that has been given to them as a person"</i></p> <p><i>"so in a way I felt that I couldn't fully access my own feelings around that and there's a bit, I was a bit disconnected from it (where you) yeah in a way"</i></p> <p><i>"I don't honestly no, I wouldn't say I have, I've heard anything that really took, I don't know I think maybe I've become unshockable "</i></p> <p><i>"and I think sometimes you do feel that you get a little bit hardened to it because you hear them so frequently but then I think there's other times when some people that really stick in your mind"</i></p>	<p>Feeling disconnected</p>		
<p><i>"it was really upsetting...I definitely went home thinking about how horrendous that must have been for</i></p>	<p>Taking stories home</p>		

<p>her”</p> <p>“even after work you’re thinking wow it must have been very difficult to even be brought up in such a situation”</p> <p>“So yeah it it does you try not to let it get into your personal like but it does”</p> <p>“but yeah I definitely think it creeps into your personal life yeah”</p> <p>“you’re at home so you are even sometimes forget that some people are watching you your family members even someone is talking to you and because you are absent minded you are thinking about your client”</p>			
<p>“it does make me very much more thankful for what I have and for my life and when I’m having tough times and struggling with things I really do try to remember that”</p> <p>“I am lucky you know I’m not in their situation you know it just make me to be more thankful”</p> <p>“I mean it...you can’t help but value your own life”</p> <p>“I think probably being very aware of my family situation as well, (...) cherishing what I’ve got”</p> <p>I guess it can make you feel you know quite lucky with your lot a well you know erm because some people have had such dreadful lives haven’t they and experiences erm that you just feel kind of blessed really do you know what I mean</p>	<p>Valuing own life</p>	<p>Positive response to stories</p>	
<p>“I see them as an individual rather than just as a diagnosis now”</p> <p>“so I think it gives me a wider</p>	<p>Changing outlook</p>		

<p><i>perspective when I work with clients about what they've been through and so for me I think it's just I appreciate the complexity of human beings more"</i></p> <p><i>"knowing how fragile it is, you know how fragile you are as the person you are you know you're more aware perhaps of how fragile human beings are (...) I don't think it's necessarily a disadvantage to know that"</i></p> <p><i>"and I think over the years I appreciate now over the years I've been practising the complexity of social beings so to speak and how as people we interact and how different things impact them in different ways, so I think it gives me a wider perspective when I work with clients about what they've been through"</i></p> <p><i>"and also I don't know I think that despite adversity one thing that I don't know if it has changed me but one thing that I hold on to is that people do have the capacity to change despite some of the awful things"</i></p>			
<p><i>"I think when I, I always think that when people feel able to share things with me I find it very much a privilege in the sense that that people have been able to open up and share and I don't take that for granted at all, to share that with me"</i></p> <p><i>"suppose it's about it's again being honoured that this person has been open and honest and been happy to share that with me I suppose that's what it is it makes me feel good"</i></p> <p><i>"quite sort of in a weird way sort of privileged to although that might sound weird but because it was the</i></p>	<p>Feeling honoured by disclosure</p>		

<p><i>first time that my client had openly spoken about it with me it just made me think well she must feel enough trust and that must be quite a big thing for her ”</i></p>			
<p><i>“for her yeah and I was so so sympathetic ”</i></p> <p><i>“yes, I think it really makes you (...) empathise and understand people’s suffering and I think unless you’re in this kind of profession I think that’s really”</i></p> <p><i>“it’s made me more certainly more empathetic to other cases other things I suppose”</i></p>	<p>Experiencing empathy and sympathy</p>		
<p><i>“and thinking what it’s be like to have the [DETAILS OF CLIENT’S TRAUMA] off of you”</i></p> <p><i>“you’re thinking wow it must have been very difficult to even be brought u in such a situation when you’re still you cannot go to anybody for help”</i></p> <p><i>“that’s I suppose I was putting myself in her shoes and thought how you know it felt for her”</i></p> <p><i>“ I remember feeling quite shocked for her and just trying to imagine what it must be like to be so to be so vulnerable you know at such a young age and then to to have succession of things through her life”</i></p>	<p>Putting oneself in client’s experience</p>	<p>Broadening perspective on self, client & world</p>	
<p><i>“yeah it’s just making recognising the links really, and then reflecting on it”</i></p> <p><i>“was just petrified throughout the whole of it that something was gonna happen and I don’t know if that was me thinking too much about that case</i></p>	<p>Seeing parallels between self & client’s life</p>		

<p>or”</p> <p>“as someone similar to myself and that helped me as to how I should come through or working through what she had been through and where she was at the moment”</p> <p>“something about the relationship and you know how I am you know with my family and that that’s another reason it’s stayed with me and I really cared”</p> <p>“and it’s also helped me to recognise things in myself an awful lot as well you know patterns of behaviour”</p>			
<p>“What I would say what I’ve actually achieved from some of the stories is actually I’ve become more aware of life so to speak so what can actually happen”</p> <p>“it’s made me really wary with my own children about who I trust with them with and probably being over-protective of them”</p> <p>“to know that people have got the potential for evil, I mean yeah you know human beings can be evil and it bothers me”</p> <p>“you know it makes me to be aware that life is difficult and like is not fair and people are dangerous you know”</p> <p>“and it was just the fact that that was you know that could happen to any of us couldn’t it that things can be snatched away from us so I suppose it’s just the vulnerability of us all but I do think”</p>	<p>Changing world view</p>		

<p><i>"it just makes you more aware that these things happen"</i></p> <p><i>"you know it makes me to be aware that life is difficult and life is not fair, people are dangerous you know"</i></p>			
<p><i>"I don't think there's any real strategies I have at home, I think sometimes to unwind I might have a glass of wine or have something like that"</i></p> <p><i>"I get home today now what do I do first if I want a cup of tea I go straight and have one I have may be some bath every day I relax for maybe 30-40 minutes or an hour in the bath so maybe that has helped me and when I'm there I don't think about work"</i></p> <p><i>"I try as much as possible to please myself you know in my own way I treat myself you know"</i></p> <p><i>"do something that will actually take me away totally away from the job itself I'm I like [NAME OF HOBBY] so I do like weekend when I'm working on [HOBBY] and my [HOBBY] and just playing with other things doing [HOBBY] it helps to actually free my mind and also I'm a [SPORT] fan"</i></p> <p><i>"only yoga which has saved my life yeah it's been brilliant way to manage my stress"</i></p>	<p>Looking after oneself</p>	<p>Developing personal coping strategies</p>	<p>Developing individual ways to cope with client's story</p>
<p><i>"but I'm fortunate that I've got a really really supportive [FAMILY MEMBER] and I'm able to go home and say I'm feeling absolute crap I've had this this this and this"</i></p>	<p>Negotiating social support</p>		

"stressed and take my stress out on my [FAMILY MEMBER] you know but I would get angry about little tiny things"

"yeah in that instance I did share it with my [FAMILY MEMBE] but I try not to share share too much with [FAMILY MEMBER] because it's not his job really its our home its its its my home life it's my terms so"

"I don't think about anything I don't worry myself I will probably be on the phone chatting to [FAMILY MEMBER]"

"as long as I can do my job well, do what I'm here for, earn a wage, my (FAMILY MEMBER) is my priority you know (FAMILY MEMBER) out of everything is my main focus and my main reason for being now so that's helped because as soon as I go in that door that's what's important"

"so it's having like to share the burden with other people professionals be it or relatives clients friends or family its makes the job much easier really and to involve the clients erm significant others has been one of my coping strategies because it helps"

"I say for me as i said before its a case of sometimes being you know being quiet, not taking phone calls you know and just having that time out where I can have some music or just help me distract a little bit"

"at home and I won't pick up the phone I mean people know not to call me anymore my friends because I won't speak to them I've had enough you know"

"cos it you can't do that at home"

<p><i>because of, well you can to a point but it's not the same because you can't reveal details about the person so you know my ** can listen to how I'm feeling but not I don't think he really understands cos he's not a social worker or a cpn so he's not involved in mental health at all, erm",</i></p>			
<p><i>"but, having to present yourself as being strong, is I guess what I'm saying, and coping you know even if a manager says are you ok with that, sometimes saying yes just because you want to give that view of yourself that you're coping, you're managing that you can do your job well"</i></p> <p><i>" I've had (*) years of being sneaky (laughs) and you can hide it"</i></p> <p><i>“.probably I have fear that if we're not coping maybe I'm going to become a service user"</i></p> <p><i>"you need to be emotionally tough and resourceful so maybe you kind of become that or you (laughs) pretend to become that but you know I don't"</i></p>	<p>Hiding the not coping</p>		
<p><i>"I think as health professionals we're taught (...) trained to detach ourselves and look at the look at the facts as much as possible so that that's a (...) that's a protection"</i></p> <p><i>"I think you had to be un-shockable to some level at some point because you wouldn't cope you know"</i></p> <p><i>"whether that's my avoidance of wanting to know or me not wanting to damage the client more by putting them through something that I'm not</i></p>	<p>Detaching from stories</p>		

<p><i>trained to handle”</i></p>			
<p><i>“sometimes because I try to switch off yeah I forget things as well”</i></p> <p><i>“I wouldn’t like to say that I switch on and off but in another way I do because that’s the only way of functioning”</i></p> <p><i>“ it’s a case of kinda (...) trying to keep work as work and but it doesn’t always happen”</i></p> <p><i>“I suppose that’s where I try not to think about things too much when I get home you just go right that’s it”</i></p> <p><i>“ yeah you know I think emotionally I’ve always (...) had something put into place where at the end of the working day I take my [NAME OF PROFESSION] hat off and I put my home hat on”</i></p> <p><i>“.. I’ve got a very clear point where I enter my house and shut that door, I suppose it’s there somewhere but it doesn’t consciously come with me “</i></p>	<p>Switching off from work</p>		
<p><i>“institutional sort of attitudes really, I don’t think people are very although we work in mental health I don’t think we are psychologically minded, it’s more about function (...) as long as you put the right words in the right places and document as you should have done then the other part of it is just your job”</i></p> <p><i>“I think it’s just the way it’s presented it’s presented very erm its all about the work that’s going on rather than the no one’s ever said to me how do you feel, what does it make you feel</i></p>	<p>Feeling blocked by culture of team & service</p>	<p>Barriers to seeking support</p>	

<p><i>like when she says something like that or he says no one's ever asked me that"</i></p> <p><i>"probably, I think there's generally a general sort of, unspoken rule... you should be able to have a stiff upper lip, don't get upset, things are not meant to affect us, I think people just think we're robots and just get on with it"</i></p> <p><i>"the informal culture and yeah this kind of bravado macho sort of thing of we're all doing fine and you know"</i></p> <p><i>"it does impact on people and I think when that's not looked at you know you never know how professionals are responding to when they hear information and what they bring home"</i></p>			
<p><i>"I think it's there's a number of my own paranoia as to how that person will respond in terms of and then taking the actual information and the context that that I want to discuss how to process or they will take it in the context of can she manage her workload"</i></p> <p><i>"I don't know, I suppose what I'm thinking is that if I know it's silly but if I disclose how it makes me feel then I'm not functioning well"</i></p> <p><i>"..it was weird because I didn't want to necessarily let what people might see as a weakness in me"</i></p> <p><i>" I don't think its stopped me talking about something, it might just stop just my response I guess I wouldn't feel, I wouldn't get upset in front of</i></p>	<p>Fearing misinterpretation</p>		

<p><i>people or yeah would just be aware of my emotions, I would only say so much at work yeah”</i></p> <p><i>“..the perception that maybe some people think you know it’s like a yeah its weak and perhaps I’m a little bit unhinged or something”</i></p> <p><i>“and if you can’t handle it, I’ve actually had [NAME OF COLLEAGUE] say this to me if you can’t handle it then why are you working in services so that you know I think the words were well are you suitable for mental health services ”</i></p>			
<p><i>“..I think a lot of people are feeling like that but there is that sense of you could be judged. Yeah like what’s wrong with you why wouldn’t you be able to cope with all of this it’s a bit macho you know”</i></p> <p><i>“I couldn’t at the time I didn’t feel not safe but I just didn’t wanna burden anyone at the time with how I felt about it”</i></p> <p><i>“I don’t know, I suppose I would be judging myself, I would just feel, even thinking about its yeah, but if somebody else did it I would be like oh no, I would be supportive of them but I just couldn’t do it myself”</i></p> <p><i>“I liked that I was able to do that and on the other hand I didn’t because I felt very vulnerable and I felt very as I said like a service user like you know I needed the service”</i></p>	<p>Feeling uncomfortable expressing emotions</p>		

<p><i>“..we tend to talk about cases and tend to talk about erm what you’re doing with the person we tend not to talk about how it makes me feel”</i></p> <p><i>“I think it’s something that I struggle with, if I just wanted to kind of just not offload so to speak but share that information with somebody, but if the person cancelled or they may come with their own agenda to supervision and may not really prepare for what I want to bring myself”</i></p> <p><i>“that many people around so we have to do the clinical stuff then we have do to the managerial supervision as well so it does get intertwined sometimes”</i></p>	<p>Differing priorities in supervision</p>	<p>Experiencing levels of support in supervision</p>	<p>Evaluating organisational support</p>
<p><i>“I think though there would be room if I wanted to discuss trauma but quite honestly I think that I am so used to not doing it that I don’t”</i></p> <p><i>“the way the service has changed and the increasing demands on care coordinators that there’s so much sort of ground to cover in supervision”</i></p> <p><i>“you might be talking about what you’re doing with a client how you’re doing it there may be some questions about how you’re managing emotionally but really you don’t get to that that level of talking about it so you carry these stories and their narratives and what’s happened to them around with you the whole time”</i></p> <p><i>“ so you might be dealing with really difficult stuff and then yet again it’s just you know any number of audits and gaps there are where things haven’t been done and can you go away and make sure you find the time to do that please thanks very</i></p>	<p>Experiencing service demands</p>		

<p><i>much”</i></p> <p><i>“..time is limited and there’s not time to think about, it’s just getting things done and I think that’s what I’ve noticed its just the nature of things, that’s changed with the service over the last year of two years that I’ve noticed it’s more about what is produced and what looks on paper rather than the quality of the engagement with the service user and what and and dealing with traumatic experiences and working through them with clients and how you as a professional manage that that seems a very lost focus I think now”</i></p>			
<p><i>“supervision gets changed...everyone is so busy I haven’t had supervision for many many weeks I think I’d gone about 2 months without any supervision”</i></p> <p><i>“On the policy it says that we should be having clinical supervision but as I say I was without a clinical supervisor for a while and it wasn’t sort of chased up as such”</i></p> <p><i>“It’s definitely a lack of clinical supervision”</i></p>	<p>Accessing supervision</p>		
<p><i>“ I have a supervisor every 6 weeks so you know you wait 6 weeks to discuss it and you know by that time you know I may have found someone else that I can process that information with and not want to share it with that person anyway because for me that can be too late you know”</i></p> <p><i>“In terms of the organisation I mean it offers what it needs to I’m</i></p>	<p>Timeliness of supervision</p>		

<p><i>unfortunately accessing what you need at the time you need it can be a challenge”</i></p> <p><i>“Yes I communicate a lot so by the time I go to supervision really I don’t have much to discuss as I might have dealt with the problem”</i></p> <p><i>“that’s not to say that in supervision that I wouldn’t bring something up that affected me personally but I would just say if it’s if it’s timely I you know rather than waiting for supervision”</i></p>			
<p><i>“I think if I find someone a colleague who I can say if they have time or they can make time to go through ones that have been emotionally difficult or draining then...I can do that with them”</i></p> <p><i>“that’s a really important function to have colleagues sitting around you that you can just say this was particularly tough or I’ve had a tough day and in a sense at other times it would be their time to you know voice those concerns”</i></p> <p><i>“I’ve got quite a few contacts from within the profession but outside of work so I can contact them on a regular basis so we did discuss cases in a you know not in a formal situation”</i></p> <p><i>“probably the biggest level of support was with other care coordinators and colleagues who are also friends”</i></p>	<p>Relating to colleagues</p>	<p>Experiencing other forms of organisational support</p>	
<p><i>“So I talk to anybody in the team everybody in the team and anyone in the building”</i></p>	<p>Feeling supported by team</p>		

<p><i>"I mean I can't fault the team I mean the team are very very sort of nice they're there for you"</i></p> <p><i>"although the team as I said are very very supportive and they're all aware and they're very very supportive"</i></p>			
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APPENDIX 19: Journal submission guidelines



Journal of Traumatic Stress

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Edited By: Daniel S. Weiss, Ph.D.

Impact Factor: 2.55

ISI Journal Citation Reports © Ranking: 2012: 23/114 (Psychology Clinical); 37/120 (Psychiatry (Social Science))

Online ISSN: 1573-6598

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Author Guidelines

1. The *Journal of Traumatic Stress* accepts submission of manuscripts online at:

<http://mc.manuscriptcentral.com/jots>

Information about how to create an account or submit a manuscript may be found online in the "Get Help Now" menu. Personal assistance also is available by calling 434-817-2040, x167.

2. Three paper formats are accepted. All word counts should include references, tables, and figures. *Regular articles* (no longer than 6,000 words) are theoretical articles, full research studies, and reviews. Purely descriptive articles are rarely accepted. In special circumstances, the editors will consider longer manuscripts (up to 7,500 words) that describe complex studies. Authors are requested to seek special consideration prior to submitting manuscripts longer than 6,000 words. *Brief reports* (2,500 words) are for pilot studies or uncontrolled trials of an intervention, case studies that cover a new area, preliminary data on a new problem or population, condensed findings from a study that does not merit a full article, or methodologically oriented papers that replicate findings in new populations or report preliminary data on new instruments. *Commentaries* (1,000 words or less) cover responses to previously published articles or, occasionally, essays on a professional or scientific topic of general interest. Response commentaries, submitted no later than 8 weeks after the original article is published (12 weeks if outside the U.S.), must be content-directed and use tactful language. The original author is given the opportunity to respond to accepted commentaries.

3. The *Journal* follows the style recommendations of the 2010 *Publication Manual of the American Psychological Association* (APA; 6th). Manuscripts should use non-sexist language. Files must be formatted using letter or A4 page size, 1 inch (2.54 cm) margins on all sides, Times New Roman 12 point font, and double-spacing for text, tables, figures, and references.

4. The title page should include the title of the article, the running head (maximum 50 characters) in uppercase flush left, author(s) byline and institutional affiliation, and author note (see pp. 23-25 of the APA manual).

5. An abstract no longer than 200 words follows the title page on a separate page.

6. Format the reference list using APA style: (a) begin on a new page following the text, (b) double-space, (c) use hanging indent format, (d) italicize the journal name or book title, and (e) list alphabetically by last name of first author. If a reference has a Digital Object Identifier (DOI), it must be included as the last element of the reference.

Journal Article

Kraemer, H.C. (2009). Events per person-time (incidence rate): A misleading statistic? *Statistics in Medicine*, 28, 1028–1039. doi: 10.1002/sim.3525

Book

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Hillsdale, NJ: Erlbaum.

Book Chapter

Meehl, P. E. (2006). The power of quantitative thinking. In N.G. Waller, L.J. Yonce, W.M. Grove, D. Faust, & M.F. Lenzenweger (Eds.), *A Paul Meehl reader: Essays on the practice of scientific psychology* (pp. 433–444). Mahwah, NJ: Erlbaum.

7. Tables and figures should be formatted in APA style. *Count each full-page table or figure as 200 words and each half-page table or figure as 100 words.* Tables should be numbered (with Arabic numerals) and referred to by number in the text. Each table and figure should begin on a separate page. Only black and white tables and figures will be accepted (no color). Figures (photographs, drawings, and charts) should be numbered (with Arabic numerals) and referred to by number in the text. Place figures captions at the bottom of the figure itself, not on a separate page. Include a separate legend to explain symbols if needed. Figures should be in Word, TIFF, or EPS format.

8. Footnotes should be avoided. When their use is absolutely necessary, footnotes should be formatted in APA style and placed on a separate page after the reference list and before any tables.

9. The *Journal* uses a policy of **unmasked review**. Author identities are known to reviewers; reviewer identities are not known to authors. During the submission process, authors may request that specific individuals not be selected as reviewers; the names of preferred reviewers also may be provided. Authors may request blind review by contacting jots@ucsf.edu prior to submission in order to provide justification and obtain further instructions.

10. Statement of ethical standards: All work submitted to the *Journal of Traumatic Stress* must conform to applicable governmental regulations and discipline-appropriate ethical standards. Responsibility for meeting these requirements rests with all authors. Human and animal research studies typically require approval by an institutional research committee that has been established to protect the welfare of human or animal subjects. Data collection as part of clinical services or for program evaluation purposes generally does not require approval by an institutional research committee. However, analysis and presentation of such data outside the program setting may qualify as research (i.e., an effort to produce generalizable knowledge) and require approval by an institutional committee. Those who submit manuscripts to the *Journal of Traumatic Stress* based on data from these sources are encouraged to consult with a representative of the applicable institutional committee to determine if approval is needed. Presentations that report on a particular person (e.g., a clinical case) also usually require written permission from that person to allow public disclosure for educational purposes, and involve alteration or withholding of information that might directly or indirectly reveal identity and breach confidentiality.

11. Reports of randomized clinical trials should include a flow diagram and a completed CONSORT checklist (available at <http://consort-statement.org/resources/downloads>). The checklist should be designated as a "Supplementary file not for review" during the online submission process. As of 2007, the *Journal of Traumatic Stress* now follows CONSORT Guidelines for the reporting of randomized clinical trials. Please visit [181](http://consort-</p></div><div data-bbox=)

statement.org for information about the consort standards and to download necessary forms.

12. Submission is a representation that the manuscript has not been published previously and is not currently under consideration for publication elsewhere. A statement transferring copyright from the authors (or their employers, if they hold the copyright) to the International Society for Traumatic Stress Studies will be required before the manuscript can be accepted for publication. Click on the Copyright Transfer Agreement link above for the form. Such a written transfer of copyright, which previously was assumed to be implicit in the act of submitting a manuscript, is necessary under the U.S. Copyright Law in order for the publisher to carry through the dissemination of research results and reviews as widely and effectively as possible.

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Summary of findings for participants and University and NHS ethics panel

June 2013

Title: Care coordinators' responses to clients' trauma: the role of coping and perceived organisational support

In the past two decades research has investigated the impact of hearing traumatic stories on professionals. The impact of such disclosures and trauma-work more generally is thought to lead to a range of concepts including 'burnout', 'secondary trauma' and 'vicarious trauma' amongst other things. These concepts have been investigated in a range of professionals and non-professionals but to date no study has investigated the impact of trauma-work on 'care coordinators' who are generic mental health workers in the UK. The aim of this study was therefore to investigate the impact of hearing clients' traumatic stories on generic mental health professionals in the UK known as care coordinators. The study focused specifically on the role of individual coping strategies and perceived organisational support.

Methodology:

Twelve UK care coordinators from two NHS secondary care mental health services completed semi-structured interviews. Participants included six community psychiatric nurses, four social workers and two occupational therapists. Interview questions pertained to the impact of hearing traumatic stories, individual coping strategies and perceived organisational support. The interviews were analysed using constructivist grounded theory and a model was produced of participants' experiences.

Findings:

Summary of grounded theory model

The model suggested that participants responded to their clients' traumatic experiences by being 'active participants in the disclosure', which reflected how participants responded 'in the moment' to facilitate their clients' disclosure based on what they deemed as appropriate and supportive. After the disclosure, participants focused on 'practical aspects of disclosure' which included offering practical support and moving the client on. In addition, participants also experienced a personal response to clients' stories which included an emotional impact, some distinctly positive and negative responses and a broadening of their outlook on themselves, their clients and the world. Participants then developed their own coping strategies for managing the negative response to their clients' stories and experienced some personal barriers in seeking support for hearing stories. Lastly, the model reflects participants' perceptions of organisational support for disclosures, which included experiences of supervision and other sources of support.

Core category 1: Being an active participant in the disclosure

Participants actively responded to disclosures through creating space for the disclosure, validating the experience, providing comfort and encouragement and managing their own emotions. Practical support included strategies to help the client to move on.

Core category 2: Responding to client's story

Care coordinators also experienced a personal impact to clients' disclosures. This covered a range of experiences including emotional responses (including sadness, shock and anger), a negative result of stories (carrying stories permanently, feeling disconnected & taking stories home) and a positive response to disclosures (valuing their own life, experiencing the disclosure as an honour, changing their outlook and an increase in empathy and sympathy). Lastly, a broadening of participants' perspectives on themselves, their client and the world occurred which was not experienced as wholly positive or negative.

Core category 3: Developing individual ways to cope with client's story

Participants all coped with repeated exposure to traumatic disclosures by developing a range of coping strategies aimed at managing the more negative responses to disclosures. These included self-care, social support, hiding the not coping, detaching from stories and switching off from work. In addition to developing coping

strategies, participants also encountered barriers to seeking support which included feeling blocked by the culture of the team, fearing misinterpretation and feeling uncomfortable in expressing emotions.

Core category 4: Evaluating organisational support

Participants explored their experiences of seeking organisational support for traumatic disclosures. Participants spoke about their experience of varying support in supervision including differing priorities, supervision culture, accessing supervision and the timeliness of supervision. Other forms of organisational support included relating to colleagues and feeling supported by the team.

Implications for practice:

The findings of this study suggest that care coordinators may be at risk from the negative impact of trauma-work through their exposure to clients' traumatic stories. This may result in symptoms of vicarious trauma (changes in outlook on the world) as well as secondary trauma and burnout more generally. Therefore organisations have a responsibility to acknowledge and understand further the possible negative effects experienced by care coordinators.

Importantly, organisations also have a responsibility to address where possible the negative impact of exposure to traumatic stories. Practical suggestions include consideration of how the organisational culture might be preventing care coordinators from seeking help for traumatic stories. Furthermore, ensuring that supervision is regular and timely and that it can encompass individuals' responses to trauma-work would be important. A role for Clinical psychologists may be to assist in fostering a culture of emotional expression in relation to traumatic stories and where possible assist care coordinators in sharing their responses.

Lastly, care coordinators may also benefit from organisations implementing specific training in managing disclosures within generic mental health work as well as considering a professional organisation that could support care coordinators to manage this aspect of their role.

