Therapists, Complex Trauma, and the Medical Model:

Making Meaning of Vicarious Distress and Limitations to Intervention with Complex Trauma in the Inpatient Setting

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Submitted in partial fulfilment of the requirements for the degree of Master of Clinical Psychology

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Declarations

Statement of Originality

This thesis contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text. I give consent to this copy of my thesis, when deposited in the University Library**, being made available for loan and photocopying subject to the conditions of the Copyright Act 1968.

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I hereby certify that the work embodied in this thesis contains a scholarly work of which I am a joint author. I have included as part of the thesis a written statement, endorsed by my supervisor, attesting to my contribution to the joint scholarly work.

Signed:

____________________________________   __________________
Erin Adams  Date
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Abstract

Scope: Complex narratives of childhood maltreatment are common in adult mental health inpatients and are associated with an increased risk of lifetime diagnoses of multiple psychiatric disorders (Chen, Murad, Paras, Colbenson et al., 2010; Edwards, Holden, Felitti, & Anda, 2003). In the aftermath of such experiences, many trauma survivors require the psychiatric and psychological support offered by inpatient mental health services. Inpatient therapists who are vicariously exposed to such trauma narratives face risk to their own physical and psychological wellbeing. Encouragingly, a small body of research suggests vicarious exposure may offer the opportunity for positive personal growth in therapists. However, what is unknown is how therapists make sense of their thoughts, feelings, and responses following exposure to difficult and complex narratives when limited by an inpatient medical model of intervention.

Purpose: This phenomenological investigation sought to understand and describe the “lived” experience of therapists exposed to complex trauma narratives within a mental health inpatient setting. It is particularly interested in both positive and negative interpretations of experiencing such work.

Methodology: Four highly trained inpatient trauma therapists were recruited. Each therapist participated in a semi-structured interview exploring the impact of inpatient narratives of trauma on their personal and professional lives. Interviews were transcribed and analysed using Interpretive Phenomenological Analysis (IPA). IPA offers a detailed examination of an individual’s “lived” experience and seeks the insider’s perspective through a process of re-iterative interpretative activity.

Results: One superordinate theme: Therapeutic integrity and vicarious growth overarched four subordinate themes: 1) Severity, complexity, and repetition; 2) Personal distress and the medical model; 3) Intrapersonal confrontation; and 4) Growth. The
first theme explores how distress becomes an intrusive part of responding to their own vicarious exposure. It provides evidence of their intrinsic conflict over time when working within a structured framework of intervention with complex and challenging inpatient trauma narratives. Participants’ sense of self-doubt, guilt, and failure are seen as erosive in the second theme as they each attempted to impose a western culture medical model of intervention on complex psychosocial traumatic experiences. Theme 3 reflects participants using their distress to question their therapeutic integrity challenging former values of intrapersonal honesty, altruism, and relational connection with patients. The final theme captures psychological wellbeing and growth through reconnection with self-integrity and their professional selves.

**Conclusions:** This study highlights the risks to psychological wellbeing in therapists working with complex trauma in an inpatient setting when limited by a medical model framework of psychological intervention. Promisingly, it provides hope that despite vicarious distress, positive and growthful redefining of therapeutic identity through altruism, honesty, and the relational connection may cultivate psychological growth across domains of compassion, empathy, humility, and gratitude. In essence, when time to develop the therapeutic relational alliance in complex trauma is prioritised, therapeutic integrity, psychological wellbeing, and growth was observed in these participants.

**Implications of the larger work:** These findings highlight the potential benefits of a reciprocal relational approach to psychological intervention when complex trauma challenges both patient and therapist well-being in the inpatient system. Without consideration for the power of the therapeutic relationship, and the necessary time to allow for growth and wellbeing to emerge out of complex trauma, it is likely that brief intervention through a medical model will have little impact on long-term
psychopathological complications in trauma inpatients, and risk vicarious trauma responses in therapists.
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Literature Review

Complex narratives of childhood maltreatment such as sexual or physical abuse, or witnessing maternal battering are common in adult mental health inpatients (Edwards, Holden, Felitti, & Anda, 2003). For example, a history of sexual abuse is associated with an increased risk of lifetime diagnoses of multiple psychiatric disorders (Chen, Murad, Paras, Colbenson et al., 2010). Several systematic reviews have noted an association between childhood sexual abuse and adult posttraumatic stress disorder (PTSD), depression, eating disorders, and suicide attempts (Chen et al., 2010).

However, reflecting on such narratives during therapy though often distressing for the client is also likely to negatively impact the supporting therapist. For those who offer empathic support to patients with complex trauma histories, vicarious exposure is not without risk to their own psychological wellbeing (see Adams & Riggs, 2008; Kadambi & Truscott, 2004). Encouragingly, a small body of research has found that vicarious exposure may offer the opportunity for positive internal transformation in therapists as they integrate these trauma narratives (Linley & Joseph, 2004). However, what is unknown is how therapists make sense of their exposure to difficult and complex trauma narratives when restricted to an inpatient medical model of intervention. With this in mind, this qualitative study explores both the positive and negative interpretations of trauma therapists within an inpatient setting, and how they make sense of the impact working with severely unwell inpatients has on their lives.

The negative effects of trauma have been well documented with recent research showing an association between trauma history and the severity and trajectory of mental illness following a range of traumatic experiences (McFarlane, Bookless, & Air, 2001; Mueser, Rosenberg, Goodman, & Trumbetta, 2002). Research and clinical practice has traditionally focussed on these traumatic experiences as precursors to extremely
distressing physical and psychological outcomes in primary trauma survivors (Herman, 1997; Tedeschi & Calhoun, 2004; Van der Kolk, McFarlane, & Weisaeth, 1996). Such exploration has been largely driven by a medicalised model of thinking which sees external symptomology as evidence for underlying disease or disorder (Bohart & Tallman, 1999; Joseph, 2012).

However, it is now widely recognised that it is not only the trauma survivor who may be adversely affected by traumatic events, but also those who are vicariously exposed. Figley’s (1998) systemic trauma theory explains how prolonged exposure and empathic support to trauma survivors may have a contaminating effect on those vicariously exposed. The risks of psychopathology following vicarious trauma exposure are particularly recognised across a broad range of professional cohorts including police workers (Follette, Polusney, & Milbeck, 1994), nurses (Spinelli, 2011), lawyers (Levin & Greisberg, 2003), researchers (Wasco & Campbell, 2002), funeral directors (Linley & Joseph, 2006), disaster and humanitarian aid workers (McCormack & Joseph, 2013; Zimering, Gulliver, Knight, Munroe, & Keane, 2006), and therapists (Arnold, Calhoun, Tedeschi, & Cann, 2005; Brady, Guy, Poelstra, & Brokaw, 1999; Dlugos & Friedlander, 2001; Linley & Joseph, 2007; Pearlman & Saakvitne, 1995; Schauben & Frazier, 1995).

**Adverse Trauma Responses**

At present, there is no universally accepted term that comprehensively describes the uniqueness and scope of carer responses following vicarious trauma exposure (Kadambi & Truscott, 1996). Terms such as emotional contagion (Figley, 1995), secondary victimisation (Figley, 1982), burnout (Maslach & Jackson, 1982), compassion fatigue (Figley, 1995), negative countertransference (Gold & Nemiah, 1993), secondary traumatic stress (Stamm, 1995), and more recently vicarious traumatisation (McCann & Pearlman, 1990) have all been used to capture vicarious post
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trauma responses. Due to overlapping themes and interactional effects (Sexton, 1999) these terms are often used interchangeably leaving the relationship between constructs largely unclear (Linley & Joseph, 2007). However, despite similarities, there are significant classification differences that can be highlighted.

The terms emotional contagion and secondary victimisation have been used to capture the contamination effect outlined by Figley (1998). Those affected by their vicarious exposure to trauma experience emotional and stress related disturbances that mirror the survivor’s sensory, emotional, and imagery reactions (Hatfield, Cacioppo, & Rapson, 1994). Therapists are at significant risk of experiencing emotional contamination given their repeated empathic exposure to client narratives of distress.

The emotionally taxing nature of general therapeutic work has been captured by the term burnout (Maslach & Jackson, 1982). Burnout describes a gradual, emotionally destructive process occurring through prolonged exposure to chronic workplace pressures and organisational factors (e.g., working hours, conditions, administrative setting; Figley, 1995; Rothschild, 2006). Repeated exposure to client presentations, deep-seated trauma related symptomology, and lengthy treatment periods have all been found to contribute to burnout in therapists (McCann & Pearlman, 1990). Symptoms include emotional exhaustion, depersonalisation, increased vulnerability, and reduced feelings of efficacy over time (Figley, 1995; Rothschild, 2006). Whilst the concept of burnout is relevant to therapists, it fails to recognise the potential for more pervasive and permanent changes arising through exposure to psychologically challenging trauma narratives (McCann & Pearlman, 1990).

The unique experiences of trauma-focussed therapists have been captured by the concepts of secondary traumatic stress (STS; Stamm, 1995), otherwise known as compassion fatigue (Figley, 1995), and vicarious traumatisation (McCann & Pearlman,

It is the conscious and unconscious emotional and behavioural responses and/or defences to a specific client, their trauma narrative, transference material, and trauma re-enactments that trigger traumatic countertransference (Herman, 1992; Pearlman & Saakvitne, 1995; Wilson & Lindy, 1994). Similar to primary posttraumatic stress common countertransference responses include helplessness, grief, rage, vulnerability (Herman, 1992), horror, guilt, dread (Danieli, 1988), intrusive imagery, rumination, irritability and somatic reactions (Wilson & Lindy, 1994). However, countertransference defences are specifically driven by the client/therapist interactions and are classified as avoidance responses (e.g., repression of empathy through emotional distance, minimisation of trauma narratives, and denial of relational warmth; McCann & Pearlman, 1990) and over-identification responses (e.g., client idealisation, empathetic enmeshment, excessive advocacy, guilt, and desires for perpetrator retribution; Figley, 1995, 1998; McCann & Pearlman, 1990).

Over time, maladaptive countertransference defences have the potential to affect not only specific client/therapist dynamics, but also generalise to all areas of the therapist psyche. Decreased self-awareness, self-protectiveness, and challenge to the therapist’s own identity, beliefs, and worldview facilitate this generalisation (McCann & Pearlman, 1990; Wilson & Lindy, 1994). If not recognised, acknowledged, and contained by the therapist, countertransference material may cultivate more permanent
and pervasive changes as characterised by the phenomenon of vicarious traumatisation (McCann & Pearlman, 1990; Wilson & Lindy, 1994).

**Vicarious Traumatisation in Therapists**

Vicarious traumatisation describes the negative transformation of the therapist’s inner experience, inclusive of memory systems and schemas about oneself, others and the outside world (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). It typically occurs through cumulative empathetic engagement with the emotional experience of one or more traumatised individuals leading to negative schematic distortions (Adams & Riggs, 2008; Kadambi & Truscott, 2004; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995; Schauben & Frazier, 1996). Such distortions have been reported in areas of safety, trust, esteem, control, and in beliefs regarding spirituality and personal worldview (Adams & Riggs, 2008; Pearlman & Saakvitne, 1995; Schauben & Frazier, 1996). Vicarious traumatisation also captures the manifestation of subclinical posttraumatic stress symptoms which often mirror those reported by the trauma survivor (Arnold, et al., 2005; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995; Spinelli, 2011).

The concept of vicarious traumatisation and its theoretical underpinnings offers a framework for normalising and respecting the therapist’s negative responses to trauma work (Kadambi & Truscott, 2004). Constructivist self-development theory (CSDT) integrates psychoanalytic and cognitive theories in its conceptualisation of the phenomenon of vicarious traumatisation (McCann & Pearlman, 1990; Saakvitne, Pearlman et al, 1996; Spinelli, 2011). CSDT seeks to extrapolate the relationship between cognitive manifestations of psychological needs known as schemas, and the process of psychological adaptation (McCann & Pearlman, 1990).
CSDT posits each individual develops cognitive schemas about themselves, others and the world, which serve as their own unique and personal template of reality (Trippany, White, Kress, & Wilcoxon, 2011). In some cases, these templates of reality are challenged through prolonged exposure to trauma narratives. Consequently, adaptive, yet often distorted beliefs based on trauma exposure are formed. For example, prolonged exposure to sexual abuse narratives may challenge pre-existing schemas around personal safety. Under an adapted premise that the world is in fact dangerous, the therapist engages in heightened protective behaviours such as avoiding public places after dark.

Whilst the transformation of beliefs may be seen as an adaptive form of self-protection, there is potential for more permanent and maladaptive schematic change (Trippany et al., 2011). This risk is heightened given schematic change is cumulative (i.e., reinforced by ongoing exposure), and pervasive (i.e. potential to generalise to all aspects of one’s frame of reality; McCann & Pearlman, 1990). The extent to which schemas are challenged is dependent on the salience of the schema, and the therapists’ current, and early interpersonal, cultural, social, familial, and intrapsychic experiences (Saakvitne et al., 1996). A growing body of research has begun to explore not only the degree to which vicarious traumatisation affects the individual, but also the possible moderators of this negative transformation.

**Vicarious Traumatisation Research.**

Research investigating vicarious traumatisation has primarily focussed on the identification and measurement of posttraumatic symptomology to the exclusion of more pervasive changes to cognition, beliefs and schemas (Sabin-Farrell & Turpin, 2003). Moreover, attempts to measure negative outcomes have traditionally utilised quantitative methods such as questionnaire and self-report survey. For example, the
widely used Impact of Events Scale-Revised (IES-R; Weiss & Marmar, 1997) is a 22-item self-report measure used to give therapists insight into the symptomology of traumatic stress. The development of the Traumatic Stress Institute Belief Scale-revision L (TSI-BSL; Pearlman, 1996) represented a significant step towards measuring the more pervasive changes inherent within vicarious traumatisation. This 80-item scale assesses disruption in cognitive schemas and beliefs regarding self and others over five domains (safety, trust/dependence, esteem, intimacy, control) deemed sensitive to the effects of direct and vicarious trauma exposure.

Despite the development and application of such measures, research exploring the impact of vicarious traumatisation on therapists and the personal and organisational moderators that are involved have been plagued by mixed findings (Sexton, 1999). For example, contrasting reports of vicarious traumatisation and other negative post trauma outcomes, numerous researchers have suggested the majority of health professionals are not adversely affected, emotionally or psychologically, by their clinical work (Coster & Schwebel, 1997; Elliot & Guy, 1993; Raquepaw & Miller, 1989; Thoreson, Miller, & Krauskopf, 1989). For example, only 5% of mental health professionals working with sexual violence, cancer, and general clients, reported elevated levels of traumatic stress when measured by the TSI-BSL and IES (Kadambi & Truscott, 2004).

Discrepancies regarding the pervasiveness, scope, and severity of vicarious traumatisation have also been reported when a mixed qualitative and quantitative approach has been utilised. For example, mental health workers verbally reported viewing therapeutic work as traumatising; however, such perceptions were not captured by quantitative measure of distress (Sabin-Farrell & Turpin, 2003). Methodological limitations such as lack of sensitivity, or poor reliability and accuracy of self-report questionnaires may in part explain these discrepancies (Steed & Downing, 1998).
Whilst inconsistencies are evident, the phenomenon clearly resonates with trauma therapists when explored through qualitative methods (Kadambi & Truscott, 2004). For example, all female sexual assault therapists interviewed in Steed and Downing’s (1998) study reported negative emotional responses (e.g., anger, pain, frustration, sadness, horror, shock), somatic complaints (e.g., low energy, poor sleep), and posttraumatic stress symptomology arising in consequence to their clinical work. Moreover, thematic content analysis revealed schematic disruption across themes of increased vulnerability, suspiciousness, loss of faith and trust in fellow man, and alterations in sense of self-identity.

Changes in cognitive schemas regarding safety and lack of security, worldview, awareness of power/control and lowered trust have also been reported through semi-structured interviews with domestic violence counsellors (Iliffe & Steed, 2000). In addition, negative changes to relationship with self and isolation from others, have been reported by highly qualified trauma therapists (Benatar, 2000). Lay counsellors have also reported lasting changes around tolerance, interpersonal relationships, and changes in beliefs, which they felt were triggered by the provision of therapy (Ortlepp & Friedman, 2002).

In an attempt to gain a more comprehensive understanding of vicarious traumatisation researchers began exploring the personal and organisational factors which may act as facilitators to vicarious traumatisation. For example, the association between vicarious traumatisation and percentage of trauma survivors in therapist caseload has been investigated. McCann and Pearlman (1990) anticipated a higher therapist caseload of trauma survivors would positively correlate with vicarious trauma symptomology. In support, significant albeit weak positive correlations (between .16 and .27) have been found between a higher caseload of sexual violence survivors and
self-reported vicarious traumatisation, disrupted beliefs (primarily concerning trust and the goodness of people) and posttraumatic stress symptomology (Schauben & Frazier, 1995).

A national survey of 1000 psychotherapists also revealed a positive correlation between greater exposure to sexual abuse survivors and trauma symptomology (Brady et al., 1999). However, no significant disruptions to cognitive schemas were revealed. In fact, those who reported greater exposure to sexual abuse narratives also reported higher levels of spiritual well-being. This finding suggests that some therapists exposed to distressing narratives may define an alternate discourse regarding the role of trauma and may potentially cultivate positive outcomes following exposure to trauma and adversity.

This finding is particularly pertinent given the high percentage of therapists who report having their own personal history of trauma. For example, 83% of the 148 female therapists included in Schauben and Frazier’s (1995) study reported at least one form of victimisation and 37% reported two or more. Theoretical literature suggests therapists with a personal history of traumatisation are more likely to be adversely affected by their clinical work than those with no trauma history (Pearlman & Saakvitne, 1995). However, this association has also been marred by inconsistencies.

Pearlman and Mac Ian (1995) found greater schematic disruption as indicated by higher scores on five of the seven TSI-BSL subscales in therapists with a history of victimisation. In contrast, a history of victimisation was unrelated to symptoms of distress in sexual violence counsellors even when the client’s trauma narrative matched the therapist’s (Schauben & Frazier, 1995). This latter finding replicates other studies (see Elliot & Guy, 1993; Follette et al., 1994) which indicate therapists who themselves are survivors of trauma are at no greater clinical, or psychological disadvantage than
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those without a trauma history. The degree to which the trauma related information alters the individual’s schematic foundation may in part account for these discrepancies.

When a personal history of trauma is coupled with limited clinical experience, the risk of schematic change is heightened. For example, experienced therapists display fewer disruptions in self-trust, self-intimacy and self-esteem (Gamble, Pearlman, Lucca, & Allen, 1994; Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995). Lower rates of supervision and greater exposure to acutely unwell hospital inpatients have also been found to contribute to higher levels of schematic disruption in newer therapists with trauma histories (Pearlman & Mac Ian, 1995). These findings are consistent with burnout literature which suggests being younger or less clinically experienced is positively correlated with higher burnout rates (Ackerley, Burnell, Holder, & Kurdek, 1988). Such findings may be explained by a reluctance to seek supervision or support due to feelings of shame, incompetency, and anxiety following vicarious trauma symptomology (Neumann & Gamble, 1990; Pearlman & Mac Ian, 1995) or rather the complexity and severity of inpatient psychopathology.

The Medical Model

The concept of vicarious traumatisation offers a framework for normalising and respecting the therapist’s negative responses to trauma work (Kadami & Truscott, 2004). However, a bias towards exploring adverse outcomes risks pathologising trauma work (Arnold et al., 2005). This physical and psychological pathologising of trauma experiences and work has been largely driven by a medicalised model of thinking which sees external symptomology as evidence for underlying disease or disorder (Bohart & Tallman, 1999; Joseph, 2012).

As such, research and practice of psychotherapy continues to be heavily influenced by the medical model, particularly within the inpatient setting (Bohart &
Tallman, 1999). Many critics suggest the assumptions and terminology used within this model have been ineffectively superimposed onto what are essentially interpersonal processes and procedures in psychotherapy (Elkins, 2009). Further inadequacies are evident in the attempted application of causal disease models of mental distress and classification through narrowly defined treatment parameters and categories. These parameters frame psychiatric care as a succession of distinct interventions that can be analysed and objectively measured independent of context (McCready, 1986; Bracken, et al., 2012). For therapists working with complex trauma, this approach fails to recognise therapy and the therapeutic relationship as an interpersonal process characterised by unconditional regard, empathy, compassion, and therapist congruence (Elkins, 2009). To date, little research has been dedicated to exploring the impact of exposure to complex trauma work when constrained by the limitations of a western culture medical model of intervention.

Methodological Limitations

Such an unchartered area of enquiry represents one of the significant limitations in the growing field of vicarious trauma research. A field that has largely been hindered by methodological shortcomings, inconsistent results, limited baseline data, and an incomplete understanding of moderating variables (Kadambi & Ennis, 2004). For example, there is no questionnaire that solely focusses on the measurement of vicarious traumatisation. As such, it is difficult to determine whether standardised quantitative methods are capturing the phenomenon of vicarious traumatisation as opposed to comparable constructs of negative posttrauma outcomes. Furthermore, despite recommendations that a combination of scales measuring disruptions in beliefs and posttraumatic symptomology be used, there remains no guarantee that the entirety of the vicarious trauma construct is being adequately measured (Sabin-Farrell & Turpin,
2003). It would be useful to utilise qualitative enquiry methods to gain a more comprehensive understanding of the domains and moderating variables (e.g., model of intervention) associated with vicarious traumatisation from the perspective of those affected. Such domains may then be incorporated into the development of a well-standardised measure specifically designed to capture the unique phenomenon of vicarious traumatisation.

**Posttraumatic Growth**

Research exploring adverse responses to direct and indirect trauma have often revealed a paradox in which many of those who report negative outcomes following their trauma exposure also report areas of positive growth (Seligman & Csikszentmihalyi, 2000). Positive outcomes have been variously known as ‘perceived benefits’ (McMillen & Fisher, 1998), ‘thriving’ (Abraido-Lanza, Guier, & Colon, 1998), ‘stress-related growth’ (Park, Cohen, & Murch, 1996) and ‘positive changes in outlook’ (Joseph, Williams, & Yule, 1993). However, the term that has received widespread recognition in the research literature is ‘posttraumatic growth’ (Tedeschi & Calhoun, 1995).

Posttraumatic growth captures the positive redefinition of oneself, inclusive of values, beliefs, sense of self-identity, and worldview following trauma exposure (Helgeson, Reynolds, & Tomich, 2006; Linley & Joseph, 2004; McCormack, Hagger & Joseph, 2011; Tedeschi, & Calhoun, 1996). Recent research suggests posttraumatic growth is associated with an increase in psychological well-being (PWB) over and above subjective well-being (SWB; Durkin & Joseph, 2009). This positive transformation highlights engagement with the existential challenges of life through areas of autonomy, relationships, personal growth, life purpose, mastery, and self-acceptance, as opposed to a restorative process defined by symptom alleviation and
emotional regulation (Joseph & Linley, 2005; Ryff, 1989; Ryff & Singer, 1996; Keyes, Shmotkin, & Ryff, 2002). The Psychological Well-Being Post-Traumatic Changes Questionnaire (PWB-PTCQ; Joseph, Maltby, Wood, Stockton, & Hunt, 2012) provides a framework for capturing posttraumatic growth which compliments existing measures of symptom severity whilst also extrapolating PWB themes.

The concept of posttraumatic growth is not uncommon; a systematic review of 39 studies suggests between 30-70% of direct trauma survivors experienced some form of positive growth following adversity (Linley & Joseph, 2004). The potential for posttraumatic growth has been identified following a range of traumatic and challenging experiences, including combat (Aldwin, Levenson & Spiro, 1994; McCormack & Joseph, 2013), natural disasters (Linley & Joseph, 2006), genocide (McCormack & Joseph, 2013), interpersonal violence (Cobb, Tedeschi, Calhoun, & Cann, 2006; Woodward & Joseph, 2003), rape (Smith & Kelly, 2001; Borja, Callahan & Long, 2006), cancer (Weiss, 2002), childhood sexual abuse (McMillen, Zuravin, & Rideout, 1995), medical complications (Stanton, Bower, & Low, 2006), HIV infection (Richards, 2001) and terrorist attacks (Linley, Joseph, Cooper, Harris, & Meyer, 2003).

Posttraumatic growth has been commonly reported across three domains: (1) enhanced, and greater appreciation for interpersonal relationship; (2) improved view of self and self-worth; and (3) positive changes in life philosophy, values, and beliefs (see Joseph, 2012). It has been associated with personality traits of extraversion and optimism, emotional positivity, enhanced acceptance, and a positive problem focussed coping style (Linley & Joseph, 2004). More recently, empathy, love, humility and gratitude, all features of an altruistic identity were found to facilitate vicarious posttraumatic growth in wives of veterans and humanitarian aid personnel through self-reparation and moral redefinition often in the absence of positive support (McCormack,
Hagger, & Joseph, 2011; McCormack & Joseph, 2013). In essence for some individuals, researchers have found support for the notion “what doesn’t kill me only makes me stronger” (see Joseph, 2012).

**Theoretical Model of Posttraumatic Growth.**

The question remains, why do some individuals experience chronic and debilitating mental health outcomes in the aftermath of direct or indirect trauma exposure, whilst others are able to utilise their experiences for meaning making, purpose and growth? Joseph and Linley (2005) utilised Roger’s (1964) organismic valuing process theory (OVP) as the foundation for the development of their organismic valuing theory of growth through adversity. This theory provides an explanatory, rather than descriptive account of how PSTD symptomology may be averted, and how psychological adaptation may be facilitated following trauma and adversity.

Joseph and Linley (2005) suggest trauma related information is processed in one of two ways, 1) assimilation, or 2) accommodation (positive or negative) with respect to four theoretical considerations. Firstly, the individual must fully integrate and reorganise new trauma-associated information into the self-structure. Secondly, through competition between vulnerability and growth factors, trauma related information is either assimilated or accommodated. Positive accommodation is facilitated through pre-trauma growth factors (i.e. autonomy, competence, and relatedness) whilst negative accommodation is more likely to occur in their absence. Assimilation of information occurs when individuals attempt to regain pre-trauma schematic assumptions which subsequently repress opportunities for growth. The third consideration relates to how the traumatic event is understood by the individual, and whether it is significant enough to allow incorporation. An existential attempt to understand the meaning of the traumatic event, and integrate new information into ones psyche facilitates positive
accommodation and growth. Lastly, is recognition that psychological wellbeing and posttraumatic growth do not automatically guarantee subjective well-being but a more life enriching psychological well-being. This final consideration illuminates why reports of distress and growth often co-exist in trauma survivors.

This consideration was highlighted by a meta-analysis of 87 studies which revealed positive posttrauma outcomes were related to increased sense of wellbeing and lower rates of depression, but also more avoidant and intrusive posttraumatic experiences (Helgeson et al., 2006). This finding must be interpreted with caution as it has led many to question the benefits of growthful transformation following adversity. An alternative interpretation posits intrusive symptomology may be a marker of cognitive processing rather than distress, as the individual attempts to make meaning of the implications of their traumatic experiences (Helgeson et al., 2006). It is through cognitive processing and meaning making of trauma and its implications that posttraumatic growth may be cultivated.

In essence, to facilitate cognitive processing and ultimately promote posttraumatic growth, a moderate level of posttraumatic stress is required (Joseph, 2012). Many consider posttraumatic growth to be both a process and an outcome, arising through an ongoing struggle with adversity, and psychological and physical distress (Cadell, Regehr, & Hemsworth 2003; Joseph et al., 1993; Joseph & Linley, 2005; Tedeschi & Calhoun, 1995; 2004). For example, a qualitative study exploring the vicarious experiences of wives of Vietnam veteran’s suggested posttraumatic growth occurs gradually over “time” with no definitive point of change between negative traumatisation and posttraumatic growth (McCormack et al., 2011). As such, distress and trauma may be seen as coexisting narratives of growth or opposing ends of the same construct (Cadell et al., 2003; Joseph & Williams, 2005; Joseph & Linley, 2005).
Vicarious Posttraumatic Growth

Given those vicariously exposed to trauma report negative outcomes similar to those of the trauma survivor, it is safe to assume they may also experience comparable areas of posttraumatic growth. The term vicarious posttraumatic growth describes the process of positively redefining self and worldviews following exposure to vicarious traumatic distress (McCormack et al., 2011). This positive transformation arises through conscious and unconscious empathic engagement with traumatic material (McCann & Colletti, 1994; Pearlman & Saakvitne, 1995).

A growing body of research recognising the potential for positive outcomes following vicarious traumatic exposure has been established in wives of prisoners of war (Dekel & Solomon, 2006), wives of Vietnam veterans (McCormack et al., 2011), interpreters (Splevins, Cohen, Joseph, Murray, & Bowley, 2010), disaster survivors (Linley et al., 2003), humanitarian aid workers (McCormack & Joseph, 2013) and therapists (Arnold et al., 2005; Brady et al., 1999; Brockhouse, Mstfi, Cohen, & Joseph, 2011; Dlugos & Friedlander, 2001; Schauben & Frazier, 1996).

Research Exploring Vicarious Posttraumatic Growth.

Research has predominately focussed on measuring, rather than describing positive outcomes through quantitative studies and measures including the PWB-PTCQ, the Posttraumatic Growth Inventory (PTGI; Tedeschi & Calhoun, 1996) and The Changes in Outlook Questionnaire (CiOQ; Joseph, Linley, Andrews et al., 2005). Domains of posttraumatic growth commonly reported by therapists include positive trait-oriented changes in self (e.g., increased levels of sensitivity, compassion, insight, tolerance, empathy), personal and spiritual development, and well-being (Arnold et al., 2005; Brady et al., 1999; Herman, 1992; Pearlman & Saakvitne, 1995; Schauben & Frazier, 1995). Work related benefits including enhanced relationships and
communication skills, increased appreciation for human resiliency, and the satisfaction of being part of their clients’ growth and healing process have also been reported by therapists (Arnold et al., 2005; Brady et al., 1999; Herman, 1992 Pearlman & Saakvitne, 1995; Schauben & Frazier, 1995).

Factors which facilitate growthful transformation include those relating to the therapist (i.e. social support, sense of coherence), the therapeutic relationship (i.e., therapeutic bond, empathy) and the working environment (i.e. organisational support; Linley & Joseph, 2007). Linley and Joseph (2007) highlighted the importance of support, as individuals showing higher levels of posttraumatic growth were more likely to be actively partaking in personal therapy and clinical supervision. However, posttraumatic growth theories do not currently account for the possibility of growth out of adversity in the absence of positive support.

Recent research has begun to explore other moderators of posttraumatic growth, particularly in the absence of positive support. It has been suggested intrinsic factors such as a healthy altruistic identity may facilitate posttraumatic growth and psychological adaptation in the presence, or absence of social support (McCormack et al., 2011). In studies of humanitarian personnel exposed to complex trauma, disruption to a healthy altruistic identity left some individuals feeling alienated, isolated and struggling to reintegrate with family, career and society post-mission (McCormack, Joseph, & Hagger, 2009; McCormack & Joseph, 2013). Redefining that altruistic identity through self-reparation and moral-redefinition in the absence of validating support promoted renewed psychological wellbeing. Moreover, empathy, love, humility and gratitude, all features of an altruistic identity, were found to facilitate posttraumatic growth in the absence of positive support (McCormack et al., 2011; McCormack & Joseph, 2013). These more recent finding suggest (1) the theoretical conceptualisation
of posttraumatic growth has not yet been fully captured; (2) despite lack of positive support a broader range of intrinsic factors may facilitate growth following adversity; (3) the moderators and pathways to personal re-definition and subsequent posttraumatic growth following adversity have not been fully explored (McCormack & Joseph, 2013).

At present, there remains a paucity of research specifically designed to explore the therapist’s experience of vicarious posttraumatic growth. Reports of positive outcomes have been mentioned largely indirectly in the context of more comprehensive explorations of negative trauma outcomes (Arnold et al., 2005). Moreover, there has been no comprehensive exploration of how an ‘expert’ medical model designed to provide brief or structured interventions might affect opportunities for growth in the therapeutic alliance between therapists and their clients with complex trauma narratives. This issue is particularly pertinent for inpatient therapists guided by the medical model dictate of evidence-based practice and a categorical focus on diagnoses and psychopathological interventions. Such a medicalised approach seemingly negates the interpersonal relationship, and the very factors that promote personal growth.

Methodological Limitations

Exploration into this untapped field of research may serve to address some of the shortcomings evident within the growth literature. Researchers have typically been hindered by similar limitations to those found within the vicarious traumatisation literature including a lack of universally accepted definition and clear conceptualisation of the phenomenon. However, the development of The Psychological Well-Being-Post Traumatic Changes Questionnaire (PWB-PTCQ; Joseph et al., 2012) serves to bridge these limitations by providing a recognised framework for posttraumatic growth. However, ongoing research continues to reveal previously uncaptured domains of posttraumatic growth. As such, it is possible current methods of research and associated
psychometric tools are failing to capture the entire growth experience. A more comprehensive exploration of posttraumatic growth through use of a phenomenological approach may offer an optimal means of gaining an understanding of posttraumatic growth from the individual’s perspective. Additional growth domains uncovered through qualitative studies across broader populations offer insights for future positivist methods of enquiry.

Conclusions

In summary, chronic exposure to trauma narratives has the potential to positively and/or negatively transform the therapist’s inner world, inclusive of schemas, beliefs, and values, leading to lasting psychological and emotional change (Pearlman & Saakvitne, 1995). At present, there is a paucity of research that seeks to understand and describe the ‘lived’ experience of therapist’s transformative process of growth and trauma following vicarious exposure to trauma. In particular, it is unknown how therapists make sense of their exposure to difficult and complex narratives of trauma when limited by a first-world inpatient medical model of intervention. It may be that an alternate or adjunct model of care and support to mentally unwell individuals with a complex history of trauma may offer therapeutic and personal reward for both patient and therapist.

With this in mind, the current phenomenological study utilised semi-structured interviews to explore the ‘lived’ experience of four trauma-focussed therapists working with mental health inpatients with complex trauma histories. Given the exploratory nature of this study, and its phenomenological subject matter, an Interpretative Phenomenological Analysis (IPA; Smith, 1996) approach was utilised. This approach stimulated a detailed understanding of how these women made meaning from their experiences and the positive and negative interpretations they bring to their work with
severely mentally unwell inpatients. Through this research, we hoped to bring greater clarity to the conceptualisation of vicarious traumatisation and posttraumatic growth from the perspective of those affected whilst exploring the impact of applying a medicalised model of intervention to complex trauma and its psychological aftermath.
References


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THERAPISTS, COMPLEX TRAUMA, AND THE MEDICAL MODEL


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Therapists, Complex Trauma, and the Medical Model:
Making Meaning of Vicarious Distress and Limitations to Intervention with Complex Trauma in the Inpatient Setting

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Abstract

There is a paucity of research exploring the ‘lived’ experience of therapists exposed to complex trauma narratives within a mental health inpatient setting. Moreover, how therapists make sense of their thoughts, feelings and responses, both positive and negative from such work, when limited by a medical model of intervention, is unknown. This idiographic investigation explores the phenomenological experiences of four senior therapists working with severely unwell mental health inpatients with complex trauma histories. Semi-structured interviews were conducted and data analysed using Interpretative Phenomenological Analysis (IPA). One superordinate theme, Therapeutic integrity and vicarious growth, overarched four subordinate themes: 1) Severity, complexity, and repetition; 2) Personal distress and the medical model; 3) Intrapersonal confrontation; and 4) Growth. Two themes described the co-existing experiences of distress, guilt, self-doubt, and sense of failure arising from a misfit between a medical model therapeutic approach and the complex psychosocial traumatic experiences of their clients. Third, the collision between vicarious distress and sense of therapeutic futility motivated a personal search for therapeutic and personal integrity. Fourth, redefining ‘self’ through intrapersonal honesty, altruism, and relational connectedness with patients was interpreted as psychological wellbeing and growth. This study suggests that working strictly within the limitations of a medical model with complex trauma has the potential to risk long-term psychopathology for both client and therapist. However, when time to develop the therapeutic relational alliance in complex trauma is prioritised, therapeutic integrity, psychological wellbeing and growth was observed in these participants. Implications for these findings are discussed.

Keywords: Trauma therapy, medical model, vicarious traumatisation, posttraumatic growth, Interpretative Phenomenological Analysis (IPA).
Introduction

Complex narratives of childhood maltreatment such as sexual or physical abuse, or witnessing maternal battering are common in adult mental health inpatients (Edwards, Holden, Felitti, & Anda, 2003). For example, a history of sexual abuse is associated with an increased risk of lifetime diagnoses of multiple psychiatric disorders (Chen, Murad, Paras, Colbenson et al., 2010). Several systematic reviews have noted an association between child sexual abuse and adult posttraumatic stress disorder (PTSD), depression, eating disorders, and suicide attempts (Chen et al., 2010). However, reflecting on such narratives during therapy though often distressing for the client is also likely to negatively impact on the supporting therapist. For those who offer empathic support to patients with complex trauma histories, vicarious exposure is not without risk to their own psychological wellbeing (see Adams & Riggs, 2008; Kadambi & Truscott, 2004). Conversely, a small body of research has found that vicarious exposure may offer the opportunity for positive internal transformation in therapists as they integrate these trauma narratives (Linley & Joseph, 2004). What is unknown is how therapists make sense of their exposure to difficult and complex trauma narratives when limited by an inpatient medical model of intervention. With this in mind, this qualitative study explores both the positive and negative interpretations of trauma therapists working with severely unwell mental health inpatients, and how they make sense of the impact of such work and the constructs they work within on their lives.

Figley’s (1998) systemic trauma theory describes how prolonged exposure and empathic support to trauma survivors may lead to a contamination of those vicariously exposed. The risks of psychopathology following vicarious trauma exposure have been reported across a broad range of professional cohorts including police workers (Follette, Polusney, & Milbeck, 1994), nurses (Spinelli, 2011), lawyers (Levin & Greisberg,
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2003), disaster workers (Zimering, Gulliver, Knight, Munroe, & Keane, 2006), humanitarian aid workers (McCormack & Joseph, 2013), researchers (Wasco & Campbell, 2002), funeral directors (Linley & Joseph, 2006) and therapists (Arnold, Calhoun, Tedeschi, & Cann, 2005; Brady, Guy, Poelstra, & Brokaw, 1999; Dlugos & Friedlander, 2001; Linley & Joseph, 2007; Linley, Joseph, & Loumidis, 2005; Pearlman & Saakvitne, 1995; Schauben & Frazier, 1995). The uniqueness and scope of carer responses has been captured by terms such as emotional contagion, compassion fatigue (Figley, 1995), secondary victimisation (Figley, 1982), burnout (Maslach & Jackson, 1982), negative countertransference (Gold & Nemiah, 1993), secondary traumatic stress (Stamm, 1995), and more recently vicarious traumatisation (McCann & Pearlman, 1990).

Vicarious traumatisation describes the negative transformation of the therapist’s inner experience, inclusive of memory systems and schemas about oneself, others, and the outside world (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). It typically occurs through cumulative empathic engagement with the emotional experience of one or more traumatised individuals leading to negative schematic distortions (Adams & Riggs, 2008; Kadambi & Truscott, 2004; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995; Schauben & Frazier, 1996). Vicarious traumatisation also captures the manifestation of subclinical posttraumatic stress (PTS) symptomology that often mirror those reported by the trauma survivor (Arnold, et al., 2005; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995; Spinelli, 2011).

The exploration of trauma exposure as a precursor to negative physical and psychological outcomes has been largely driven by a medicalised model of thinking which sees external symptomology as evidence for underlying disease or disorder (Bohart & Tallman, 1999; Joseph, 2012). Research and practice of psychotherapy
continues to be heavily influenced by the medical model, particularly within the inpatient setting (Bohart & Tallman, 1999). Many critics suggest the assumptions and terminology used within this model have been ineffectively superimposed onto what are essentially interpersonal processes and procedures in psychotherapy (Elkins, 2009).

Further inadequacies are evident through the attempted application of causal disease models of mental distress and classification through narrowly defined treatment parameters. These parameters frame psychiatric care as a succession of distinct interventions that can be analysed and objectively measured independent of context (Bracken, et al., 2012; McCready, 1986). For therapists working with complex trauma, this approach fails to recognise therapy, and the therapeutic relationship, as an interpersonal process characterised by unconditional regard, empathy, compassion and therapist congruence (Elkins, 2009). To date, little research has been dedicated to exploring the impact of exposure to complex trauma work when limited by the limitations of a first world medical model of intervention.

Whilst the risk of psychopathology exists, research exploring adverse responses to traumatic experiences often reveal a paradox in which many who report negative outcomes also report areas of posttraumatic growth (Seligman & Csikszentmihalyi, 2000). Posttraumatic growth has been conceptualised as a transformative engagement with the existential challenges of life through areas of autonomy, relationships, personal growth, life purpose, mastery, and self-acceptance (Durkin & Joseph, 2009; Joseph & Linley, 2005; Ryff, 1989; Ryff & Singer, 1996; Keyes, Shmotkin, & Ryff, 2002). This transformation reflects increased psychological well-being (PWB), over and above subjective well-being (SWB) and the medical model’s focus on emotion regulation and symptom alleviation (Durkin & Joseph, 2009).
Earlier research exploring the construct of posttraumatic growth recognised three domains: (1) improved interpersonal relationships; (2) enhanced view of self and self-worth; and (3) positive changes in life philosophy, values and beliefs (see Joseph, 2012). With the burgeoning literature into vicarious posttraumatic growth there is evidence that similar positive gains are described following vicarious exposure to trauma through positively redefining oneself, inclusive of values, beliefs, sense of self-identity, and worldview (McCormack et al., 2011). Inclusive in this literature is the potential for positive outcomes following vicarious trauma in wives of prisoners of war (Dekel & Solomon, 2006), wives of Vietnam veterans (McCormack et al., 2011), interpreters (Splevins, Cohen, Joseph, Murray, & Bowley, 2010), disaster survivors (Linley, Joseph, Cooper, Harris, & Meyer, 2003), humanitarian aid workers (McCormack & Joseph, 2013) and therapists (see Brockhouse, Mstfi, Cohen, & Joseph, 2011). Despite the absence of positive support, commonly associated with psychological growth post trauma, newly identified domains of growth i.e. empathy, love, humility and gratitude, facilitated vicarious posttraumatic growth in the wives of Vietnam veterans and humanitarian aid personnel (McCormack, Hagger, & Joseph, 2011; McCormack & Joseph, 2013).

Reports of vicarious posttraumatic growth in therapists highlight positive trait-oriented changes in self (e.g., increased sensitivity, compassion, insight, tolerance, empathy), and personal and spiritual well-being (Arnold et al., 2005; Brady et al., 1999; Herman, 1992; Pearlman & Saakvitne, 1995; Schauben & Frazier, 1995). Facilitating factors include those relating to the therapist (i.e. social support, sense of coherence), the working environment (i.e. organisational support) and the therapeutic relationship (i.e., therapeutic bond, empathy; Linley & Joseph, 2007). However, these findings have been largely captured in the context of more comprehensive explorations of negative
trauma outcomes. There remains a paucity of research specifically designed to explore the therapist’s experience of vicarious posttraumatic responses. Moreover there has been no comprehensive exploration of how a medical model, which seemingly negates the interpersonal relationship and the very factors that promote personal growth, may affect opportunities for growth in therapists working with complex trauma.

With this in mind, the current phenomenological study explored the ‘lived’ experience of four trauma-focussed therapists working with mental health inpatients with complex trauma histories. Given the exploratory nature of this study, and its phenomenological subject matter an Interpretative Phenomenological Analysis (IPA; Smith, 1996) approach was utilised. This approach stimulated a detailed understanding of how these women made meaning from their experiences and their positive and negative interpretations of vicarious trauma exposure. Utilising semi-structured interviews, each therapist had the opportunity to detail how their work with trauma survivors within the confines of a medical model had affected their personal and professional lives. Through the use of IPA we aimed to identify pervasive schematic changes reflective of both positive and negative interpretations, particularly the impact of pathologising conceptualisation of trauma experiences in clients on therapists’ psychological well-being.

Methodology

Participants

The four female participants (pseudonyms used throughout), aged between 39 and 51, were highly trained professionals each employed in Australian inpatient psychiatric facilities (see Table 1). Mary and Joanne worked as Psychiatric Consultants with 23 and 25 years’ clinical experience respectively; between five and seven of these years were located within an inpatient setting. One Clinical Psychologist (Helena) had
10 years’ clinical experience including eight in the inpatient setting, and one full time Psychologist/Clinical Manager (Kate) had nine years’ clinical experience including five in the inpatient setting. Each participant provided clinical treatment to patients with a range of diagnosed mental health conditions (e.g., sleeping, personality, eating, psychotic, dissociative and cognitive disorders, disorders due to a medical condition, factitious, adjustment and somatoform disorders, trauma and stress disorders, sexual, gender identity disorders and dual diagnosis presentations). Participants estimated a mean of 66% (range = 50-80%) of patients treated had been admitted to the inpatient facility on more than one occasion.

Each participant reported vicarious exposure to traumatic patient narratives (e.g., all forms of abuse and neglect, serious accident/illness/medical procedure, traumatic grief/separation, witness or victim to domestic, school, community, personal/interpersonal or political violence, natural or manmade disasters, substance related trauma, system induced trauma and bullying of family members). The provision of trauma-focused clinical work accounted for a mean of 53% (range = 50-60%) of their practice. Three women reported experiencing at least one event (unrelated to their clinical work) they regarded as personally traumatic over the course of their lifetime.

Insert Table 1 here

**Procedure**

A purposive strategy was used to recruit participants for whom vicarious exposure to acutely unwell mental health inpatients was both relevant and held personal significance. Participants were sourced through professional word of mouth within two inpatient psychiatric hospitals in an eastern Australian city. Following ethical approval, willing participants were contacted face-to-face or via email to explain the study. A semi structured interview schedule was developed using the “funnelling” technique of
IPA (Smith & Osborn, 2008). The second author carried out each audio-recorded interview in the location and time of the participants choosing. Each interview lasted between 1 hour and 1 hour 20 minutes. The interviews were conversational in nature allowing time for subjective reflexivity, exploratory prompting, clarification, and empathic support. Each interview followed the direction of the participant with questions adapted in respect to the participants’ responses. This process allowed the interviewer to explore any interesting and significant narratives that arose. Participants were invited to offer a rich and detailed account of both positive and negative changes arising from their vicarious exposure to inpatient trauma narratives. Key areas of exploration included personal, professional, psychological, philosophical, existential, cognitive, relational, and goal-related changes. All interviews were transcribed verbatim by the second author. These provided the data set for analysis.

Analytic Strategy

The phenomenological and hermeneutic qualitative approach of Interpretive Phenomenological Analysis (IPA; Smith, 1996; Smith, Flowers, & Osborn, 1997; Smith & Osborn, 2008) was utilised in this study. This approach provides a flexible set of guidelines adaptable to the specific aims of the researcher. Table 2 provides the step-by-step stages of this analytic process. Following the four-stage process described by Smith and Osborn (2008), each interview was transcribed and analysed individually. First, each transcript was read with first impressions recorded in the left-hand column of the transcript. Secondly, fresh readings focussed on gaining a detailed understanding of psychological concepts whilst mapping specific emergent themes/phrases. Thirdly, themes and labels were clustered through a thorough and deductive analysis. Care was taken not to lose the participants own words in the researchers interpretation of the narrative. Fourth refinement of understanding and interpretation of the data led to the
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development of a table outlining super and subordinate themes. A descriptive analysis, which treated the transcripts as one data set then followed. Independent analyses were conducted by the first and second authors before robust discussion occurred to concur on emerging themes. This ensured that interpretations were grounded in the text (Glaser & Strauss, 1967). A record of decisions and reflections made during the analysis was retained.

Insert Table 2 here

Interpretive Phenomenological Analysis (IPA) provides a method of exploring how individuals make sense of particular experiences within their personal and social world (Smith, 1996). It aims to capture the lived experience of the individual and how they assign meaning to particular life events. IPA proposes that individuals are the expert in their own lives and attempts to describe, rather than explain. As such, the researcher aims to capture the individual’s inner lifeworld by giving freedom for the exploration of personal perceptions of unique events. This method requires an in-depth analysis of the data inclusive of interpretative activity as both participant and researcher are engaged in a shared process of interpretation and meaning making. The IPA method recognises the parallel relationship between the participants’ perception of meaning formation and identification and the researchers’ attempts to make sense of such perceptions

Results

One superordinate theme: Therapeutic Integrity and Vicarious Growth, overarched four subordinate themes: 1) Severity, complexity, and repetition; 2) Personal distress and the medical model; 3) Intrapersonal confrontation; and 4) Growth (see Table 3). The superordinate theme reflects the participants’ sense of self-doubt, guilt and sense of failure as they try to impose a medical model/diagnostic approach to
complex psychosocial traumatic experiences. The participants described experiencing burnout and vicarious distress as trying to force a square peg into a round hole. This collision between vicarious distress and sense of therapeutic incompetence motivated a personal search for therapeutic and personal integrity. Time and respect for professional experience encouraged redefining of ‘self’. Intrapersonal honesty, altruism, and relational connectedness with patients allowed a metamorphosis of self-integrity recognised as paramount to psychological wellbeing and growth if they were to remain in this profession.

Insert Table 3 here

Severity, Complexity, and Repetition

This theme captures exposure to the complexity and severity of the patient population whose presentation, and clinically and emotionally “more challenging” narratives gave voice to horrific and sometimes prolonged traumatic experiences. Narratives detailing neglect and physical and sexual abuse were directly linked to the intensity of distress experienced by participants:

And the more traumatic the story the more tiring that is because you’re trying to empathise and also understand and not look horrified. I think that’s the other thing you’re sort of trying to not sort of judge the patient (Joanne).

Sensitive to their own vicarious responses participants described flashbacks, nightmares, fatigue, intrusive thoughts, and avoidance coping similar to those reported by their patients. Intense feelings of anger, anxiety, and sadness were reported during patient engagement, and for days to years following. At times, horrific trauma narratives kept them struggling to maintain genuine empathy and support for their patients:
So then I get angry when I hear about what they’ve gone through in that moment or I get sad … it’s been hard … I would have trouble staying present, I would have trouble staying connected, I would get tired (Kate).

Insightful to their constant exposure within the acute inpatient environment, participants recognised the risk of entering a chronic state of traumatisation and burnout. The repetitious and cyclical nature of transgenerational trauma weighed heavily on participants. They described disconnectedness and recognised a growing desensitisation to the sheer volume of trauma, where an erosion of compassion to narratives of horror and disbelief crept in surreptitiously:

Well I don’t know whether I’m desensitised to it or like I’m just chronically traumatised … So it’s hard for me to say whether it’s like locked and shelved like in a pathological sense or whether it’s just a um … a desensitisation in some sort of healthy sense that I’m more able, more able to rapidly assimilate that sort of stuff because of just chronic exposure (Joanne).

The long-term effects of inpatient work were described as a “slow tainting” process, an emotional contamination akin to “dripping dye into water”. Over time contamination impacted on schemas, negatively changing ‘self’ into a suspicious, doubting, and mistrusting individual experiencing nihilistic fears about the future of the human race:

There are a lot of negatives, it has eroded my trust in the human race, it sort of makes me fearful for my son as he grows up in this world about what people can do to each other …humans aren’t great people … they’re capable of doing pretty horrible things to each other (Joanne).

**Personal Distress and the Medical Model**
Whilst the first theme captured distress through vicarious exposure to complex and severe inpatient presentations, what also emerged was frustration, distress and a sense of threat to the participants’ moral integrity. Working within a medical model embedded in first world psychopathological practices and subject to the dictates of categorisation and prescriptive practices, bred self-doubt, guilt and a sense of failure. Horrific stories, acute treatment timeframe, the artificial therapeutic relationship, and a diagnose-treat-discharge approach to patient care left the participants feeling de-skilled and complicit in their patients’ distress. Limited by what they came to believe were artificial objectives they recognised that success as a return to an ideal state of being was not realistic in respect to inpatient complex psychosocial trauma:

You know this trauma work takes years and years to work through (Joanne).

Recognising that objectives for success devalued and minimised their complex distress, they personalised failure and questioned their own capabilities. Self-doubt and guilt undermined their energies to provide long-term treatment:

You’ve got this person who was traumatised and gang raped from the age of 3 … do you really think your 10 hours you spent with them is going … you know what I mean … So it’s also about having realistic expectations (Kate).

Time constraints within the acute inpatient setting created an internal struggle to negotiate the depth to which trauma narratives should be unpacked and explored, whilst simultaneously monitoring patient well-being:

Sometimes you will stop asking questions because you’re not going to be there … how much do you ask because you’re not going to be there to pick up the pieces (Joanne).

The complexity and severity of patient’s biopsychosocial factors and trauma histories represented a significant challenge for participants, necessitating a higher
degree of clinical reflection and consideration. The constraint of working within an expert model of intervention which they grew to believe as inappropriate for complex narratives of suffering, brought conflict and self-blame for not alleviating the suffering:

As a consultant you sort of feel that the buck stops with you (Mary).

Limited therapeutic success meant that clinical reflection quickly turned to self-doubt and questioning of their role in the patient’s lack of progress. Organisationally positioned as ‘experts’ at the top of the medical model hierarchy of authority, responsibility triggered anxious accountability, intense pressure and burden, and self-doubt. A tentative balancing of the expert role and self-doubt led to cyclical self-questioning of clinical ability and judgment of therapeutic success:

They’re more challenging and you know there are times where I think am I doing the right thing by this person. Am I missing something, am I you know, um … not fully treating them (Mary).

Self-doubt and guilt flourished as participants described organisational pressure to discharge patients prior to observation of significant improvements in mood, circumstance, or patient specified readiness to leave. They questioned their therapeutic integrity fearing for patient wellbeing following discharge:

You know there’s a risk that they might self-harm, um … or commit suicide I guess. And um … and that you’re, you know you’re discharging someone who is distressed (Mary).

A lack of one-on-one therapeutic contact and acute hospitalisation often hindered the development of the successful relational connection in the inpatient environment. The presence of a multidisciplinary team in psychiatric consults fostered a limited, unnatural empathic therapeutic relationship between patient and psychiatrist:

The other thing that is kind of difficult is you know seeing a patient when there’s two other people in the room. So the nurse and the, the CMO. Um
because then it’s kind of observed, you have a completely different relationship with the patient (Mary).

An internal struggle arose between pressure to adhere to the medical model approach for timely discharge, and a desire to prolong patient hospitalisation in order to facilitate, and witness therapeutic success:

The difficulty is how to kind of … get them to discharge … So say people who are personality disordered they don’t feel much better, they think they should stay longer … how do you kind of negotiate with them. Listen to what they are saying and yet still saying it’s time to go kind of thing (Mary).

Distress and a struggle to maintain an altruistic commitment to caring became obvious corollary of the futility and disillusion experienced when working within the medical model:

You’re just one person trying to make an indent on that and you’re probably not going to make a difference as an inpatient psychiatrist (Joanne).

Externally driven by the medical models idealised “fix” it approach within a given time and budget to patient care, fostered a sense of futility and failure in making significant positive change. Their disappointment and sense of ineffectiveness grew pervasively with limited opportunities for therapeutic success within the inpatient model:

All you’re doing really is bandaging the situation rather than having any long-term sort of impact (Joanne).

Intrapersonal Confrontation

This theme highlights how feelings of incompetency, disillusionment, and high levels of distress forced internal discourse that admitted diminished therapeutic integrity. In a search for authenticity, former aspects of self, honesty, altruism, and relational connection with patients were recognised as conduits to complex trauma care.
Over time, they consciously questioned the restrictions of working strictly within a medical model of therapeutic discourse with complex trauma and endorsed a freedom to engage with the relational connection, particularly the formation of a deep therapeutic relationship with their patients:

Sometimes the biggest impact is when you really connect in a particular moment um … and there’s been a shift then in the therapy (Mary).

Considering their own fear of consolidating victimhood status on their clients through the restrictions of inpatient and medical model approach to care, the relational connection, and not medication, was recognised as the important element in cultivating client change in psychotherapy. The participants mused on the hidden dynamics within a restrictive and one size fits all therapeutic approach in maintaining the narrative of victimhood. Personal strength to follow their professional and personal insightfulness led them to alter their therapeutic approach to patient interaction and treatment within the inpatient system:

Drugs won’t fix it for her … it’s the therapy. It’s the containment of therapy that’s going to be helpful (Mary).

No longer solely concerned with pharmacological treatments, categorisation, or ideals of success, they prioritised a holistic approach to treatment that recognised the intrinsic strengths of their patients and the complexity of their presentations:

I think over time like I’m probably far less medically oriented. I think there’s a place for medicine but I also think … like psychotherapy is really important in that healing process. I don’t think drugs can heal people’s relationships (Joanne).

Challenging the relational connection stimulated acceptance of the all-encompassing nature of trauma-focused work, and an altruistically motivated investment of the therapist’s physical and emotional self. Participants’ redefined
therapeutic integrity through a strong altruistic identity, one committed to assisting those in need despite risk or cost to self:

To be able to do that and not have an emotional response where you might perhaps become someone who starts to numb themselves and I don’t want to do that, that’s not who I want to be, that’s not the sort of therapist I want to be (Kate).

The potential to engage in avoidance coping strategies when listening to patients “awful”, “horrendous”, and “horrific” narratives of distress were put aside as the importance of the relational connection and a desire to act altruistically was prioritised above risk of personal threat. Through challenging their sense of altruism, participants developed a renewed sense of advocacy on behalf of their patients despite personal risk of social or professional isolation:

I have an obligation in some ways … to say actually you know, no that’s not actually what it’s about and explain … You’re advocating but you’re also putting yourself out there (Helena).

By redefining their therapeutic integrity, participants challenged their sense of honesty regarding their role and professional limitations within a flawed inpatient system. Participants spoke of aspiring to “share” the patient’s journey, rather than directing the journey from the role of ‘expert’. Honestly rejecting the role of ‘expert’ and organisational expectations that they “have all the answers” facilitated acceptance of self-doubt and cultivated equality through which genuine patient change could occur:

You notice that the clients are different … how they respond to you when you’re not trying to be technically perfect … or when you’re not trying to be the expert … you know I think that’s …that’s a mistake we all make this idea that we have to be the expert all the time … and … and that’s not what they’re looking for … you can get that out of a book (Kate).
Growth

This theme highlights the emergence of a newly defined self out of vicarious exposure to complex trauma narratives through compassion, empathy, and self-respect. Redefining therapeutic integrity through the relational connection facilitated opportunities to use this distress for growth:

If this is what happens for me when I just heard the story what must it be like for the person to have experienced it. Hence that high level of compassion … I have a lot of respect … because how can you not when you hear what they’ve actually gone through (Kate).

Recognition of the strength and courage of their patients who willingly expose themselves to trauma work cultivated growthful humility. Humbled by their vicarious exposure, participants appreciated with renewed self-awareness and honesty the value of their own virtues and the value of the relational connection:

There’s something about someone just sitting across from you in all their pain and all their, with all their guards down, talking through this horrendous things that’s happened for them. Um, and trusting you, um, enough to go there. It’s kind of … it’s kind of humbling I think (Helena).

Gratefulness and an appreciation for their own lives flourished through their humility, as they neither judged their patients, nor themselves. Through this renewed sense of morality, domains of tolerance, open-mindedness, and forgiveness facilitated a greater appreciation for their own lives:

It makes you appreciate your life and appreciate where you’re at (Kate).

Moreover, redefining themselves according to these sharpened values positively altered how participants sought to approach and interact with the world around them:

I think I live in the moment more. I think I realised you know, through that work that … because there are certain random things that I have no control
over I don’t want to miss out on the days where those things haven’t happened (Kate).

Through a sense of personal growth and redefinition of therapeutic integrity participants accepted there are no instant results in their work. This acceptance freed them from self-imposed expectations and self-doubt to search for and appreciate the witnessing of small patient successes despite the restrictions of an inpatient medical model:

I think its small gains … where you see, the occasional resilient person that’s got through and made the best of what they’ve got and they’ve done really well and that, it’s like that’s worth three of the others (Joanne).

Discussion

This study highlights the risks to psychological wellbeing in therapists working with complex trauma in an inpatient setting when confined within a medical model framework of mental health intervention. Similarly, it provides insight into growth from vicarious exposure to trauma when authenticity allows relational connectedness, honesty, and altruism to dictate therapeutic integrity. It also demonstrates how qualitative approaches such as IPA (Smith, 1996) can make an invaluable contribution to research through exposing subjective interpretations of previously untapped phenomena. In particular, exploring the ‘lived’ experience of vicarious exposure to trauma in these therapists highlighted the positive and negative impact of such work, and how therapists make sense of the different models of intervention for wellbeing. These findings can direct future nomothetic research hypotheses.

The participants of this study experienced significant psychological distress as they struggled to maintain genuine empathy, support, and compassion in the face of chronic exposure to uniquely complex and severe inpatient presentations. Reports of vicarious distress are hardly surprising given the growing body of research describing
negative outcomes in therapists following vicarious exposure to client trauma narratives (see Arnold, et al., 2005). However, what is noteworthy and unique to this study, are the participants ‘lived’ experiences of frustration and distress arising through exposure to complex trauma within the constraints of a first world medical model of therapeutic intervention.

The current exploration of vicarious trauma exposure in the inpatient setting highlighted two new findings. First, accounts suggested participants utilised perceived limitations of the medical model to redefine therapeutic integrity through altruism, the relational connection, and honesty. Secondly, through this therapeutic redefinition participants came to experience positive changes reflective of increases in compassion, empathy, gratitude, and humility.

The significance of these findings is trifold. First, they suggest a medical model approach to complex psychological intervention may generate detrimental consequences for therapist well-being within the inpatient system. Second, they extend the conceptualisation of positive and negative sequelae in therapists working with trauma survivors to an additional inpatient therapeutic setting and client population. Last, they highlight an alternate pathway to vicarious posttraumatic growth by reconnecting with self-integrity and redefining therapeutic identity.

Research and practice of psychotherapy continues to be heavily influenced by the medical model, particularly within the inpatient setting (Bohart & Tallman, 1999). Limited by the aims and objectives embedded within this framework participants perceived a deep-seated responsibility to “fix” their patients. Moreover, a pressure to adhere to the dictates of evidence-based practice through a categorical focus on negative intervention within acute treatment timeframes bred self-doubt, guilt and a sense of failure. Participants were left feeling deskilled and complicit in their patient’s distress as
they attempted to conform to a culture of dichotomising psychotherapeutic interventions which focus primarily on the alleviation of suffering and distress (Joseph & Linley, 2006).

Whilst seemingly valuable, this dichotomy further serves to focus research and practice on the alleviation of negative symptomology to the exclusion of promoting positive well-being (Joseph & Linley, 2006). Pressure and therapeutic constraint to adhere to this dichotomy, whilst simultaneously recognising the limitations to “fixing” patients within this model, cultivated a sense of futility, failure, and disappointment. Participants came to reflect on the medical model’s failure to consider their therapeutic practice, and the therapeutic relationship as an interpersonal process characterised by unconditional regard, empathy, compassion, and therapist congruence.

Spurned by such limitations and their own ensuing distress, participants redefined their therapeutic integrity within the medical model by challenging their sense of honesty, altruism, and the relational connection. Participants sought to honestly accept, understand, and connect with their patients by engaging with, and prioritising the non-technical aspects of therapeutic work (e.g., relationships, meanings, values). Such factors contrast the technological paradigm underlying the medical model which although has not ignored these aspects, has kept them as secondary concerns. Importantly in this study, it was through a growing rejection of the medical model, and an embracing of a more person-centred therapeutic approach, that participants came to experience personal growth through domains of compassion, empathy, gratitude, and humility.

Limitations

This qualitative study is not without limitations. Phenomenological investigations provide an alternate approach to positivist methods by providing an
understanding of individual subjective distress. However, unlike nomothetic studies we are unable to generalise findings, nor infer cause and effect. Although generalising the experiences of these participants would be inappropriate, the negative impact, and the positive benefits to self-integrity when working with complex trauma in an inpatient setting governed by the medical model are important findings of this study. Future studies may consider whether time as a therapist impacts differently on negative and positive outcomes as these participants were all greater than five years in professional practice with complex trauma. The experiences described by these highly trained clinicians suggest therapist self-care and therapeutic experience is both personally and professionally important in the face of vicarious trauma exposure. Whilst several participants reported a personal trauma history, it was beyond the scope of this paper to comment on how interpretations of such experiences may affect vicarious trauma responses. Future research may seek to explore therapist trauma history and the phenomena of vicarious traumatisation and growth when working with complex trauma within the limitations of the medical model.

As an interpretive process, the data is open to the natural biases and presuppositions of the researchers. Both the first and second authors have had exposure to client, and inpatient narratives of trauma through their clinical experiences. Every attempt has been made to externalise the researchers’ subjective interpretations and biases through robust discussion, shared input, independent audits, and clear audit trails.

Conclusions

Overall, this study offers unique insight into the potential for psychological distress in therapists exposed to complex inpatient narratives of trauma. Notably, limitations to therapeutic success within the medical model significantly contributed to therapist distress and well-being. Promisingly, whilst the provision of trauma focused
therapy to trauma survivors has been largely regarded as a challenging and draining profession; these findings suggest such work may prompt significant and often profound personal growth. There is hope that despite vicarious distress, positive and growthful redefining of therapeutic identity through altruism, honesty, and the relational connection may cultivate psychological growth through domains of compassion, empathy, humility, and gratitude. These findings highlight the potential benefits of a reciprocal relational approach to psychological intervention for therapist well-being within the inpatient system. Additional research may seek to further capture the impact working within the medical model has on therapists and care professionals whilst detailing how a medicalised framework may impede or facilitate opportunities for personal growth following adversity.
Authors Contributions

Erin Adams contributed to the conception and design of the research, collection, analysis, and interpretation of data, drafting of the thesis and article, and final approval of the version to be published. Dr Lynne McCormack contributed to the conception and design of the research, analysis, and interpretation of data, critical revision of the thesis and article, and final approval of the version to be published.

Acknowledgments

The authors would like to thank the women of this study who generously offered their time and insight into their clinical experiences with severely unwell mental health inpatients

Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed that no financial support was given for the research, authorship, and/or publication of this article.

Ethical Standards

The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation. Ethical approval of the study granted by the University of Newcastle’s Human Research Ethics Committee (HREC ref no: H-2013-0254).
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THERAPISTS, COMPLEX TRAUMA, AND THE MEDICAL MODEL

doi:10.1177/0022167810377506

personnel: Reintegrating with family and community following exposure to war  
doi:10.1080/13668803.2012.735478

Family, 16*(2), 147-163.

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Health, 11,* 261-271. doi:10.1080/08870449608400256


Transcript extract notation

[ … ] Indicates pause in speech
Table 1

*Participant Demographics*

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Profession</th>
<th>Years of Clinical Experience</th>
<th>Total Years in inpatient setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mary</td>
<td>Psychiatrist</td>
<td>23</td>
<td>5</td>
</tr>
<tr>
<td>Joanne</td>
<td>Psychiatrist</td>
<td>25</td>
<td>7</td>
</tr>
<tr>
<td>Helena</td>
<td>Clinical Psychologist</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>Kate</td>
<td>Psychologist</td>
<td>9</td>
<td>5</td>
</tr>
</tbody>
</table>
Table 2  

*Stages of Interpretative Phenomenological Analysis Process*

<table>
<thead>
<tr>
<th>Stage</th>
<th>Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Repetitive listening to recorded interview, transcribing verbatim, and preparing the first transcript.</td>
</tr>
<tr>
<td>2</td>
<td>Interpretation of transcript by paraphrasing and summarising the participant’s phenomenological and hermeneutic experience followed by annotation of emerging themes.</td>
</tr>
<tr>
<td>3</td>
<td>Thematic analysis of first transcript to identify vicarious exposure to inpatient trauma narratives leading to superordinate and subordinate themes.</td>
</tr>
<tr>
<td>4</td>
<td>Stages 1, 2, and, 3 repeated for each transcript searching for convergence and divergence and clustering of themes that supported evidence of the superordinate theme.</td>
</tr>
<tr>
<td>5</td>
<td>Exploration of overarching higher theme “Therapeutic Integrity and Vicarious Growth”.</td>
</tr>
<tr>
<td>6</td>
<td>Chronological listing of emerging themes for connectedness.</td>
</tr>
<tr>
<td>7</td>
<td>Further examination of higher theme, assessing its relationship and links to the psychological growth out of the limitations of the medical model.</td>
</tr>
<tr>
<td>8</td>
<td>Clustering of themes around concepts and theories.</td>
</tr>
<tr>
<td>9</td>
<td>Data from transcript independently audited to verify investigators validity of interpretations from within the text.</td>
</tr>
<tr>
<td>10</td>
<td>Subjective analysis of interpretation of themes representing the phenomenon of the “lived” experience, in the context of working with complex trauma within the confines of the inpatient medical model leading to redefining of therapeutic integrity.</td>
</tr>
<tr>
<td>11</td>
<td>Narrative account of theoretic links to themes generated through pertinent verbatim extracts from transcript.</td>
</tr>
<tr>
<td>12</td>
<td>Development of links from redefining therapeutic integrity through exposure to inpatient trauma narratives to psychological growth through gratitude, humility, empathy, and compassion.</td>
</tr>
</tbody>
</table>
Table 3

*The Superordinate Theme: Therapeutic Integrity and Vicarious Growth* overarching *four subordinate themes*

<table>
<thead>
<tr>
<th>Subordinate Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severity, Complexity, and Repetition</td>
</tr>
<tr>
<td>Personal Distress and the Medical Model</td>
</tr>
<tr>
<td>Intrapersonal Confrontation</td>
</tr>
<tr>
<td>Growth</td>
</tr>
</tbody>
</table>
Appendix A

Scope of Journal of Occupational Health Psychology

The *Journal of Occupational Health Psychology* publishes research, theory, and public policy articles in occupational health psychology, an interdisciplinary field representing a broad range of backgrounds, interests, and specializations. Occupational health psychology concerns the application of psychology to improving the quality of work life and to protecting and promoting the safety, health, and well-being of workers.

The *Journal* has a threefold focus on the work environment, the individual, and the work–family interface. The *Journal* seeks scholarly articles, from both researchers and practitioners, concerning psychological factors in relationship to all aspects of occupational health and safety. Included in this broad domain of interest are:

- articles in which work-related psychological factors play a role in the etiology of health problems
- articles examining the psychological and associated health consequences of work
- articles concerned with the use of psychological approaches to prevent or mitigate occupational health problems

Special attention is given to articles with a prevention emphasis. Authors should consider the financial costs of identified problems and/or economic benefits of interventions they evaluate. Manuscripts dealing with issues of contemporary relevance to the workplace, especially with regard to minority, cultural, or occupationally underrepresented groups, or topics at the interface of the family and the workplace, are encouraged.

Each article should represent an addition to knowledge and understanding of occupational health psychology.

Subscribe to the RSS feed for *Journal of Occupational Health Psychology*

*Journal of Occupational Health Psychology* is a registered trademark of American Psychological Association

Prior to submission, please carefully read and follow the submission guidelines detailed below. Manuscripts that do not conform to the submission guidelines may be returned without review.

Submission

Submit manuscripts electronically through the [Manuscript Submission Portal](#) (.rtf, PDF, or .doc).

Joseph J. Hurrell Jr., PhD
Editor, *Journal of Occupational Health Psychology*
1796 Stonelick Hills Drive
Batavia, Ohio 45103
Email

General correspondence may be directed to the Editor's Office.

Manuscripts submitted for publication consideration in the *Journal of Occupational Health Psychology* are evaluated according to the following general criteria:

- Mastery of the relevant literature
- Theoretical/conceptual framework
- Measures of key constructs
- Research design
- Data analysis
- Interpretations and conclusions
- Writing style (clarity)
- Appropriateness of topic for JOHP
- Theoretical contribution to occupational health psychology
- Practical implications for occupational health psychology

While the journal doesn't have restrictions regarding manuscript page length, typical submissions are 30 to 40 double-spaced pages in length, with up to 4–6 figures and 3–4 tables. Extra figures, tables or additional material can be placed in a "supplementary material file."

Submission letters should include a statement regarding any possible conflict of interest in conducting or reporting of their research and a statement of compliance with APA ethical standards. Authors are also
encouraged to suggest up to five reviewers who are especially qualified to review their work and who would not have a conflict of interest in serving as a referee.

**Masked Review Policy**

The journal accepts submissions in masked review format only. Each copy of a manuscript should include a separate title page with author names and affiliations, and these should not appear anywhere else on the manuscript. Furthermore, author identification notes should be typed on the title page. Authors should make every effort to see that the manuscript itself contains no clues to their identities.

Manuscripts not in masked format will not be reviewed. Please ensure that the final version for production includes a byline and full author note for typesetting.

**Manuscript Preparation**

Prepare manuscripts according to the *Publication Manual of the American Psychological Association* [6th edition]. Manuscripts may be copyedited for bias-free language (see Chapter 3 of the *Publication Manual*).

Review APA's Checklist for Manuscript Submission before submitting your article. Double-space all copy. Other formatting instructions, as well as instructions on preparing tables, figures, references, metrics, and abstracts, appear in the *Manual*.

Below are additional instructions regarding the preparation of display equations, computer code, and tables.

**Display Equations**

We strongly encourage you to use MathType (third-party software) or Equation Editor 3.0 (built into pre-2007 versions of Word) to construct your equations, rather than the equation support that is built into Word 2007 and Word 2010. Equations composed with the built-in Word 2007/Word 2010 equation support are converted to low-resolution graphics when they enter the production process and must be rekeyed by the typesetter, which may introduce errors.

To construct your equations with MathType or Equation Editor 3.0:

- Go to the Text section of the Insert tab and select Object.
- Select MathType or Equation Editor 3.0 in the drop-down menu.

If you have an equation that has already been produced using Microsoft Word 2007 or 2010 and you have access to the full version of MathType 6.5 or later, you can convert this equation to MathType by clicking on MathType Insert Equation. Copy the equation from Microsoft Word and paste it into the MathType box. Verify that your equation is correct, click File, and then click Update. Your equation has now been inserted into your Word file as a MathType Equation.

Use Equation Editor 3.0 or MathType only for equations or for formulas that cannot be produced as Word text using the Times or Symbol font.

**Computer Code**

Because altering computer code in any way (e.g., indents, line spacing, line breaks, page breaks) during the typesetting process could alter its meaning, we treat computer code differently from the rest of your article in our production process. To that end, we request separate files for computer code.

**In Online Supplemental Material**

We request that runnable source code be included as supplemental material to the article. For more information, visit Supplanting Your Article With Online Material.

**In the Text of the Article**

If you would like to include code in the text of your published manuscript, please submit a separate file with your code exactly as you want it to appear, using Courier New font with a type size of 8 points. We will make an image of each segment of code in your article that exceeds 40 characters in length. (Shorter snippets of code that appear in text will be typeset in Courier New and run in with the rest of the text.) If an appendix contains a mix of code and explanatory text, please submit a file that contains the entire appendix, with the code keyed in 8-point Courier New.

**Tables**

Use Word's Insert Table function when you create tables. Using spaces or tabs in your table will create problems when the table is typeset and may result in errors.
Submitting Supplemental Materials

APA can place supplemental materials online, available via the published article in the PsycARTICLES® database. Please see Supplementing Your Article With Online Material for more details.

Abstract and Keywords

All manuscripts must include an abstract containing a maximum of 250 words typed on a separate page. After the abstract, please supply up to five keywords or brief phrases.

References

List references in alphabetical order. Each listed reference should be cited in text, and each text citation should be listed in the References section.

Examples of basic reference formats:

- **Journal Article:**

- **Authored Book:**

- **Chapter in an Edited Book:**

Figures

Graphics files are welcome if supplied as Tiff or EPS files. Multipanel figures (i.e., figures with parts labeled a, b, c, d, etc.) should be assembled into one file.

The minimum line weight for line art is 0.5 point for optimal printing.

For more information about acceptable resolutions, fonts, sizing, and other figure issues, please see the general guidelines.

When possible, please place symbol legends below the figure instead of to the side.

APA offers authors the option to publish their figures online in color without the costs associated with print publication of color figures.

For authors who prefer their figures to be published in color both in print and online, original color figures can be printed in color at the editor's and publisher's discretion provided the author agrees to pay:

- $900 for one figure
- An additional $600 for the second figure
- An additional $450 for each subsequent figure

Permissions

Authors of accepted papers must obtain and provide to the editor on final acceptance all necessary permissions to reproduce in print and electronic form any copyrighted work, including test materials (or portions thereof), photographs, and other graphic images (including those used as stimuli in experiments). On advice of counsel, APA may decline to publish any image whose copyright status is unknown.

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Publication Policies

APA policy prohibits an author from submitting the same manuscript for concurrent consideration by two or more publications.

See also APA Journals® Internet Posting Guidelines.

APA requires authors to reveal any possible conflict of interest in the conduct and reporting of research (e.g., financial interests in a test or procedure, funding by pharmaceutical companies for drug research).

- Download Disclosure of Interests Form (PDF, 38KB)

Authors of accepted manuscripts are required to transfer the copyright to APA.
THERAPISTS, COMPLEX TRAUMA, AND THE MEDICAL MODEL

- For manuscripts not funded by the Wellcome Trust or the Research Councils UK
  Publication Rights (Copyright Transfer) Form (PDF, 83KB)
- For manuscripts funded by the Wellcome Trust or the Research Councils UK
  Wellcome Trust or Research Councils UK Publication Rights Form (PDF, 34KB)

**Ethical Principles**

It is a violation of APA Ethical Principles to publish "as original data, data that have been previously published" (Standard 8.13). In addition, APA Ethical Principles specify that "after research results are published, psychologists do not withhold the data on which their conclusions are based from other competent professionals who seek to verify the substantive claims through reanalysis and who intend to use such data only for that purpose, provided that the confidentiality of the participants can be protected and unless legal rights concerning proprietary data preclude their release" (Standard 8.14).

APA expects authors to adhere to these standards. Specifically, APA expects authors to have their data available throughout the editorial review process and for at least 5 years after the date of publication. Authors are required to state in writing that they have complied with APA ethical standards in the treatment of their sample, human or animal, or to describe the details of treatment.

- Download Certification of Compliance With APA Ethical Principles Form (PDF, 26KB)


**Other Information**

- Appeals Process for Manuscript Submissions
- Preparing Auxiliary Files for Production
- Document Deposit Procedures for APA Journals
Appendix B

Ethics Approval

HUMAN RESEARCH ETHICS COMMITTEE

Notification of Expedited Approval

To Chief Investigator or Project Supervisor:  Doctor Lynne McCormack
Cc Co-investigators / Research Students:  Miss Erin Adams
Re Protocol:  Secondary posttrauma responses in therapists: Making meaning of exposure to acutely unwell mental health inpatients
Date:  03-Oct-2013
Reference No:  H-2013-0254
Date of Initial Approval:  03-Oct-2013

Thank you for your Response to Conditional Approval (minor amendments) submission to the Human Research Ethics Committee (HREC) seeking approval in relation to the above protocol.

Your submission was considered under Expedited review by the Ethics Administrator.

I am pleased to advise that the decision on your submission is Approved effective 03-Oct-2013.

In approving this protocol, the Human Research Ethics Committee (HREC) is of the opinion that the project complies with the provisions contained in the National Statement on Ethical Conduct in Human Research, 2007, and the requirements within this University relating to human research.

Approval will remain valid subject to the submission, and satisfactory assessment, of annual progress reports. If the approval of an External HREC has been "noted" the approval period is as determined by that HREC.

The full Committee will be asked to ratify this decision at its next scheduled meeting. A formal Certificate of Approval will be available upon request. Your approval number is H-2013-0254.

If the research requires the use of an Information Statement, ensure this number is inserted at the relevant point in the Complaints paragraph prior to distribution to potential participants. You may then proceed with the research.
For Noting:
Flyer
Please add the version number, date and H-reference number of H-2013-0254 to the flyer prior to distribution. Please also ensure Marketing and Media have approved the flyer prior to distribution.

Conditions of Approval

This approval has been granted subject to you complying with the requirements for Monitoring of Progress, Reporting of Adverse Events, and Variations to the Approved Protocol as detailed below.

PLEASE NOTE:
In the case where the HREC has "noted" the approval of an External HREC, progress reports and reports of adverse events are to be submitted to the External HREC only. In the case of Variations to the approved protocol, or a Renewal of approval, you will apply to the External HREC for approval in the first instance and then Register that approval with the University's HREC.

- Monitoring of Progress

Other than above, the University is obliged to monitor the progress of research projects involving human participants to ensure that they are conducted according to the protocol as approved by the HREC. A progress report is required on an annual basis. Continuation of your HREC approval for this project is conditional upon receipt, and satisfactory assessment, of annual progress reports. You will be advised when a report is due.

- Reporting of Adverse Events

1. It is the responsibility of the person first named on this Approval Advice to report adverse events.
2. Adverse events, however minor, must be recorded by the investigator as observed by the investigator or as volunteered by a participant in the research. Full details are to be documented, whether or not the investigator, or his/her deputies, consider the event to be related to the research substance or procedure.
3. Serious or unforeseen adverse events that occur during the research or within six (6) months of completion of the research, must be reported by the person first named on the Approval Advice to the (HREC) by way of the Adverse Event Report form (via RIMS at https://rims.newcastle.edu.au/login.asp) within 72 hours of the occurrence of the event or the investigator receiving advice of the event.
4. Serious adverse events are defined as:
   o Causing death, life threatening or serious disability.
   o Causing or prolonging hospitalisation.
   o Overdoses, cancers, congenital abnormalities, tissue damage, whether or not they are judged to be caused by the investigational agent or procedure.
   o Causing psycho-social and/or financial harm. This covers everything from perceived invasion of privacy, breach of confidentiality, or the diminution of social reputation, to the creation of psychological fears and trauma.
   o Any other event which might affect the continued ethical acceptability of
5. Reports of adverse events must include:
   - Participant's study identification number;
   - date of birth;
   - date of entry into the study;
   - treatment arm (if applicable);
   - date of event;
   - details of event;
   - the investigator's opinion as to whether the event is related to the research procedures; and
   - action taken in response to the event.

6. Adverse events which do not fall within the definition of serious or unexpected, including those reported from other sites involved in the research, are to be reported in detail at the time of the annual progress report to the HREC.

- **Variations to approved protocol**
   If you wish to change, or deviate from, the approved protocol, you will need to submit an Application for Variation to Approved Human Research (via RIMS at [https://rims.newcastle.edu.au/login.asp](https://rims.newcastle.edu.au/login.asp)). Variations may include, but are not limited to, changes or additions to investigators, study design, study population, number of participants, methods of recruitment, or participant information/consent documentation. **Variations must be approved by the (HREC) before they are implemented** except when Registering an approval of a variation from an external HREC which has been designated the lead HREC, in which case you may proceed as soon as you receive an acknowledgement of your Registration.

**Linkage of ethics approval to a new Grant**

HREC approvals cannot be assigned to a new grant or award (ie those that were not identified on the application for ethics approval) without confirmation of the approval from the Human Research Ethics Officer on behalf of the HREC.

Best wishes for a successful project.

Professor Allyson Holbrook

**Chair, Human Research Ethics Committee**

*For communications and enquiries:*

**Human Research Ethics Administration**

Research Services  
Research Integrity Unit  
The Chancellery  
The University of Newcastle  
Callaghan NSW 2308  
T +61 2 492 17894  
F +61 2 492 17164  
[Human-Ethics@newcastle.edu.au](mailto:Human-Ethics@newcastle.edu.au)

*Linked University of Newcastle administered funding:*

<table>
<thead>
<tr>
<th>Funding body</th>
<th>Funding project title</th>
<th>First named investigator</th>
<th>Grant Ref</th>
</tr>
</thead>
</table>

Appendix C

University Ethics Approval

FACULTY OF SCIENCE AND INFORMATION TECHNOLOGY

FSIT-G2+ Form

Faculty Ethics Methodology Review Sub-Committee

PEER REVIEW OF METHODOLOGY – PROPOSAL SUBMITTED FOR ETHICS APPROVAL

Faculty Confirmation

Title of Project: Vicarious growth and trauma: the subjective “lived” experience of highly trained mental health professionals

Applicant(s): Erin Adams

☐ Staff ☐ PhD/MSc ☐ Honours ☑ Coursework

The research proposal methodology has been peer reviewed and it is confirmed by FEMRS that it meets the list of requirements on the attached G2 form.

The proposal was reviewed by:

☑ The relevant School under devolved authority ( ☐ DCIT ☑ Psych ☐ SELS )

Reviewer(s):

FEMRS Action ☑ Review assessed as appropriate and sufficient – no further action

☐ Review process audited by the committee –

☐ no action required, as fully appropriate/compliant

☐ additional review required; completed/approved

☐ The Faculty (via reviewer(s) appointed directly by this FEMRS committee)

Reviewer(s): ________________________________

Outcome: ☐ project assessed as appropriate and sufficient

☐ applicant action/re-review required; completed/approved

☐ An external competitive research grant body (__________________________)

FEMRS Declaration

As a member of the FEMRS without any conflict of interests, I declare that I am satisfied that an appropriate peer review of research methodology has been conducted and that the research proposal may go on for ethics approval.

Print name: Date: 07/06/2013 Signature:
PART G2 – PEER REVIEW AND HEAD OF SCHOOL DECLARATION

STEP 1 – Peer review confirmation

The research proposal contained herein has been peer reviewed by (please list):

☐ The following competitive research grant body and given a positive review:

In: (year) ____________

CR

X

Reviewed by:

The postgraduate methodology review panel

On: (date) ____________

and it is confirmed that:

• the proposal has been peer reviewed by experienced researchers in the field of study who are independent of the research and the researchers;
• the aims of the research are clearly identified;
• the research proposal is well designed and methodologically sound;
• the research proposal is supported by an appropriate literature review;
• the research procedures are appropriate to the aims of the research;
• the proposed study sample is appropriate;
• if the research is conducted according to the protocol, it is expected to yield valid and useful data;
• the researcher(s) has the necessary expertise to conduct the research and perform the procedures/techniques required by the research; and
• where relevant, all methodological issues have been resolved to the satisfaction of the peer reviewers.

Title Rev Dr First name Martin Last name Johnson

Signed ____________ Date ____________

As: Chair, Psychology Methodology Review Committee (or Chair, Review Committee/Panel)

STEP 2 – Head of School Declaration

Where the Head of School has a conflict of interest with the proposed research, eg. an investigator on the project, a member of the research group, or a personal relationship to any member of the research team, the Declaration is to be completed by the Deputy Head of School.

I declare that:

• I am satisfied that an adequate peer review has been conducted and that the research proposal is ready for submission for ethics approval;
• the resources required to undertake this project are available; and
• the researchers have the skill and expertise to undertake this project appropriately.

Title Dr First name Martin Last name Johnson

Position HoS

Signed ____________ Date ____________
Volunteers Needed

Secondary Posttrauma Responses in Therapists:
Making Meaning of Exposure to Acutely Unwell Mental Health In-patients
Version 2, Approval Number: H-2013-0254

You are invited to participate in a study exploring the “lived” experience of highly trained mental health professionals working with traumatised individuals in acute inpatient settings. It aims to explore both the positive and negative interpretations of your experiences whilst gaining insight into how you make sense of, and assign meaning to these experiences. We hope to provide insight into not only the risks of psychopathology from such work but how therapists can make meaning of these narratives in their own lives whilst possibly offering insight into professional self-care and wellbeing.

Who is Eligible: Clinical Psychologists and Psychiatrists who have a minimum of 10 years experience in their field and a minimum of 5 years working with severely unwell mental health inpatients with trauma histories

What Will You Be Asked To Do? Complete self-report questionnaires and an audio recorded interview exploring your clinical experiences.

If You Would Like More Information About Participating, Contact:
Chief Investigator: Dr Lynne McCormack (Senior Lecturer/Clinical Psychologist) on 49 85 45 43 or Student Researcher Erin Adams.

Erin Adams 0401 598 653
Erin Adams 0401 598 653
Erin Adams 0401 598 653
Erin Adams 0401 598 653
Erin Adams 0401 598 653
Erin Adams 0401 598 653
Erin Adams 0401 598 653
Appendix E

Information Statement

Dr Lynne McCormack
School of Psychology
Faculty of Science & IT
University of Newcastle
Callaghan NSW 2308
AUSTRALIA
Ph: 4985 4543

Information Statement for the Research Project:

Secondary Posttrauma Responses in Therapists: Making Meaning of Exposure to Acutely Unwell Mental Health In-Patients

02.09.13 Version 2

I warmly invite you to participate in this valuable research project which is being conducted by Dr Lynne McCormack (Senior Lecturer/Clinical Psychologist) and Erin Adams (Student Researcher/ Provisional Psychologist) from the School of Psychology at the University of Newcastle. This research will be undertaken as part of Erin Adams’ Master of Clinical Psychology subject Psyc6511.

Why is the Research Being Conducted?
Mental health professionals are often exposed to the traumatic material of their clients in the course of their empathic and therapeutic work. Many professionals can experience vicarious distress as they attempt to make sense out of the stories they hear from clients, and integrate those stories into their own existing cognitive schemas. However, recent research investigating the positive effects of trauma work have yielded evidence which suggests the provision of therapeutic care to traumatised individuals, whilst extremely challenging can be equally rewarding for mental health professionals. The current research aims to explore both the positive and negative experiences of such professionals in the hope of providing insight into not only the risks of psychopathology from such work but how therapists can make meaning of these narratives in their own lives whilst possibly offering insight into professional self-care and wellbeing.

Who can participate in the research?
We are seeking Clinical Psychologists and Psychiatrists who have a minimum of 5 years’ experience working with severely unwell mental health inpatients.

What choice do you have?
Participation in this research is entirely your choice and only those people who give their informed consent will be included in the project. A decision to participate will not disadvantage you in any way. Similarly, you may decline to answer any question/s within the demographics and self-report questionnaire and/or within the interview. You may stop the semi-structured interview at any time if you do not wish to continue. You may withdraw until such time as the data has been transcribed without giving any reason and have the option of withdrawing any of your data. If you do so, the audio recording will be erased and the information provided will not be included in the study. The study consent form is attached overleaf. Should you decide to participate this signed form will be collected at the interview.
What would you be asked to do?
If you agree to participate in the study, you will be asked to:

- Read and sign an informed consent form, which the student researcher will collect at the time of the interview. The location of the interview will be determined collaboratively between the participant and student researcher. Privacy and confidentiality will be a priority in location selection.
- Ask any questions you have related to the study.
- In the interview room prior to the interviews commencement you will be asked to provide demographic details relating to yourself and your clinical experience and complete 3 self-report measures of distress and growth.
- Partake in an audio-recorded interview with the student researcher where you will be asked about the positive and negative aspects of your experience working with severely unwell mental health inpatients.
- Complete a post-interview consent form
- Willingness to be contacted for further research into this field of study.

Because the interviews will reflect your interpretations at the time of the interview, we will not ask you to review or edit the transcript of the interview. However, you may request a copy of any publications arising from the study.

How much time will it take?
The questionnaires should take approximately 15 minutes in total to complete. The interview is usually around an hour, it may take less or more depending on how much you would like to share with the researcher. If you need a break at any time, this can be negotiated with the student researcher. Your participation in this study will require you to only participate in this one session.

What are the risks and benefits of participating?
Although it is possible that participants in the interview may feel some increase in stress levels as difficult therapeutic experiences are recalled, the interviews are not expected to cause significant distress, particularly as the study is also interested in positive outcomes. Although some of the questions in both the interview and the questionnaire will be of a sensitive nature, you will be contributing to our understanding of how individuals define vicarious exposure to client distress in the workplace and how one assigns meaning to these experiences.

Any feelings of distress will be supported and you will be provided with contact details for counselling services in the local area, such as the Beyond Blue or Lifeline telephone counselling service, if additional support is required. You may pause or cease the interview if you wish at any time.

Beyond Blue: 1300 22 4636
Life line: 13 11 14

Further information

How will your privacy be protected?
Each interview will be transcribed by the student researcher Erin Adams and overviewed by Chief Investigator Lynne McCormack. Both researchers will be bound by a confidentiality agreement ensuring the privacy and confidentiality of the participants. Your data collected from this interview will be de-identified immediately after collection and will remain de-identified in the study and in any research publications or conference papers. All hard data and audio files will be stored in locked filing cabinets located within the Chief Investigators locked office or on password protected hard drives, accessible to the research supervisor and student researcher, for
the duration of the research and publication of any findings. Furthermore, access to the
data will be limited to the researchers expect as required by law. The data and consent
forms will be held for a minimum of 5 years or until all investigations are complete.
Following this time all hard copies of data will be shredded and electronic data will
undergo appropriate erasure procedures in accordance with the University of Newcastle
destruction approval process.

How will the information collected be used?
The information collected from this research will form a substantial component of the
thesis to be submitted by the student researcher. In addition, the data collected may be
used for educational purposes or academic publication. Individual participants will not
be identified in any reports arising from the project. You may request a copy of any
publications arising from the study.

What do you need to do to participate?
Now that you have contacted the researchers to indicate your willingness to participate
in the study, please read this Information Statement and be sure you understand its
contents before you sign the consent form. If there is anything you do not understand, or
you have questions, contact either researcher on the below email or phone contact. The
student researcher will contact you via phone to arrange a time convenient to you for the
interview. You will be asked to bring your signed Consent Form to the interview.

Further information
If you would like further information about this project please contact Dr Lynne
McCormack or Erin Adams on the contact numbers listed below. Thank you for
considering this invitation to be part of this valuable research.

Yours sincerely

Dr Lynne McCormack
Senior Lecturer/Clinical Psychologist
School of Psychology
University of Newcastle
Lynne.Mccormack@newcastle.edu.au
Ph: 4985 4543

Erin Adams
Student Researcher/Provisional Psychologist
School of Psychology
Faculty of Science & IT
University of Newcastle
Erin.L.Adams@uon.edu.au
Ph: 0401 598 653

Complaints about this research
This project has been approved by the University’s Human Research Ethics Committee,
Approval No. H-2013-0254

Should you have concerns about your rights as a participant in this research, or you
have a complaint about the manner in which the research is conducted, it may be given
to the researcher, or, if an independent person is preferred, to the Human Research
Ethics Officer, research Office, The Chancellery, The University of Newcastle,
University Drive, Callaghan NSW 2308, Australia, telephone (02) 49216333, email
Human-Ethics@newcastle.edu.au
Consent Form For The Research Project:
Secondary Posttrauma Responses in Therapists: Making Meaning of Exposure to Acutely Unwell Mental Health In-Patients

02.09.13 Version 2

I have been invited to participate in the above study, which is being conducted by Dr Lynne McCormack (Senior Lecturer/Clinical Psychologist) and Erin Adams (Student Researcher/Provisional Psychologist) from the School of Psychology at the University of Newcastle. My agreement is based on the understanding that the research study looks at my experience, both positive and negative of secondary trauma exposure through work in an acute mental health setting.

I consent to: (please TICK each box)

☐ I agree to participate in the above research project and give my consent freely.
☐ I understand that I can refuse to consent, or withdraw from the study at any time without explanation and this will not affect my relationship with the University of Newcastle.
☐ I understand that my personal information will remain confidential to the researchers and all interview data will be de-identified and stored separately.
☐ I have received and read the attached ‘Participant Information Sheet’ and I understand that the project will be conducted as described in the Information Statement, a copy of which I have retained.
I consent to attending an interview session as part of this study which will be audio recorded.

☐ I understand that I will be asked to complete several questionnaires

☐ I consent to de-identified excerpts from the data being used for research purposes, scientific publication, conference presentation and/or for teaching purposes.

☐ I understand that I will not be required to proof the transcript but may request an audio copy of my interview.

☐ I give permission to be contacted in the future for follow-up studies using the following contact details (optional)

☐ I have had the opportunity to have all questions answered to my satisfaction.

Participant Name: 

…………………………………………………………………………………………………………………………

Participant Signature: ……………………………………….. Date: …………..

CONTACT DETAILS:

NAME:

Email address:

Phone Numbers: (m) (h) (w)
Appendix G

Demographics Questionnaire

Dr Lynne McCormack
School of Psychology
Faculty of Science & IT
University of Newcastle
Callaghan NSW 2308
AUSTRALIA
Ph: 4985 4543

Demographics Form For The Research Project:
Secondary Posttrauma Responses in Therapists: Making Meaning of Exposure to Acutely Unwell Mental Health In-Patients
02.09.13 Version 2.

1. What is your gender?  M  F
2. In what year were you born? ………
3. Highest level of education completed? ........................................
4. In what year did you complete your highest level of education? …………
5. How many years of clinical experience do you have in your field (equivalent full time)?………
6. What is your current professional working role within the Inpatient Psychiatric Facility? (i.e. Health, Clinical etc)…………………………………………………………
7. How many years have you worked in this Inpatient Psychiatric Facility? (equivalent full time).………………………………………………
8. What is your employment status at the Inpatient Psychiatric Facility? (circle appropriate)
   Casual  Part-time  Full-time  Consultant
9. What percentage of your clinical work in the Inpatient Psychiatric Facility is trauma-related (i.e. providing treatment to traumatised individuals)………………
10. Approximately what percentage of the patients you treat in the Inpatient Psychiatric Facility have been admitted on more than one occasion?………..
11. Within the inpatient facility what client presentations have you been exposed to?
   ▪ Disorders usually first diagnosed in infancy, childhood or adolescence  ☐
   ▪ Substance-related disorders  ☐
- Mood disorders
- Anxiety disorders
- Sleep disorders
- Personality disorders
- Delirium, dementia, amnesia and other cognitive disorders
- Mental disorders due to a general medical condition
- Schizophrenia and other psychotic disorders
- Dissociative disorders
- Eating disorders
- Dual diagnosis presentations
- Factitious disorders
- Adjustment disorders
- Somatoform disorders
- Trauma and stress related disorders
- Sexual and gender identity disorders
- Impulse control disorders not elsewhere classified
- Sexual Abuse or Assault
- Other .................................................................

12. Within the inpatient facility what type of vicarious trauma have you been exposed to?

- Physical Abuse or Assault
- Emotional Abuse/Psychological Maltreatment
- Neglect
- Serious Accident or Illness/Medical Procedure
- Witness to Domestic Violence
- Victim/Witness to Community Violence (i.e. Neighbourhood drive by shooting)
- School Violence
- Natural or Manmade Disasters
- Forced Displacement (i.e. immigrants escaping political persecution)
- War/Terrorism/Political Violence
- Victim/Witness to Extreme Personal/Interpersonal Violence (i.e., Suicide)
- Traumatic Grief/Separation
- System-Induced Trauma (i.e. Traumatic removal from the home/foster placement)
- Drug and/or alcohol related/induced trauma
- Other .................................................................
13. At any stage of your life have you personally experienced a traumatic event/s?

- Physical Abuse or Assault
- Emotional Abuse/Psychological Maltreatment
- Neglect
- Serious Accident or Illness/Medical Procedure
- Witness to Domestic Violence
- Victim/Witness to Community Violence
- School Violence
- Natural or Manmade Disasters
- Forced Displacement
- War/Terrorism/Political Violence
- Victim/Witness to Extreme Personal/Interpersonal Violence
- Traumatic Grief/Separation
- System-Induced Trauma
- Drug and/or alcohol related/induced trauma
- Other ……………………………………………………………………

Thank you for taking part in this valuable research.

Dr Lynne McCormack
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School of Psychology
Faculty of Science & IT
University of Newcastle
Callaghan NSW 2308
AUSTRALIA
Ph: 49854543

Erin Adams (Student Researcher)
Provisional Psychologist
School of Psychology
Faculty of Science & IT
University of Newcastle
Callaghan NSW 2308
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Ph: 040159865
Appendix H

Interview Guide

Dr Lynne McCormack
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Faculty of Science & IT
University of Newcastle
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Semi-Structured Interview Guide For The Research Project:
Secondary Posttrauma Responses in Therapists: Making Meaning of Exposure to Acutely Unwell Mental Health In-Patients
02.09.13 Version 2

Semi-structured interview for guiding the interviewee:

How have your experiences as a mental health professional working with severely unwell in-patients impacted on you over your working life so far?

How and in what way particular types of stories from your clients have impacted on you and your work/non-work life?

How do you feel you as a person may have changed because of these experiences?

What about this type of work experience in particular has impacted on you either positively or negatively?

How do you make sense of the human dynamics that you have been caught up in?

Are there any psychological, philosophical, existential thoughts that have altered or become part of your thinking as a part of this experience?

How may your future be influenced from this experience?

How has it influenced your feelings, thoughts, relationships and goals?

Further Information

If you would like further information about this project please contact Dr Lynne McCormack or Erin Adams on the contact numbers listed below.

Yours sincerely

Dr Lynne McCormack
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Psychologist Clinical Psychologist
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Erin Adams
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Provisional Psychologist
School of Psychology
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Appendix I

Post Interview Consent Form

Dr Lynne McCormack
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Post-Interview Consent Form for the Research Project:
Secondary posttrauma responses in therapists: Making meaning of exposure to acutely unwell mental health in-patients.

Chief Investigator: Dr Lynne McCormack
Student Researcher: Erin Adams

- Prior to participating in this study, I was made aware that I would not be asked to review or edit the content of my interview.
- Having now completed the interview, I re-confirm my consent to the de-identified data collected being used for research, scientific literature, presentation at conference, or for teaching purposes.

Participant Name:
..........................................................................................................................................................

Participant Signature: ........................................ Date: ..........................