‘Looking through a Lens of Terribleness’: A Thematic Analysis of the experience of practitioners working in the field of domestic violence.

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Acknowledgments

Primarily my utmost gratitude goes to my participants. Their enthusiasm to make time for me, and their willingness to explore their own sensitive and personal experiences are at the core of this project. Their passion for their work, their clients and their professions was palpable. Their commitment to continue to work in an area where clients present day after day with traumatic stories of human pain is inspiring and astonishing.

Domestic violence is covert insidious and brutal. Every opportunity to increase awareness is vital, especially if we as professionals are in a position to make a difference. I would like to sincerely acknowledge the client's powerful and sobering stories that have been recounted and remembered throughout this project. I hope that their voices will be heard.

I am so grateful and thankful for the support of my family and close friends who have enabled and facilitated me to take the time out of our lives to fulfil this study. Most importantly my sister, children and husband, their patience humour and love have made this a team effort, thank you!

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Abstract

‘How do Specialist Domestic Violence Practitioners, Social Workers and Counsellors Experience Professional Trauma and Fatigue when Working with Survivors of Domestic Abuse?

Practitioners who work with those who have experienced domestic violence are often listening to how their clients have experienced fear, terror, physical violence and emotional abuse. How this might impact the practitioner, both professionally and personally is at the centre of this project.

Through a Qualitative Thematic Analysis, this study asks, how do practitioners experience listening and supporting those who have lived through domestic violence? I have worked in the domestic violence field for over ten years in various roles, and as such am aware of three roles that are listening to clients on a regular if not daily basis. Social Workers in a Child Protection setting, Specialist Domestic Violence practitioners in a specialist domestic violence agency and counsellors practicing in a specialist domestic violence setting.

Work based stress is identified in literature as an area of concern for practitioners whilst listening to trauma from their clients. Concepts such as compassion fatigue, vicarious trauma secondary trauma and burnout are also discussed in the literature as ways in which practitioners may be effected by their work. By recruiting and interviewing professionals within these roles and using a qualitative approach I was able to ask the participants about their experiences, and how they as individuals have been impacted both professionally and personally.

This project examines the current literature and best practice guidance specific to the individual professions, whilst maintaining an awareness of the difference and similarities of the practitioners who are in essence listening to the same stores of trauma. Five themes developed. The Brutality of Domestic Violence, Support, The Weight of Responsibility, The Impact and Training and Awareness.

The experience of practitioners came through the interviews, the results and discussion examine these phenomena and how participants felt they were supported by their organisations.

In conclusion, the participants discuss similar experiences and impacts of listening to the trauma, irrelevant of their role, whilst experiencing different support from their organisations, for listening to the same stories. This study highlights key areas where practitioners feel they could be supported in a more holistic and reflective way and identifies further areas of research.

Declaration

No part of the material submitted in this dissertation has been previously submitted for a degree in this or any other university.

Contents

Chapter 1: Introduction

1.1 Aim of Dissertation

This project aims to qualitatively explore the experience and impact on practitioners who are regularly supporting victims and or survivors of domestic abuse. Survivors of domestic abuse have powerful and traumatic experiences to share. McNab (as cited in Tehrani, 2010) suggests that 'Trauma is contagious; when anyone comes into contact with it they risk a piercing impact leaving them infected and vulnerable' (p283). My suggestion is, that practitioners that support survivors of domestic violence in a professional capacity listen to these traumatic experiences and are therefore vulnerable to this contagion.

I have worked in the domestic violence sector for over ten years in several roles. Initially as a Specialist Domestic Violence Practitioner (SDVP) supporting survivors of domestic violence (DV), and then as a manager supporting practitioners. As an onsite social work practice educator I supported student social workers (SW's). As a recently qualified counsellor working with survivors of DV in a specialist agency and committed to receiving one to one clinical, or reflective supervision. This varied experience led me to question, how are other practitioners supported when they are listening to similar stories from survivors of DV, especially if they weren't able to access a model of reflective and therapeutic supervision similar to counsellors?

The focus of the present study is to explore with practitioners what helps them to cope with the emotional onslaught that working in this area of work can bring. I am also interested to find out whether the different professionals chosen for this project, SDVP's counsellors and SW's have similar or different experiences, and the extent to what this might be. What is the practitioners experience of accessing support from their organisation? Who listens to the

professionals that are hearing the survivor's stories? Who cares for the carers, helps the helpers and support those who are supporting?

1.2 What is the extent of domestic violence in the UK?

The Office for National Statistics (2015) report that each year around 2.1million people in the UK suffer some form of domestic abuse, 1.4 million women and 700,000 men. The most recent findings from Women's Aid (2016) Days to Count Survey suggest that there are over 351 specialist services supporting victims of domestic violence. They work with survivors on a daily basis in both a crisis support role and / or a counselling and therapeutic role in the UK.

Donovan (2016) estimates that there are currently 28,570 children's social workers in the UK. Brandon, Belderson, Warren, Howe, Gardner, Dodsworth and Black, (2008), suggest that of the families included in their biennial analysis of serious case reviews, over 60% involved domestic violence as a factor where children have been killed or seriously injured. These findings start to illustrate the degree of contact SW's have with families traumatised by domestic violence on a daily basis.

1.3 Language

For stylistic purposes it is necessary to make some decisions about the terms used in this study. Using *victim* and *survivor* interchangeably, is common practice in the domestic violence arena. Some clients relate to having been a victim of crime, others more strongly with being a survivor of a trauma. In practice if we are to place autonomy with the client, it has to be for the client to decide if they find it helpful to have a label at all. For the purpose of this study I shall use the term survivor. This seems to accurately portray what practitioners are hoping to support their clients to move towards.

The terms ‘patient’, ‘client’ and ‘servicer user’ are all terms used by different professionals for those accessing services. In this present study I shall endeavour to use appropriate language when talking to members of different professionals during the interviews. For the purpose of reporting this study I shall use the term ‘client’, as this is a counselling project.

Compassion fatigue, secondary trauma, burnout and vicarious trauma, are all terms used to describe the impact and / or the potential diagnosis of this impact for professionals working with trauma. I shall explore these terms further as part of the literature review. In order to attempt to reduce terminology I shall collectively refer to these concepts, where possible, as ‘professional trauma and fatigue’.

Finally, this study encompasses three professions; Social Work, Counselling, and the Specialist Domestic violence sector. This study discusses three different roles; counsellors, SDVP’s, and SW’s. I shall use the term ‘practitioner’ when collectively discussing these professionals.

1.4 Organisational Support

At the beginning of this project, supervision appeared to be the main way staff are supported. However, supervision appears to mean different things to different sectors and organisations. Clinical supervision, management supervision, case supervision and just supervision are all terms that I have come across. There appears to be confusion as to what ‘supervision’ is meant to be for practitioners in helping professions.

Hawkins, Shohet, Ryde and Wilmot (2012) define supervision as "a joint endeavour in which a practitioner with the help of a supervisor, attends to their clients, themselves as part of their client practitioner relationships and the wider systemic context, and by doing so improves the quality of their work, transforms their client relationships, continuously develops themselves, their practice and the wider profession" (p5).

From my professional experience, SDVP's, SW's within children's safeguarding teams and counsellors within specialist DV agencies, are listening to, and supporting clients living with the impacts of trauma every day. They appear to receive very different organisational support. For this reason, I have chosen to explore the experiences of professionals in these roles.

Tehrani (2011) asserts that practitioners working with trauma can absorb the total physiological, psychological, and emotional consequences of their clients. It is my experience and understanding, that SW's and SDVP's have management supervision as a support mechanism to help them to continue to work effectively and safely. Richardson (as cited in Tehrani, 2011) suggests that supervision is just one effective method of support. This should be alongside a combination of colleague support, and autonomy in practice which all go towards providing positive working environments to support practitioners working with clients in trauma.

Counsellors may have management supervision in addition to the supervision required by accrediting bodies in order to practice ethically and safely. The British Association of Counselling and Psychotherapy (BACP) set out their expectations in their professional framework for practitioners to commit to clinical or therapeutic supervision, 'in order to work as effectively, safely and ethically as possible' (British Association of Counselling and

Psychotherapy, 2016, p11). The BACP also recommend supervision to any practitioner who is providing therapeutic support, or who works in roles that require regularly giving or receiving emotional support. This would suggest that SW's and SDVP's giving emotional support as a part of their role, in addition to listening to the trauma their clients are bringing to them, would benefit from this clinical or therapeutic supervision.

1.5 The research question.

'How do Specialist Domestic Violence Practitioners, Social Workers and Counsellors Experience Professional Trauma and Fatigue when Working with Survivors of Domestic Abuse?' Whilst those in caring roles endeavour to create relationships and support plans to help survivors, the question I keep returning to is, who or what helps the practitioner?

As managers and professionals, do we need to be aware of how professional trauma and fatigue could impact on staff? If we wish to address high sickness rates and staff turnover, do we need to understand how professional trauma and fatigue could contribute to this. The knowledge in isolation that it may impact on practitioners, is not enough to attempt to prevent it. Therefore, issues and ideas on training both professionally as well as academic learning will be important.

There is a danger in doing what we've always done; that the support for professionals becomes custom and practice, a tick box exercise on a supervision template and providing the same support that we've always provided without asking the practitioners themselves if it helps or makes a difference?

1.6 Methodology - Thematic Analysis

Chapter 3 describes the full methodology for this study. I have chosen to interview practitioners in order to hear what they have to say about professional trauma and fatigue when working with survivors of DV. Following the interviews, I will transcribe the data and code the transcripts in order to identify emerging themes, writing up the results and discussing the outcomes.

1.7 Stakeholders

The purpose of this study is to explore the lived experience of practitioners. I hope that the practitioner's experiences may reveal patterns of support. Although the participants work in different sectors, there is a a commonality that they are all working with individuals who have experienced DV. It is hoped that the results of the present study will offer themes or patterns of ideas for practice that will support the practitioners. Managers, commissioners, and individual practitioners, will have the opportunity to explore and review their own practice in the areas of social work, counselling, and specialist domestic violence support work, in comparison to this study.

Whilst the concept of management supervision may currently be accepted as appropriate for a SW, is clinical supervision more appropriate for them? They are working on the front line in child protection. Given the value placed on reflective practice as trainees and student's, institutes of education may also have an interest in this study. Practicing counsellors working within the framework of the BACP have a requirement to commit to a ratio of supervision to client facing hours, would management supervision also be necessary in a DV setting, and if so why?

There appears to be a disparity between the types of supervision offered in health and social care settings, and an inequality between the types of support that are offered between different practitioners. However, they are all listening to the same stories and traumas and face the same personal pressures.

1.8 Links with the counselling profession.

I have previously researched the person centred approach and how it may fit when working with survivors of domestic violence. I also wonder if the desired relationship between the counsellor and client to enable change, may bring value to the relationship between the manager and practitioner, supporting practitioners who are working *with* survivors.

Herman (1987) suggests that recovery can *only* take place within a relationship and not in isolation. She argues that in order to empower the client, they 'must be the author and arbiter of her own recovery,' (p133). This echoes Rogers (1951) view that the client is the expert of knowing what hurts, and therefore what heals. I believe that this may translate into the supervisory relationship between practitioners and supervisors.

I started this project believing that the commitment to supervision by counsellors of reflective and therapeutic supervision, may have benefit to other practitioners. This is an issue covered in Chapter 6 whilst addressing reflexivity. It is important at the start of this study to make explicit any thoughts, bias, or prejudice, that I will have brought to the project. However, could managers or supervisors benefit from receiving a basic interpretation of Rogers core conditions? Will practitioners feel more able to stay professionally strong if they are not being judged, if they are treated honestly, and receive an empathic understanding in their supervisory sessions? I believe the ultimate stakeholder will be the client. It will also be their

support and lives that are affected by a practitioner who may be experiencing professional trauma or fatigue.

Chapter 2: Literature Review

2.1 Introduction

To put this project into context, it is necessary to review literature on how working with clients who are survivors of domestic violence has been experienced by practitioners in three areas of work: social work, counselling and the specialist domestic abuse sector. Practitioners working with survivors of domestic violence are hearing similar stories and absorbing potentially traumatic material, whilst carrying out their daily duties of supporting survivors. I am interested to investigate whether practitioner's experiences vary dramatically due to their professional role, from a personal professional and organisational perspective. I am also keen to find any similarities in experience between the practitioners, their role, and organisational support.

Initially I shall explore the evidence that suggests how work based stress may be an issue, and which professionals appear to be more at risk. I shall then consider the concepts that may impact on practitioners working with trauma; such as burnout, compassion fatigue, secondary trauma and vicarious trauma. I shall then consider how these may impact on the three professional groups of social work, counselling and SDVP's.

Finally, I will look at organisational practice across the sectors and consider similarities and differences between the roles and the areas of work. This will involve finding what might be recommended or seen as good practice within each professional group. I will also search for any similarity of interventions across the professions, and what may appear to be effective in reducing the potential impact.

2.2 Literature Search

I searched for relevant literature to review through the bibliographic data bases Psych Info, EBSCO and the search engine Google Scholar. I used the terms, work based stress, social work, counsellor, domestic violence, compassion fatigue, burnout, and secondary trauma. I was also able to draw from my existing literature on social work, counselling psychotherapy and domestic violence.

2.3 Work Related Stress

In the United Kingdom The Health and Safety Executive HSE (2015) set out work related stress, depression or anxiety, as a harmful reaction that people have because of undue pressures and demands placed on them in the workplace. The HSE continue to say that stress accounts for 35% of all work ill health cases, and that 43% of all working days lost are due to ill health.

The highest rates of work based stress cited in the HSE report are within the Health and Social Care occupations. This report concludes that increased workload, lack of managerial support and organisational change are the primary factors for work based stress. The professionals in this present study, SW's, counsellors, and SDVP's, all work within a social care and health setting, where the highest rates of work based stress are reported nationally.

2.4 Additional risks for practitioners working with trauma.

Given that the literature suggests work based stress is high in social care and health, it was necessary to look deeper, for any additional issues which may affect practitioners working with clients experiencing domestic violence or trauma. In order to understand the experience of the practitioners, it is important to recognise the possibility that they may be hurt

emotionally and psychologically by listening to the traumatic stories they hear their clients telling them.

Herman (1997) suggests trauma is infectious, and that engaging in work that support those that are revealing their traumatic experience poses a risk to the practitioner's psychological health. Herman (1997) asserts that "Just as no survivor can recover alone, no therapist can work with trauma alone" (p141).

Historically the potential danger of working with those who have been shocked and traumatised came to note during the first and second world wars. Conditions such as 'shell shock by proxy', 'old sergeant's syndrome' and 'burnout' were acknowledged. Newell, Nelson-Gardell, & MacNeil (2015) present a chronological review of these various terms and constructs. They describe historically how people have been negatively impacted upon, through caring for, or helping, clients who have experienced trauma. Compassion fatigue, vicarious traumatization, burnout, and secondary trauma, are all terms that have been used to describe the phenomena of being hurt emotionally by caring for others and listening to their experience of trauma.

Fruedenberger (1974) and Maslach (1976) were pioneers in research on burnout and define it as a psychological syndrome or strain that develops as a reaction to chronic stress in the workplace. Burnout is a concept referred to and accepted in many areas of work, not just in the health and social care environment. It can also describe the impact of work based stress in many other professions.

Figley (1995) acknowledged that whilst compassion and empathy are necessary elements to work with clients effectively, working with trauma regularly can have a cost to the practitioner. Figley (1995) called this compassion fatigue, a term to describe behaviours and emotions that are displayed by those caring for others.

Acknowledging burnout and compassion fatigue, McCann & Pearlman (1990b) introduced their theory of Vicarious Trauma. They concentrated on a framework to present their theory based on the specific impact of working with those who have been victimised. This theory narrows down work based stresses even further, unique to practitioners who are supporting victims in the field of trauma.

Sodeke-Gregson, Holttum, & Billings (2013b) discuss compassion fatigue as being an overarching term for practitioners who experience symptoms and disruptions to their personal and professional lives due to their care and support of others. They also suggest that to date, research studies provide a mixed response to these hypothesised theories.

The literature suggests that practitioners working in an environment where they are supporting clients who have experienced trauma are at risk of being effected by concepts such as burnout, compassion fatigue, and vicarious trauma. I then investigated if there was any evidence to suggest that the impact of these concepts could be cushioned, or if there could be positive experiences recorded by practitioners working with trauma?

2.5 Resilience and Compassion Satisfaction

Sodeke-Gregson et al (2013b) build on an understanding that practitioners who work with trauma clients may be impacted both positively and negatively. Their quantitative study aimed to fill a gap in what they believe is inconsistent evidence around the negative impacts on working with trauma.

Larsen and Stamm (2008) propose compassion satisfaction (CS) to be 'the sense of fulfilment or pleasure that therapists derive from doing their work well' (p.282). Larsen and Stamm (2008) have also designed an assessment tool, Professional Quality of Life Scale (PROQOL) for practitioners at risk of professional trauma and fatigue which aims to measure compassion fatigue against compassion satisfaction. Potentially this could be used as an early intervention assessment during supervision.

Sodeke – Gregson et al (2013b) wanted to investigate the reported levels of Compassion Fatigue and Compassion Satisfaction from a national sample of UK therapists. They also wanted to find out through an online survey if there were any variables that could predict compassion satisfaction and compassion fatigue. Their study suggested that a large number of therapists were seemingly at high risk of secondary trauma, however the majority of therapists suggested an average potential for compassion satisfaction and burnout. Interestingly an increased caseload did not seem to dictate higher risk of burnout, although findings did suggest that quality supervision as opposed to the quantity of supervision related to the therapists wellbeing.

Research has started to indicate the importance of emotional resilience for those working in the helping professionals as a buffer to work based stress. Lloyd King and Chenoweth (2002)

and Collins (2008) both found higher levels of work related stress and burnout amongst SW's than many other occupational groups. Aitken (2012) also reported in their international study of nurses that 42% of the sample described themselves as burned out.

This is cause for concern, issues around work based stress are meaning that many professionals are leaving jobs in order to pursue less emotionally demanding roles (Barak 2001). Retention in these areas is also problematic, the Local Government Association (LGA) (2009) reported 60% of local authorities have difficulty retaining staff.

For reasons of staff retention and embracing a duty of care for staff, an understanding of emotional resilience is becoming more important in the helping professions. Grant and Kinman (2013) suggest that emotional resilience is a complex and a multi-faceted construct. However, it may be considered an important quality for staff to survive and thrive when caring for those who have been traumatised thus enabling practitioners to adapt in a positive way to work based stress. Kinman and Grant (2011) suggest that self awareness, reflective ability, accurate empathy a good support network and a commitment to self-care are all attributes associated with emotional resilience.

Several papers explore resilience, burnout and compassion fatigue within social work. Most recently Kapoulitsas' (2014) interviewed six SW's to gain a greater understanding of their experience of working with distressed clients. Whilst this paper doesn't focus on working with domestic violence survivors specifically, she found that a supportive work environment and positive supervision played a pivotal role in shaping the concept of resilience amongst participants. This is also a qualitative piece of research, designed to listen to SW's voices.

2.6 The literature by profession

2.6.1 Social Work

McFadden et al, (2014) conducted a systematic literature review of some sixty-five studies on resilience and burnout specifically in Child Protection social work. This evaluation contained suggestions that could support resilience and reduce burnout. Individual positive coping styles, personal development and ongoing training were all discussed as important factors in a worker having the ability to cope and enjoy job satisfaction through resilience.

McFadden et al (2014) concluded that a defensive organisational culture, poor social supports and unmanageable workloads were the main contributory factors to high staff turnover. Conversely positive coping styles of SW's, personal development, good quality initial and ongoing training, and a constructive organisational culture and supervisory support contributed to staff retention and a higher resilience for staff.

Newell and McNeil (2010) state that the emotional and psychological risks that could impact on SW's have been overlooked and should be conceptualised into two separate areas in order to address them. The first area of risk is the potential for trauma related stress. This includes vicarious trauma, secondary traumatic stress and compassion fatigue, which are concepts directly linked to working with those who have experienced trauma.

Secondly, professional burnout, can be accepted in many jobs or roles, but should not be overlooked as a potential issue in social work. They are keen to stress the importance of these concepts being infused into learning and training as a preventative, as opposed to curative, measure further down the line of a worker's career.

2.6.2 Counselling

Rothschild's (2006) book 'Help for the Helper' aims to support self-care strategies in order to manage burnout and stress. Although not aimed specifically at counsellors it draws from a counselling knowledge base and directs the reader through an understanding of neurobiology research and psychology literature. Rothschild suggests a strong link between empathy and professional trauma and fatigue. By its very definition empathy requires the practitioner to enter 'into the private perceptual world of the other and become thoroughly at home in it,' (Rogers, 1980).

If practitioners are aiming to empathically enter the world of the victim, then they will be doing so alongside the trauma stress and anxiety a client maybe experiencing. An exposure to trauma and anxiety by association, will have an impact on the counsellor and potentially lead to burnout and stress.

In her book, written for counsellors working with survivors of domestic violence Sanderson (2008) dedicates a chapter to professional issues. She suggests that the impact of working with trauma is "usually referred to as secondary traumatic stress (STS)" (p238). Sanderson (2008) continues to refer to Figley (2002) and McCann and Pearlman (1989) on how trauma impacts on helpers. She concludes that if STS is not addressed this can lead to burnout (Figley 1995), secondary traumatic stress disorder (Pines and Aronson 1988), or compassion fatigue.

Sanderson (2008) continues to suggest that symptoms for STS can mimic the symptoms of the survivor's symptoms to trauma. The continued cumulative impact of working with survivor's day after day may lead up to "shattered assumptions a pervasive uncertainty and

higher levels of anxiety" (p238). These higher levels of anxiety may also lead to professional burnout and fatigue. Whilst discussing the use of empathy within the relationship as a part of authenticity, honesty, and clarity, Sanderson (2008) does not appear to address the impact that may affect the counsellor as a result of the conditions counsellors attempt to provide.

Jenner (2016) very recently discusses her discovery and understanding of the cost of being an empathic therapist and the impact on your health. This article does not focus specifically on work with trauma, but suggests that the impact can be high simply working as a therapist, sitting alongside a client and endeavouring to grasp their experience. Jenner (2016) unravels her construction of the 'synchronised dance' (p29), and reports that when empathic connection is high, 'mirror neuron networks firing in our brains, postural and facial muscles contracting alongside our central nervous systems are activated and Intune with our clients,' (pg. 29) thus creating an impact that can drain the therapist both emotionally and physically.

Jenner (2016) continues to share her thoughts on self-care, and suggests this is not just something to be mindful of outside of the session. She suggests opportunities to try and alleviate the potential for stress and burnout within the counselling session. By attempting to consciously un-mirror and vary the counsellors level of empathic attunement this can help to reduce the potential impact of practicing empathy with clients of trauma.

This has implications for those practitioners working with survivors of domestic violence. If counsellors are working with clients who have experienced trauma, and more specifically for the purpose of this study, domestic violence, this suggests an increased risk of stress and burnout. By attempting to provide the client with an empathic understanding, trying to walk

in the client's shoes, this feels potentially dangerous and harmful for the practitioner when the clients experience is tense and frightening.

2.6.3 Specialist Domestic Violence Practitioners

Abrahams (2007) states that 'domestic violence corrodes the fabric of women's emotional and social world. Abrahams (2007) suggests the combination of advocacy support with "high level emotional support" is necessary in order to be able to provide safe and effective services (pg9). Whilst researching literature for this study, it has become clear that there is very little written on how to provide this complex and holistic support for survivors of domestic violence, and even less around supporting the practitioners who aim to provide it.

A practitioner supporting clients who are accessing domestic violence services may need a combination of practical knowledge including: housing issues, advocacy and support through a criminal process and accessing refuge and debt. Sanderson (2008) is clear that practitioner's will also need to have an awareness of Post-Traumatic Stress Disorder (PTSD), depression, anxiety, and substance misuse. Clients may present with a deep sense of loss of self as a result of emotional abuse. It is clear that practitioners supporting clients within a domestic violence setting will be working with a complex multi layered myriad of practical and emotional issues. This appears to add the pressure for SDVP's both in their knowledge and skills, in addition to working with clients who maybe traumatised.

Babin, Palazzolo, and Rivera (2012) examined the relationship between anxiety, social support, and feelings of burnout amongst American domestic violence practitioners. The authors recognised that the nature of this specialist work leaves practitioners vulnerable to burnout. Practitioners 'find themselves in high pressure situations and commonly interact

with victims who face immediate and often life threatening danger from an intimate partner' (p148).

Babin, Palazzo and Riveria (2012) acknowledge that practitioners are exposed to repeated stories of trauma and are therefore at risk psychologically and emotionally. This research suggests that training on communication and support networks may help to prevent practitioners from experiencing burnout, and therefore lead to a better quality of service for clients.

Ferencik, Lisw, & Ramirez-Hammond (2010) discuss the area of Trauma Informed Support (TIS) for clients, but also for practitioners as a way of creating awareness about the effects of trauma from the very beginning. They stress that a knowledge of trauma is an essential awareness for practitioners working with any survivor of domestic abuse. This is the first indication I have found in literature that directly addresses the specific issues for SDVP's working with survivors of domestic violence on a constant basis.

Ferencik et al (2010) take the practitioner through a detailed discussion of Vicarious Trauma, Compassion Fatigue, and Burnout. They draw attention to the "potentially permanent, subtle and / or marked changes in the personal political spiritual and professional viewpoint of the practitioner when listening to stories of one inhuman act of cruelty after another can have," (p121).

2.7 Conclusion

At the outset of this project I was aware that I was crossing the professions of social work, counselling and SDVP's. Although I was able to review literature on professional trauma and fatigue, it is ambiguous and few agree on the similarities of burnout, secondary trauma, vicarious trauma, and compassion fatigue. This confirmed the decision of making this a qualitative piece of work. By exploring the practitioners lived experience of professional trauma and fatigue, this study may find its own voice as opposed to try and fit into current constructs or concepts.

The literature on SW's, does not appear to focus on the impact of working with survivors of domestic violence at any point. Little is written about the effects of working with trauma and its impact on practitioners. McFadden (2014) alludes to pressures contributing to burnout, however the literature links more into organisational issues of caseload, culture, work and environment and the practitioner's resilience. I could not find any qualitative research on SW's experience of working with survivors of domestic violence that added to the review.

The Counselling literature contained more specific work linking the issues of professional trauma and fatigue, domestic abuse, and how they may impact on therapists. Sanderson (2008) also discusses the potential for STS. Jenner (2016) discusses the impact for counsellors working with all clients, therefore how much further is the risk for counsellors working with survivors of domestic violence?

The literature supports the view that professional trauma and fatigue can have an impact on practitioners working with trauma. The Social work literature suggests that this is generally due to organisational and or structural issues of the role. The counselling literature goes

further by suggesting that practicing the core conditions as therapists, leads to a danger of emotional and psychological harm. Finally, the specialist domestic violence literature suggests a pre-emptive focus in training on professional trauma and fatigue to create a trauma informed approach, which would ameliorate its impact on practitioners working in this challenging field.

There are gaps in the literature on how to support practitioners specifically working with clients who have experienced domestic violence. This review has not found any UK studies, quantitatively or qualitatively that specifically focus on the impact of practitioners, irrelevant of their profession working with clients presenting with issues of domestic violence hence my decision to research in this area. A qualitative approach to this study will be an excellent way of developing early stages of research by talking to the practitioners themselves and hearing their stories.

Chapter 3: Methodology

3.1 Introduction

This chapter sets out how I have developed the methodology that will enable me to engage with the question, communicate it to my participants and present the results of this research. I shall also discuss my decision to make this a qualitative study and the philosophy supporting it.

I shall set out which research method I have used and the questions created to ask the participants. I will briefly discuss the bracketing interview, and pilot study and how I recruited the participants along with a pen portrait of them. Finally, I will discuss Braun and Clarke's (2006) data analysis which I have used for this study, and conclude with a discussion on ethical standards and issues that may affect the study.

3.2 Qualitative vs Quantitative

The decision to make this a qualitative study resulted from my desire to work with people and use their words as the data. I use the term 'qualitative research' as Braun & Clarke (2013) discuss it being both a technique of data collection and analysis of research, a part of a framework, a paradigm, and 'the beliefs, assumptions, values and practices.' (p4). I hope that this will enable me to seek patterns of real experience from the participants. Pragmatically the data I wish to analyse could not be done from a quantitative approach if I am to gather the human experience.

Smith (1996) suggests when I am looking for an understanding of a process as opposed to an actual outcome, then a qualitative approach would be most appropriate. A qualitative study will enable me to analyse *what* is being said and *how* it is being said as opposed to a

quantitative study which would summarise the experience of participants in numerical form. For example, if my question was ‘How many practitioners experience professional trauma or fatigue’ then a quantitative project would be more appropriate. Fossey, Harvey, McDermott and Davidson (2002) suggest that qualitative research is a broad umbrella term for research methodologies that describe and explain people’s experiences behaviours, interactions and social contexts without the use of statistical procedures or quantification,” (p.1).

3.3 Philosophy

A phenomenological understanding of being able to see the world from the participant’s view and the professionals who are directly working with survivors of domestic abuse, is important to this study. McLeod (2011) quotes Moran (2000) for a definition of phenomenology, ‘the description of things as they appear to consciousness’, this succinctly describes how I wish the data to appear, in the moment, at that time, from the participants, in order for it to be true for them.

Whilst wanting the information to come from the participants as described above, epistemologically I believe that the participants will construct their understanding and meaning at that single point when I ask a question. They will have experience and ideas which have moulded and shaped their views over time, therefore this will add to the subjectivity of their interviews, making their information unique to them. Jean Piaget an eminent figure in developing constructionist theory and research on education suggest that people produce their own knowledge from the meaning based on their own experience, a meaning that they have constructed themselves.

As a counsellor trained and practicing using a predominantly person centred approach working in this paradigm links strongly to my own personal philosophical and theoretical leanings towards the work of Carl Rogers. Kirshenbaum & Henderson (1990) share the point in Rogers career where he began to understand the client being the expert of their own world. Rogers said 'It began to occur to me that unless I need to demonstrate my own cleverness and learning, I would do better to rely upon the client for the direction of movement in the process' (p. 13).

Philosophically I have a belief in my participants and their expertise in their own experience. I hope to cultivate a relationship with my participants by tuning into the person centred counselling core conditions of incongruence, empathy and unconditional regard. I hope this may provide an arena for them to discuss and share their thoughts and feelings appropriately.

3.4 Bracketing Interview

The subject of my project links into over ten years of my professional life meaning that as a qualitative piece of work it is necessary for me to explore my own judgements and biases in an attempt to present the most valid and reflexive piece of work from any data analysed. Rolls and Relf (2006) refer to this process of bracketing personal experience from the interview with participants.

As a part of this study I chose to participate in a bracketing interview in order to draw out my thoughts and feelings around the project. It was my intention that the bracketing interview contributed towards the validity for this project and my ability to recognise personal feelings and preconceptions in order to embrace reflexivity within the study.

Two questions within the bracketing interview had an impact on how I moved forward with the study. Firstly, a question around my choice of research alerted me to feelings of not being supported myself as a practitioner. This is not something that I wanted to bring to my participants. I was then asked how I might enable practitioners to talk about their experience. I drew on my learning as a counsellor. I realised that as long as I was aware of this potential bias, and attempted to balance it and remain as non-judgemental and empathic as I was able, this would hopefully support the participants during the interview and not be my interpretation of their words. Please see a full account of the bracketing interview at Appendix A.

3.5 Research Method

McLeod (2011) places Thematic Analysis (TA) as a variant of Grounded Theory (GT), alongside Interpretative Phenomenological Analysis (IPA), Consensual and Ideal type analysis. He cites Braun & Clarke (2006) as suggesting it should be seen as *the* 'foundational' method of analysis. Braun & Clarke (2013) moot that it is only recently that TA has started to compete with GT and IPA. The attraction of TA is down to a removal of what they call theoretical and philosophical baggage and being able to use it for a wide range of research interests.

I will analyse my data using TA due to its flexibility and freedom from fixed ideas around theory and philosophy whilst at the same time embracing those ideas that have supported my decision making process as mentioned above. It is important for me to hear what the participants say, listen to their experiences, and observations and snapshots of what really happens in their experiences on front line when working assiduously with survivors of trauma.

3.6 Research Design

Braun and Clarke (2013) suggest that interviews are an ideal way to gather data when exploring the experiences of participants. I am keen to draw information about their experiences in order to answer my research question. However, a semi structured interview allows me to facilitate participants to explore their own experiences in answers, and hopefully capturing data that will evolve into themes. A semi structure interview also enables the process to align itself to a person centred approach, letting the participant expand on areas that are important to them. I will design and record semi-structured interviews and then transcribe the data for analysis. McLeod (2011) suggests that an interview will facilitate the flexibility necessary to obtain the data I would like to collect.

3.7 Questions

This study concentrates on participant's experiences and it is therefore important that the interview schedule allowed participants to explore their experiences through open questions rather than give yes or no answers. It was important for me to be able draw an answer to a close, or reword a question slightly, if I felt the participant may be drifting away from the research question.

I attempted to keep the questions open in order to encourage dialogue. I sequenced the questions within three main areas of interest. Firstly, it was necessary for me to know if the participants already had an understanding of what professional trauma and fatigue meant to them. Secondly I was keen to explore if they had an understanding of what might reduce professional trauma and fatigue. Finally, I hoped that the participants would feel able to explore their own experience and thoughts together with any ideas they may have that would have enabled them to feel supported.

I worked with my supervisor on these three areas, writing questions that would attempt to draw out the experiences that would be most valuable to the research question. I then designed an interview schedule which I used in my pilot study.

3.8 Pilot Study

Braun & Clarke (2013) stress the importance of good preparation being key in order to design and facilitate a valuable research interview schedule. Given that this study spans three very different professions, it was important to conduct a pilot study, consisting of an interview prior to finalising the questions I wanted to use for the semi structured interviews.

I have been a SDVP and I am currently a qualified counsellor working with victims of domestic violence. I was aware that my knowledge on social work practice was limited to working alongside SW's as part of multi-agency working, and as a practice educator, mentoring university social work students in a domestic violence support agency.

It seemed prudent to conduct the pilot study with a SW in order for me to feel that my questions and knowledge would give the SW's an equal voice in the study and that any differences in the roles or terminology were identified early on. I recruited a qualified SW who had spent time in safeguarding, ensuring she had come into contact with families who are living with or have fled from domestic abuse.

Please see my full Pilot Study account at Appendix B. However, rather than dramatically change the questions, the outcome of the study led me to create a more conversational schedule. For example, I scripted a paragraph on professional trauma and fatigue at the

beginning of the interview in order to support the participants understanding of the phenomena. I also created a checklist covering confidentiality and prompting me to acknowledge the roles that the other participants had. For example, if the interview was with a SDVP I explained that the other practitioners being interviewed were SW's and counsellors to try and give the participant a understanding of the study.

3.9 Materials

The materials required for the interviews were my set of questions, and a dictaphone in order to be able to record the participant's answers.

3.10 Participants

This project spanned three professions with the commonality of these roles having a total or large proportion of a client base who have experienced or are experiencing domestic abuse. These roles consist of full time SDVP's, counsellors working or volunteering in a DV agency and SW's working with families who are living with, or fled from domestic violence.

The sampling for participants was purposive, "handpicked" (Denscome, 2003, p.15). I was able to recruit through my existing professional network, inviting individuals that I believed would add value and meaning to this specific project. In the early stages of the project I was also working within a specialist DV agency and as part of a local authority community safety partnership which gave me access to potential participants.

I recruited six participants. All participants still work in the roles or had until very recently. I recruited, two SDVP's, two counsellors and two SW's.

It felt important to recruit participants with varied levels of experience and knowledge of DV across different geographical areas and different agencies. This enabled me to avoid a 'repetition' of process within the same organisation, and 'getting to know' organisations, which I hope, enabled me to remain slightly detached from the organisation and enhance my concentration of the experience of the individual.

Following is a brief pen portrait of each participant who took part in this study. Each of the participants have been given a pseudonym in order to support confidentiality.

Lucy was until recently an Independent Domestic Violence Advocate (IDVA) and has worked in the domestic abuse sector for over ten years. Lucy was a SDVP until she attended the Safelives IDVA training which is a nationally accredited course and the first in the country to be recognised as such. Lucy's experience is across several specialised domestic violence support agencies in the voluntary sector.

Vicky has worked in the domestic violence sector for nearly ten years both as a DVSP and a fully trained Independent Sexual Violence Advocate (ISVA). Vicky's accredited ISVA training was accessed through Women's Aid, a national organisation. Although starting her career as a volunteer Vicky's role is now paid and based in a specialist domestic violence setting in the voluntary sector.

Samantha volunteered as a trainee counsellor within a specialist domestic violence agency in the voluntary sector working entirely with victims of domestic abuse. This role was a part of a placement and Samantha received training in domestic violence prior to starting her role.

Rachel volunteered in a specialist domestic violence support agency in the voluntary sector as a counsellor working specifically with victims of domestic abuse. Rachel left the organisation upon completion of her voluntary hours. Rachel also has experience in support work.

Tracy has worked in both the voluntary sector within a specialised domestic violence agency and as a qualified Social Worker for over 15 years. Tracy has worked in child protection and has over ten years' experience.

Gemma was a social work student in a child protection team and is now a qualified social worker working for a local authority in a statutory setting with families where domestic violence is a regular part of her work.

3.10.1 Skype

One of the participants was unable to attend a face to face interview and therefore I explored the possibility of conducting the interview by skype. I sought guidance from my supervisor who agreed to this. Whilst being able to ensure that I as the researcher was in a private room for the interview, Sullivan, (2012) suggests that Skype have a right to record and disclose conversations. Having discussed this with the participant who had taken part in a Skype interview previously, they were still happy to proceed and give consent electronically by email. Whilst Sullivan (2012) discusses technical issues potentially creating an issue with the flow of an interview, Markham (2008) argues that the advantages of being able to conduct interviews using software such as Skype far outweigh the disadvantages. Due to this consideration of the participant, my supervisor and the literature, it was decided to proceed.

3.11 Procedure.

Ethically in order to enable participants to provide informed consent I designed an information sheet (see Appendix C) which was sent out to all potential participants. This enabled me to provide information about the project, allowing a degree of preparation for the participants to try and ease their concerns or uncertainty about the experience. It aimed to give them the information they needed in order to consider consent. It included information on the aims and methods of the project, and give transparency to further ethical considerations of consent, data security, anonymity and confidentiality.

Apart from the interview by Skype, the other interviews took place in venues chosen by the participants. I used the Interview Schedule (see Appendix D). The participants were given another copy of the information sheet, and a consent form (see Appendix E) to sign in order to confirm they were happy to proceed. The consent form also asked the participants to confirm that they were happy to be recorded and ask any further questions along with other ethical considerations, discussed later in this chapter.

At the end of the interviews I gave each participant a debrief sheet (Appendix F) which thanked them for their time and gave telephone support numbers around any issues that may have arisen due to the sensitive nature of the subject matter, domestic abuse and any employment issues they may feel had arisen for them. I was very aware through the ethical proposal and experience in the field, that material covered in the interviews may trigger unwanted or upsetting thoughts for the participants, also covered later in this chapter.

3.12 Data analysis methods

Working through Braun and Clarke (2006) six stage process of thematic analysis **Phase 1** began by familiarising myself with the data. I transcribed the interviews and read the data thoroughly many times. I chose not to use translation software as previous experience of transcribing counselling sessions made me aware of how valuable listening to the participant's voice tone and feeling would be to the process.

The transcription process enabled me to really listen to the answers without the responsibility of keeping the interview on track or thinking ahead, and this was the first time I was able to absorb the nature of the data. The tone of voice used by the participant, the feeling that came through alongside passion and a deep caring for the client base, ran through the audio recordings and this confirmed the responsibility I held in order to code and theme the transcripts responsibly and stay true to the participant's dialogue and meaning.

Braun and Clarke's (2006) **Phase 2**, began when I had read and immersed myself in the data. I was then able to start to generate initial codes by systematically exploring the data set, reading and rereading the dialogues to start to highlight initial codes of data that were showing through at this point, see transcript Interview 1, Lucy at Appendix G. I placed each transcript onto a word document, and then placed a column next to the data in order to highlight areas of interest. The codes identified are a feature of the data that appeared to be of interest to me as the researcher. Tuckett (20025) describe this as organising the data into meaningful groups. I gave each line of the transcript a number and when referring to the submitted transcript shall use (L21) to indicate the line where the quote from Lucy transcript will be found. For all other quotes from the transcripts not submitted, I use the participants name.

I coded each participant's transcript separately, and at this early stage I was very aware of the impact that working with survivors of domestic violence was having. This appeared to be showing across the participants. An impact on personal and professional wellbeing as Lucy describes, "the impact is twofold, on the surface you may feel upset . . .on a deeper level, in terms of your mood, your perception of the world," (L21).

Braun and Clarke's (2006) **Phase 3** began as I started to search for themes. This involved examining the codes that I had highlighted and look for how these may fall into a repeated pattern. This part of the process felt a little overwhelming to start with, a balance of attempting to gather together themes but at the same time remain as true as possible to the data that had come from six individuals with six different experiences. I collected all of these codes and transposed them onto a form (see Appendix H).

I then lifted the codes from the form and wrote them onto an individual sticky note. I chose a different colour for each profession so that I could monitor how the codes spread across the roles. I then began to move the sticky notes around onto larger sheets and place them in areas of similar interest, re-focusing the analysis 'at the broader level of themes' (Braun and Clarke 2006, p19).

This was a long process, and involved moving the individual notes around until initially, I was able to see themes around support and impact. As the codes moved and gathered on the larger sheets of paper, those left then moulded into further thoughts for themes.

Phase 4 required me to review the themes, in order to refine them. A theme that was very strong with a lot of codes from the data was around *support*. I had originally placed these codes together, however I started to see that this candidate theme around support had two sub themes within it; experiences around positive support and negative support. Whilst wanting to keep these elements together, it was important to identify both sides of the codes that contributed to the theme.

Phase 5, is where I was able to start and define and name the themes. For example, the transcripts had provided codes around the abuse that the practitioners heard and recounted. 'Horrific situations' 'extreme abuse' 'dangerous' and 'rape' are examples. Braun and Clarke (2006) discuss capturing the essence of a theme, and what aspect the theme captured.
The practitioners appeared to be experiencing and communicating the 'Brutality' of their work. This felt like a strong theme evolving from the data. It was necessary to present this data in order to convey the essence of working with survivors who have experienced DV. The themes were then photographed as they were gathered through the sticky notes. Please see (Appendices I, J, K, L & M) indicting and evidencing how the codes merged into the themes as identified by myself.

Finally, **Phase 6** involved producing the report for this research. The report presents the final themes, telling the story of the data that has been transcribed and coded using extracts from the interviews. I aim to present a very real and raw description of the participant's feelings and experiences, alongside more practical themes that include thoughts on how participants experience support from their employer in the following chapters.

3.13 Ethical Considerations

McLeod (1996) suggests there may be an issue when using a qualitative approach within the counselling and psychology field as it is a sensitive area of work, exploring the relationships between people and the vulnerability of disclosure. I was very aware of the layers of potential vulnerability both to the participants and the stories they may reveal during the interview process. It was necessary for me to design the study carefully and ethically in order to minimise any harm that could be done.

As a student at Keele University, a counsellor and registered member of the British Association for Counselling and Psychotherapy (BACP), I have aligned my work within several ethical frameworks to give this research a groundwork of good ethical practice. The researcher submitted a project plan (see Appendix N) outlining the study's aim, methodological approach and data management plan alongside an ethics checklist for approval. Ethical approval was approved by Keele University School of Psychology ethics board (see Appendix O).

The BACP's Ethical guidelines for researching and counselling and psychotherapy (BACP, 2004) provide guidance on trustworthiness, managing risk, relationships with participants, research integrity and governance. This framework supported my consideration of ethical issues.

I researched the issue of consent, my participants 'rights to modify, consent or withdraw' and attempted to take into account participants particular vulnerability, especially around the subject of DV. I believe that the information sheet (see Appendix C) supported the

participants to grasp the concept of the study, and have an awareness of the topic to be discussed.

The information sheet outlined an explanation of the research aims, also aiming to give a brief understanding about the question and what would be covered in the interviews, thus supporting the BACP (2004) 'adequately informed, full and freely given consent' (p. 6). Specifically, to this study there was a real responsibility for the participant's employment, maintaining their confidentiality and that of their workplace. Questions around the support they may or may not be able to access from their employer could be critical.

Participants have been given pseudonyms and all other potentially identifying data has been removed from the transcripts. I was prepared for client stories to be recounted during the process and therefore also removed any identifying data that may have arisen with names, places towns and other individuals in order to attempt to mitigate issues around confidentiality and anonymity.

In order to address issues around the research relationship and the research integrity my hope was to foster a climate for participants to explore the issues around vicarious trauma enabling them to share honestly and openly their thoughts and feelings. Trust between the researcher and participants would be important if the study was to gather qualitative data. There was also a danger of the thoughts and feelings of the participants being lost or forgotten as they are 'professionals' and not clients, and this was something I have tried to maintain as an awareness throughout the research.

Ingrained in the researcher was a consciousness that the DV could bring forward memories of particular incidents of supporting clients, and also personal triggers. It was essential that I put in place thoughts on how to support these issues to try and minimise discomfort. This may involve exploring avenues of therapeutic support for the participants and myself. There were also helplines for the participants to contact after the interview if they felt that they needed further support. This information was included in the debrief sheet, (see Appendix F).

Chapter 4

Results

4.1 Introduction

In this chapter I shall set out the results from the data analysis. After conducting the interviews and working through Braun and Clarke's (2006) six stage analysis I identified five themes from the codes generated by the transcripts. All five themes included codes from all three professions, SW's counsellor's and SDVP's.

4.2 The Themes

Braun and Clarke (2013) make it clear that themes do not just appear and that their value, is as necessary to be strong standing alone, as well as working between themselves in a relationship. The physical process of moving the codes on sticky notes onto larger pieces of paper enabled me to see this. It was a constant process of aligning codes, searching for and interpreting similar meanings between codes, and then finally resting them within their themes. Each theme has to "capture something important about the data in relation to the research question and represents some level of patterned response or meaning within the data set" (Braun & Clarke (2006, pg82).

The main overarching themes I will present as experiences of practitioners working with clients who have experienced domestic violence are as follows:

- The Brutality of Domestic Violence.
- Support – The Good and the Bad
- The Weight of Responsibility.
- The Impact – Professionally and Personally
- Training and Awareness

As discussed earlier in the previous Chapter, the final codes are shown (see Appendix H). I inserted these codes into a table, purposely presented to highlight the practitioner who generated them and the role they have. It remains important to this study to be able to discuss any similarities and differences between the professions in the discussion chapter. The codes on sticky notes also show the profession that generated them, abbreviated to SW – Social Worker, C – Counsellor and DV – DVSP.

4.3 Theme 1. The Brutality of Domestic Violence

It is appropriate to start this chapter acknowledging the reality of working with survivors of domestic violence. This theme encapsulates the experiences of the practitioners hearing client's stories and the language and depth of descriptions vary dramatically. The final codes that I have pulled from the transcripts are shown (see Appendix I). They encapsulate the overarching experience of the practitioner working with survivors, drawing out some explicitly painful descriptions of situations quoted within the transcripts.

Lucy described listening to "all these terrible things" (L28). Tracey talks about working with "High risk victims" line 24 and Gemma talks about listening to "horrific stories". Sam describes a client's situation as "pretty horrific, it's awful" line 419 and Vicky describes "the worst case I ever worked with,".

The participants also discussed their reactions to the stories they heard. Sam says "I can't believe that happened to that woman," and "I wonder if I will see you next week" relating to a client at particularly high risk of serious injury or death. Lucy suggests that "It's all too much," (L38).

There were a lot of references to client's particular incidents that practitioners recounted in the interviews. Sam relives her horror at realising why client wore a hat to a session. "Oh shit, she's had half her hair pulled out," and several clients who told her they "had been dragged around the house by their hair".

Gemma told me about clients who she had visited and seen "punch marks in the wall". Whilst being in the client's house, her client had showed her around, particularly where the client had been "locked in a cupboard". Gemma says that the "percentages of domestic violence would have shocked me before, but now I know its entrenched."

Tracey spoke quite calmly about various client's stories of "people being set on fire, broken bones and rape." "Kids eating dinner chucked on the floor". She also discussed her horror at having forgotten about, and having to be reminded about a particular client who had been "tied to the bed with petrol poured over her, whilst he stood next to her with a lighter, threatening to set her on fire".

These extracts from the transcripts were hard to hear whilst interviewing the participants, but illuminate the horror and reality of practitioners who work with clients experiencing domestic violence. As a theme the brutality of domestic violence runs through all of the participant's transcripts. Although the final codes were not as great in number as some of the other themes, the power behind the words are vast and all-encompassing. I believe they need to be remembered and kept prominent as the other themes unfold.

4.4 Theme 2. Support – The Good and the Bad and the Ideas

The interviews with participants generated a multitude of codes within this theme and they are shown (see Appendix J). Due to the limitations of this study I have chosen to concentrate the results of two subthemes. The codes that were most prevalent were around supervision. Secondly I have included the results of the codes that brought the participants ideas for good support. This study is about the participant's experience and it is their voices that I want to be heard, specifically on how they feel they would be best supported.

4.4.1 Supervision.

The SW's and SDVP's viewed supervision as a management tool, but had a very clear idea on their preference for a clinical or therapeutic supervision as being a better practice for them listening to clients experiencing domestic violence. Gemma talked about "routine supervision, if you're lucky enough to have it." She continued that "There's one line on your supervision sheet that says 'How are you' I say 'I'm alright', this isn't the reflective supervision that we're taught is good practice.

Tracey concurs with these experiences. "Supervision in practice was a rundown of what the situation was in each case. . . no particular thought to feelings or emotions." She continues "very rarely have I ever had supervision where anyone has asked me how this has affected me, where's your learning, do you need anything else?" She concludes by saying "In fifteen years of working in this field . . . there's never been a time where anyone has taken the time to say 'how are you, do you need anything?".

Lucy said that "supervision would come . . . you think 'shit if I've done something wrong this is where I'm gonna get told off . . .didn't really have a therapeutic element at all" (L80-8.)

She continues “In reality it was a case of ‘are you alright’ which I would always say ‘yes’” (L 94.) Lucy adds more meaning to her thoughts on supervision saying that it should be “a reflective process . . . how you were impacting on the client . . . we as individuals bring our own stuff . . . that then reflects on how you deal with a client . . . the opportunity to look at things differently . . . how that client impacts on us as individuals” (L88-91).

Vicky communicates her thoughts on the supervision process, “The things you’re hearing you need to offload . . . it always seemed to me that clinical supervision is reserved for the realms of counsellors . . .I’ve never understood why”. She also points to national good practice for Specialist Domestic Violence Practitioners relating to Safelives who advise all agencies to provide clinical supervision for practitioners as good practice. Vicky says, “what surprises me is Safelives are saying this (is good practice) but to my knowledge domestic violence organisations are not implementing it.”

Vicky reinforces this view with an account of her own experience at a time she was struggling to cope with listening to the trauma. “I did ask for support on a couple of occasions . . .I was basically told to go home”. “I also requested supervision and the response I got was (from her line manager) ‘are you saying I don’t support you.” Vicky concludes, “It just made me never ask for supervision again.”

Both of the participants that were counsellors reported more beneficial supervision sessions. Samantha particularly felt her supervision was thorough and suitably therapeutic and reflective. “Definitely clinical supervision” is the key, and her supervisor was “very aware of the whole vicarious trauma thing.” Rachel and Samantha also recall how their supervisors were accessible and would endeavour to provide immediate supervision if they needed it.

4.4.2 Good support in the participant's words.

Peer support, peer supervision or informal supervision ran through most of the participant's dialogue around good support. Gemma said that the best types of support were 'informal supervision with a colleague, maybe in the car going on a joint visit," She also suggested that "if you don't have that peer group in your office . . .you can roll back your chair and think 'Oh my god!'"

Vicky discussed peer support at length, "peer support in my experience has been really good." She also remembered how "It was one of my peers who highlighted that I needed support." She continues "The role is tough . . . if you work with people who are self reflective . . .look out for each other . . .peer support has been a great help." Worryingly Vicky also suggested that "peer support is going to get less and less as people get more stretched". Tracey also identified her peers as a valuable form of support. "Peer support is major, no one else can understand the job and the pressures unless they've been there".

Lucy has the final word in this theme of support. When asked in her opinion what she thought was necessary and appropriate support for practitioners working with clients who are experiencing domestic violence she said "Supervision, clinical supervision where possible. Giving people autonomy, some sense of control in their jobs. The space and time for team building . . . meaningful structured team support . . .So it's part of it, from the beginning, the base up"(L332-335).

4.5 Theme 3. The Impact – Professionally and personally

This theme explains the impact that practitioners feel their work has had on them. There were a lot of codes that came though under this theme, mainly due to a specific question in the interview schedule (see Appendix D) asked, "Could you comment on how, in your own experience listening to the trauma can impact on you?"

The final codes that formed this theme are at (see Appendix K). It became apparent at this stage that this theme split itself into two subthemes, the professional impact and the personal impact. The impact appears less balanced across the professions in this theme, with SW's and Domestic Violence Support Workers clearly describing a deeper impact than the counsellor who were participants. I shall explore this further in the discussion chapter.

4.5.1 Impact on participants professionally.

Codes such as burnout, pressure, and treadmill arrived from the participants. Tracey talked about "burnout in terms of caseload", and the impact of feelings as though she were on a 'treadmill, due to no reflexive practice." "I'm literally on the verge of going off sick," and "this is really knocking me about," were other ways she describes the impact on her professionally.

Participants also discussed the idea that the work had to have an impact on the roles. "It can't not impact on you" said Tracey. "How can you be a normal human being who cares and it not have an impact on you" asked Lucy (L138.)

Codes arising such as hardened and desensitized also came through in this theme, alongside feelings of being unable to do the job properly. Tracey suggested "When I've got hardened to

it, it's time to leave". Lucy said "you can actually become a bit shut off . . .you're not listening to them" as she described a detachment from her clients. Vicky describes her feelings by saying I "became very hardened, initially, desensitized," and Lucy moves this forward, suggesting that "long term you don't feel those surface feelings . . . you almost become hardened to it" (L23-24.)

The covert nature of the impact professionally also became apparent, Vicky suggested that "you don't even become aware of it". Lucy describes her concern about Vicarious Trauma also being covert, "I would never have realised it at the time, talking about Vicarious Trauma you don't see it as an issue at the time" (L190-192).

4.5.2 Impact on participants Personally.

Fatigue and exhaustion codes were derived from comments the participants made about the impact on their physical and emotional self. Vicky said that when she got home from work she was "absolutely knackered, I don't want the radio on, I don't want my telephone to ring, I don't want to speak to anybody.

Vicky also suggested that the work "Exhausts you emotionally," and Tracey suggested that the role was "exhausting, zapping all of your energy." Rachel talked about perpetually living in the exhaustion of being with trauma. Lucy suggests that emotionally "it affects you on a deeper level . . .your mood . . .perception of the world" (L24-25.)

Impacts on participants as a member of a family or other relationships were strong. Tracey suggested the impact of her work echoed "as a mum, as a partner, within your home." She

continued to say that the work "challenges your values about men, community, relationships, views of the world and how people operate".

Samantha also supports this, "I cried in the car on the way to pick my kids up from school" following one session. Samantha also suggests that working with an adult client who portrayed herself as a seven-year-old girl in a red dress had a dramatic impact, "That really affected me, I have a seven-year-old daughter at home."

Vicky also shared that the work "affected how I felt about lots of things, suicide, the value of life, about men being beasts". Lucy shared similar sentiment about how she began to believe that "bad things are always going to happen," (L26.) She talked about "overanalysing things . . .making big leaps in judgement," (L29). This "360-degree effect, you're seeing everything through a lens . . . a lens of terribleness." (L46).

4.6 Theme 4 - The Weight of Responsibility

The theme of responsibility (see Appendix L) was poignant throughout all of the interviews. Codes generated through worry for the victim and responsibility to the client, managers and peers. These feelings felt heavy when listening to the interviews and re reading the transcripts. Vicky spoke strongly of how she felt "A huge position of responsibility, huge position pf trust."

Vicky continued to question her professional capability due to this responsibility, "Oh my god, who am I for you to speak to, I know nothing." And the weight of this responsibility of realising that she could "change that woman's life forever" by something she might say or do.

Lucy also felt the responsibility towards her clients, specifically when she was feeling overwhelmed and stressed. “You know that you’ve got to ring all of the people but actually you kind of don’t want to,” (L40-41). This responsibility and fear of not being able to support her clients led her to start and believe she wasn’t “able to do the role,” (L45.)

Tracey and Gemma talked about the professional responsibility of working with families who are experiencing domestic violence within the child protection arena, and how this specific area affected them personally. Tracey says, “when its domestic violence you’re having to remove the kids, it’s very much got to be done.” The legal process adds to this responsibility, “because I’ve got to do it, it’s a court order, I want to do it, but this is really knocking me about.”

Gemma appears to acknowledge this responsibility further, and the accountability that comes within the child protection role and the tensions of what resources allow her to do, or not to do, and the responsibility that comes with not being able to do everything for her clients. “I knew mum was lying, I couldn’t evidence it professionally so when you go home with your gut and you reflect and become more anxious”.

Gemma continues “yes it was absolutely shit, but I’ve done everything I can do, it’s the situations where you go ‘shit’ there’s loads of things I want to do and I can’t do it, I can’t help this person.” She concluded this part of the interview by saying “In other roles a child won’t die, but if we take a fifteen minute break, and that call comes in and I haven’t had time to do what needed to be done, we’re knackered; it’s the accountability.”

Responsibility from the managers or organisations also came through during the interviews, although Gemma felt a responsibility towards her manager. Talking about her supervision sessions she says, “she (the manager) does the typical ‘how are you doing’ I look at her because I know she’s doing twelve hour days, six days a week and my line is ‘how are you doing’ because I know she isn’t getting her supervision.”

Lucy talks at length over who should take responsibility for the staff teams wellbeing and when she had taken information about Vicarious Trauma and Burnout back to her agency “they weren’t interested at all” (L136.) She reinforced this by saying “I don’t think it (responsibility for staff wellbeing) should be about seeking support, I think it should be managers identifying there is an issue” (L259-260.)

Samantha has had a more positive experience of agency responsibility. Particularly around recruitment and the agency’s awareness of recruiting people as volunteer domestic violence counsellors. “She really grilled me on interview, it wasn’t just a case of ‘you’re in’”. Furthermore, she clearly felt supported and that the agency recognised their responsibility for their team, her supervisor said “If you need anything, just ask the family that’s there, all of them, we’re all here for you.”

4.7 Theme 5 - Training and Awareness

Training and awareness (see Appendix M), is the theme that covers the experiences of participants not feeling prepared or trained to work with clients who have experienced domestic violence. This theme covers their thoughts on both training on domestic violence in preparation for working with clients and the potential impact that professional trauma and fatigue may have on them as individuals. Not prepared, unprepared lack of understanding and lack of domestic violence awareness were the codes that informed this theme.

When interviewing Gemma, a qualified SW I asked her how domestic violence was covered on her university course her reply was "Not at all, dead simple." When she was asked if her organisation had provided her with training on professional trauma and fatigue, again her answer was brief, "They weren't covered at all."

Tracey another qualified SW talked similarly briefly about domestic violence being covered as part of her social work university degree. "Not at all, domestic abuse, I don't remember being covered in the whole degree." She expanded on this by saying there was "no preparation for what you are going to be up against. They're not preparing you with the tools of the job, doing domestic violence work and knowing domestic violence is very very different."

Similarly, to Gemma, when I asked Tracey if she had received any organisational training on professional trauma and fatigue she replied with "No never, it's very much your job, get on with it." She also added that there was "no thought for the workers or their own wellbeing at all."

Rachel discussed starting her placement as a volunteer counsellor within a specialist domestic violence agency. She recalled receiving one days training around domestic violence. She also suggested that although this was quite rightly around issues that the client might bring to her, there was no discussion about how that work may impact on her.

Vicky was clear that even though she started working in a specialist domestic violence agency there was not any training on professional trauma and fatigue. “It was never discussed with me, no discussion about things to watch out for, emotions you may feel or may not feel.” Vicky continued to say “I think I went into it really quite naïve when I look back, I wasn’t prepared, I wasn’t forearmed”. She then talked about accessing national training from Women’s Aid and that professional trauma and fatigue was covered. “If you do start to pursue a qualification or access external training that you think ‘Oh yeah, that does ring a bell’”. When asked if professional and trauma and fatigue were discussed in her agency she said, “no it wasn’t.”

Very similarly to Vicky, when Lucy was asked if domestic violence and the potential impact on her were discussed in her training with a specialist domestic violence agency she said, “It was never covered at all,” (L117.) Several years later Lucy did access professional training from Safelives for an Independent Domestic Violence Advisor (IDVA) qualification, “we talked about Vicarious Trauma and self-care . . .that was the first time. . . a light bulb moment . . .I heard the theory and thought ‘yeah that’s me’” (L118-120.)

Samantha was the only participant who recalled a positive experience around training when she started as a volunteer counsellor at a specialist domestic violence agency. “I was really impressed with the level of training before I was ever allowed near a client.” She continued,

“we were really well informed”. However, when she was asked if domestic violence was covered in her counsellors training, “well I don’t think we did it on our course, the amount of domestic violence I hear, why haven’t university taught me about this, it’s ridiculous”.

Chapter 5

Discussion

5.1 Introduction.

In this chapter I shall provide a discussion of the results by theme, aiming to put the themes into context in relation to existing literature. I will then critically evaluate this study, discussing how it may be improved or expanded and finally explore any ideas on future research which may move the results of this study further forward.

5.2 Discussion of Results.

The aim of this study was to qualitatively explore the experience and impact on practitioners, who are regularly coming into contact with and supporting, survivors of domestic violence. The study was designed to be able to listen to and analyse and present the results from practitioners working in three different professions. All practitioners, counsellors working in a domestic violence agency, SW's in a child protection role and SDVP's are working with survivors on a daily basis.

It was of particular interest to explore if there were any similarities and differences between the practitioner's experience and the support that they receive as part of their role. The research process of interviewing, transcribing and analysing the data through codes and themes has provided an insight into how the practitioners themselves experience their work.

This study identified five overarching themes.

1. The Brutality of Domestic Violence.
2. Support – The Good and the Bad
3. The Weight of Responsibility.
4. The Impact – Professionally and Personally
5. Training and Awareness

5.2.1 Theme One - The Brutality of Domestic Violence

Whilst aware that the study focussed on practitioners working with clients who have experienced domestic violence, there was a shocking reality of how brutal the work can be which appeared in the transcripts. As the interviews were transcribed, the power of the words retelling the client's stories was palpable. Samantha's shock at realising a client had lost half of her hair being pulled out was brutally vivid.

All of the participants shared specific examples of how they had experienced this brutality with stark clarity. The reality of working with clients who have experienced trauma illustrated the transcripts. I was surprised at how this shocked me, even having worked as a SDVP for many years.

It was clear that each participant had been affected by the reality of listening to client's stories. The researcher had been prepared for the participants who were SW's and SDVP's to carry this burden. I was surprised at how much both of the counsellor participants had also absorbed the client's stories given their access to reflective supervision.

From the very start of designing the questions, I was inclined to question if there would be a difference in participant's recollections due to counsellors receiving clinical or therapeutic support. This did not appear to be the case. Samantha's memory of clients discussing how they had been dragged around their houses by their hair had stayed with her. I could not define any difference between the way Samantha recalled the brutality of domestic violence and Tracey discussing clients being "set on fire, broken bones and rape." All participant's words were vivid and shocking, with or without clinical or reflective supervision.

There did seem to be a difference at times in the way these traumatic stories were told in the interviews. Tracey, specifically, was very calm and pragmatic as she talked about how her client had been tied to the bed and doused in petrol. In fact, she communicated her embarrassment and disbelief that she had forgotten about the client until a colleague had reminded her. Both SDVP's tended to use a wider brush stroke description when talking about the traumatic stories that they had heard. "All these terrible things" and "pretty awful" were words used in what seemed to be an accepted or regular way.

The way that participants worked with clients, the environment and the number of survivors that participants worked with each day, alongside the type of work carried out with the client could explain the difference in how practitioners related to the client's experiences.

Counsellors and SDVP's would not generally visit client's homes, although their client base would be entirely survivors. The SW's may not be working with a survivor every day, however they do visit survivor's homes. This appeared to have an impact on the SW's. They saw the evidence of violence and the environment where it had been perpetrated. The ultimate content and value of this theme highlights the researchers aim to explore if all of the

practitioners in each of the roles were experiencing and listening to accounts of domestic violence. The results quite clearly state that they are.

This suggests similar results to the American article by Babin, Palazzolo, & Rivera (2012) which presents findings from a quantitative study on Social Work advocates. Through a survey this research supports the results of this study by acknowledging there can be an impact of working with survivors of domestic violence. Unlike this study it does not reveal qualitative information, the lived experiences from the practitioners themselves.

Sanderson (2008) discusses the potential impact for Counsellors working specifically with survivors of Domestic Violence. She sets out her view on the importance of practitioners receiving professional support and practising self care as ways of minimising the impact. Although based on many years' experience, this book does not include the voices or feelings of counsellors working with survivors.

Ferencik, Lisw & Ramirez-Hammond (2010) specifically identify and acknowledge the risk to practitioners who support survivors of domestic violence. Their work revolves around supporting domestic violence advocates, however it does not present qualitative elements or experiences of the advocates themselves.

In this current study we can hear how the practitioners are all actively involved in listening to survivors recounting their experiences of DV. This supports my initial concern that irrelevant of the profession, the practitioners are potentially at risk of this work impacting on them both professionally and personally, and having a need for appropriate support. I would suggest that this theme appears to confirm my assumption and aim of the project, that all of the

professions interviewed for this study experience the trauma of domestic violence survivors, providing the foundation for the rest of the discussion in this chapter.

5.2.2 Theme Two - Support the Good and the Bad

My exploration around participant's experience of support in the interviews aimed to unravel the different types of support across the three professions. The aim was to find out from participants what their experience of support was in their different roles. I would then be able to explore parallels or disparities in the support that they received. This may be useful for future consideration when identifying supportive interventions for practitioners working with clients who have experienced domestic violence.

As discussed in Chapter 4, the information that came from this area of the interviews was considerable. The participants had a lot to say on what they found supportive and what they didn't, suggesting that support was very important to them. The participants also had a lot of thoughts and ideas on what support may have been more useful for them. The limited nature of this study prevented the researcher from exploring all of these areas in detail. Therefore, I limited the results to two subthemes within Supervision, Good Support in the Practitioners words.

Supervision

All of the practitioners identified receiving supervision in their roles. Supervision also appeared to be the main form of support that the practitioners received and was very important to them. The participants experience of supervision varied. Kapoulitsas (2014) also found in her qualitative study which explored compassion fatigue and resilience amongst SW's in Australia, that infrequent access to and the varied quality of supervision emerged as a theme.

The SWs and the SDVP's discussed supervision as a process that felt disproportionate to the nature of their work that involves supporting clients with traumatic stories. Lucy suggested that supervision was case management and "HR based" (L78). All of the participants believed that supervision, when working with clients who have experienced trauma, needed to be a reflective process. They felt it could be beneficial if it was an arena where they could explore the impact the work had on them, which in turn may reflect and improve the support that they were able to provide for their clients.

Vicky questioned the effectiveness of the supervision she received. She went as far as to challenge the domestic violence agencies that weren't adhering to Safelives guidance (see Appendix P). This guidance recommends that all SDVP's receive one to one clinical supervision in addition to case management supervision.

SW's, Gemma and Tracey, both discuss their experiences of supervision where case management is important and central to the process. Gemma suggested that reflective supervision should be important. She discussed one line on her supervision sheet asking how she was. She would reply, "I'm alright" to her supervisor, and the discussion ended there. All

practitioners suggested that supervision needs to go further, reflecting on them, their practice and the emotional impact on them.

Tracey was quite clear that she has never been asked how she was, or how she coped with the impact of the work within supervision. This appears to deviate from the British Association of Social Workers (BASW) policy which suggest that "good quality supervision should improve SW's capacity, confidence, competence and morale, leading to a better service for those who need social work. Effective supervision also improves recruitment, retention and job satisfaction", (BASW UK Supervision Policy 2011).

Conversely both counsellors reported satisfactory supervision, and recognised the value and opportunity of being able to access this when needed. As counsellors they are both members of the British Association of Counsellors and Psychotherapists (BACP) and as such commit to access supervision as a part of their registration. The BACP define supervision as "A specialised form of mentoring provided for practitioners responsible for undertaking challenging work with people. Supervision is provided to ensure standards, enhance quality, advance learning, stimulate creativity, and support the sustainability and resilience of the work being undertaken," (BACP 2016).

The experiences of the participants in this study appear to synchronise with the findings of (Kapoulitasas 2014), (Lloyd et al, 2002) and (Kim, 2008) who all concluded that effective and accessible supervision were core mechanism's in supporting practitioners. The definition of *effective* and *accessible* is not explicitly defined, however, the participants described their understanding of this as being a meaningful arena where they can reflect and process the trauma their clients are sharing. Samantha suggested this means space to reflect on "how's

the work affecting you . . . how are you going to manage this . . . and what are you going to do to let go of this," trauma." Vicky strengthens this when she talked about clinical supervision seeming to be reserved for counsellors, "I've never understood why."

Good support in the practitioner's words.

I had hoped that the practitioner's words would be heard through this study. As Fossey, Harvey, Mcdermott, & Davidson, (2002) state, that "subjective meanings, actions and social contexts as understood by them" were illuminated, (p1). Specifically, to this study it was hoped that their ideas for effective support would be discussed. As mentioned previously the codes generated in this theme were many, and peer support was an area that came though most of the transcripts as a positive experience.

Gemma described the support from her peers as informal supervision. In addition, Lucy and Vicky discuss peer support as a valuable contribution to their experience when working with survivors of domestic abuse. Kapoulitsas (2014) discusses similar results under the heading 'Debriefing with Colleagues'. "bouncing ideas off colleagues, not being judged, using co-workers as sounding boards and research sharing were all phrases used to describe the idea of valuable peer support, (Kapoulitsas 2014, p11).

Both SW's felt value in support from, and for their peers. Tracey discusses that no one quite understands the role unless they're doing it themselves. As discussed in Chapter 3, Gemma valued peer support and also suggested that somehow formalising this as a part of a structure could be valuable. Rachel discussed another form of peer support and expressed her value of Group Supervision.

Christenson and Kline (2000) suggest that group supervision has always been used widely in counselling circles, and that it provides an ideal arena where counsellors can learn and develop as professionals. However, they recognise participation anxiety as a phenomenon that can inhibit the process working effectively. Rachel also discusses anxiety at attending such sessions until she realised that they could be a valuable arena to share experiences with other staff, reflect on cases, and share knowledge.

In Chapter 3, Lucy was quite specific about what she felt appropriate professional support to be whilst supporting survivors of domestic violence. “Supervision, clinical supervision where possible. Giving people autonomy, some sense of control in their jobs alongside meaningful team, building” (L332 – 335). These ideas closely resonate with Richardson as cited in Tehrani (2010). She suggests that effective supervision alongside peer support and an autonomy in practice, provide SW’s with a more supportive working environment. This theme appears to suggest that irrelevant of the profession all practitioners were looking for similar models of support, peer support and appropriate reflective supervision.

5.2.3 Theme Three - The Weight of Responsibility.

The weight of responsibility is a theme generated by codes from the transcripts that described the experience of the practitioners in their roles. All practitioners communicated these feelings across all three professions. Codes revealed the responsibility that practitioners felt for their clients. They also felt responsibility towards their peers in addition to an expectation of responsibility from their organisations.

Lucy was clearly frustrated with her organisation. She had attended a nationally accredited course to gain a qualification as an Independent Domestic Violence Advocate (IDVA), and

brought back with her the recommendations for support and knowledge of professional fatigue and burnout. “They weren’t’ interested at all,” (L136), she said. This was a struggle for her as she defined this learning as a light bulb moment, and had identified with this in her own experience. She was concerned and disturbed that she felt it was being dismissed by her organisation.

Employers have a duty of care to practitioners. A combination of statutory duties, under the Health and Safety at Work Act 1974 (HSWA 1974) and common law, both aim to protect employees. However, a personal conversation with an employment solicitor suggested that there is difficulty with this area of law. It is challenging to evidence actual psychiatric injury, the damage that can occur due to occupational stress, which is where this area of responsibility would legally lie.

A guide jointly written and published by ACAS, the Health and Safety Executive the Chartered Institute of Personnel and Development Health Work and Wellbeing sets this responsibility out clearly. This guide suggests that there are business benefits to manage the impact of stress on your employees, and the legal obligation should not be seen as the sole reason for caring. The reduced costs of employee absence, improved workplace moral, increased productivity, protection from reputational damage, and the financial costs of prosecution or litigation also need to be considered.

The reason for the weight of responsibility that the practitioners feel for their clients could be explained due to the serious nature of the work and the risks that clients may have been exposed to or are still exposed to. The Office for National Statistics (2015) state that seven women a month were killed by their former or current partner in the year 2013 – 2014 in

England and Wales. This highlights the severity of risk that the practitioners in this study are working with. It may also go some way to explain why the practitioners feel such a weight of responsibility.

Samantha discussed her fears of not knowing if a woman would attend the next session due to the high risk the client was under from her ex-partner. Gemma also discusses the weight of responsibility when talking about children at risk in violent households. The fear preventing her from taking a break in case the call came through, to inform her of a serious injury or death and not having the time to complete paper work or tasks haunts her. Working with clients who are at such high risk of serious harm or death weighs heavily, and apparent in the transcripts.

The weight of responsibility starts to make sense, as the reality of a client dying, becomes clear. Having to leave the office not knowing if you have done enough weighs heavily. Gemma verbalised this, “so when you go home with your gut and you reflect and become more anxious.”

5.2.4 Theme Four - The Impact – Professionally and Personally.

The interview transcripts produced a lot of information within this theme. It was clear that all of the participants had many examples of how they believed the work that they did contributed to experiences that had affected them both professionally and personally. Consequently, this theme is divided into two subthemes, The impact professionally and the impact personally.

The Impact Professionally.

Lucy discussed how she believed that listening to survivors of domestic violence has impacted on her professionally. She discussed feeling so overwhelmed, constantly listening to her client's trauma that she even became reluctant to telephone them. She discusses feeling "shut off" (L36), and unable to "deal with hearing more stuff," (L41). This resulted in her suggesting that she was "not being able to do her role," (L41.)

These feelings are in stark contrast to how Lucy described her motivation for doing the role in the first place. She talked about her motivation being "the ability to see people change" (L302), "see people gain self-esteem, gain control over their lives . . . I want to support women to achieve and feel better about themselves, not stuck in negative cycles of behaviour," (L306).

Lucy's experience of feeling unable to do the role she had been so motivated to do appeared to be similar to Tracey when she said, "When you've got hardened to it, it's time to leave." When I asked Tracey how she practised self care, her answer was brief, "I left safeguarding." The feelings of being unable to carry out their role due to the impact on them, could be linked

to the idea of Burnout, defined as “a prolonged response to chronic emotional and interpersonal stressors on the job” (Maslach, Schaufelie, & Leiter, 2001, p. 397).

Both Vicky and Lucy liken their experience to an understanding of Vicarious Trauma. They show concern at this impact being stealth like. Newell, Nelson-Gardell & MacNeil (2015) suggest that compassion fatigue, vicarious trauma, burnout, and secondary trauma, could all be terms used to describe the experiences of the participants. I was very surprised that the participants didn’t use these terms more extensively in the interviews. This could be due to most participants suggesting they had received little or no training on these phenomena as a part of their roles and therefore not relating their feelings and experiences to theses phenomena.

The counsellors appeared to show a greater understanding of how the work could impact on them professionally, however they do not suggest that in reality it has affected them profoundly. There could be several reasons for this. Both counsellors will have been accessing clinical supervision and therefore the opportunity to reflect on their work.

The counsellors were also volunteers at their agencies, potentially more able to leave if they felt they were unable to cope. This is in contrast to those in a paid role whose livelihood depended on their salary. In fact, when Samantha was asked how she practised self care in the role she said, “I limited it to one day a week . . .I would have struggled working more than three days a week . . . I worried that I may become battle weary . . .I couldn’t have worked full time in that level of trauma.”

These results show a very serious professional impact; practitioners are leaving their roles, or feeling unable to do them. This aligns itself to recent figures on SW's burnout and the UK's current situation of relying on agency workers to cover empty posts. Wainwright (2016) suggests that "almost a fifth of all children's social workers jobs in England are vacant." The National Society for the Prevention of Cruelty to Children (NSPCC) report within this article suggest SW's are facing a 72% increase in referrals, and also suggest that "constant pressure because of media coverage and criticism of their role in high profile cases," is also to blame.

The Impact Personally.

Physical and emotional exhaustion were widely discussed in the interviews with participants. They reinforced this with words such as, fatigue, knackered and zapping all of your energy. Significantly all of the participants had an understanding of self care, and how they practiced this themselves in order to try and counter these impacts. The results from the transcripts in this study are again similar to Kapoulitsas (2014), that "the significance of promoting practitioner wellbeing was evident with all six of the participants" (p 11).

Kapoulitsas (2014) shares the results of her participants describing swimming, walking meditation and being with family and friends as ways of countering stress. Similarly, the participants of this study discuss mindful colouring books, walking in the country and time with family as ways of practising self care. Norcross (2000) outlines self care strategies, suggesting that "counterconditioning" of burnout can occur through physical activities and healing activities such as yoga alongside other distractions such as reading and watching films. Whilst these results cannot confirm if the self care practised has prevented professional fatigue or trauma, the participants were aware of the concept and how it might help them.

Tracey and Samantha talk about the emotional impact as a parent and partner. Vicky and Lucy talked about the personal impact on them as 'humans'. Samantha found value in working through this in supervision. Vicky suggests that self care can reduce the impact, this means doing "what you enjoy doing," and activities that "validate who are you are, . . . bring some of your identity back to you."

The personal impact that the participants describe appear to have affected the core of who they are as human beings. A mistrust of others, losing their identity, and losing touch with and withdrawing from the people who can provide the support that they actually felt that they needed. As Vicky says, you can "actually withdraw from the very people who make up who you are, self care for me is making sure I don't withdraw." There was no evidence of compassion satisfaction or an understanding of resilience, at the outset of this study, I thought there maybe.

5.2.5 Theme Five - Training and Awareness

Codes of feeling unprepared, combined with a lack of training came from all participants. Not having enough information on domestic violence itself in addition to training on professional trauma and fatigue were voiced by all professions.

Rachel had not experienced any training from her specialist domestic violence organisation on how professional trauma or fatigue may impact on her. Samantha had different experiences, and said that although it was not initially covered in any detail from the organisation, it had and continued to be an important part of her supervision. Both counsellors reported that they had been made aware of professional trauma and fatigue as a

part of their professional counselling training, although they both suggested it was touched on as something to watch out for, not a priority.

None of the participants coming from social work or specialist domestic violence agencies had received any training on professional trauma and fatigue as a part of induction or continued professional development. All participants are listening to survivor's stories and it would seem prudent for all professionals to have an understanding, be aware, and able to watch out for signs or symptoms that could lead to the phenomena discussed in Chapter 2 such as compassion fatigue, vicarious trauma secondary trauma or burnout.

Vicky and Lucy felt professional trauma or fatigue was covert, and could creep up without them being aware, an awareness of these phenomena may have supported an awareness for them. It would seem that organisations that are recruiting and supporting these roles could furnish the practitioners with an awareness for the potential impact on them.

Lucy felt strongly that organisations could adopt Ferencik, Lisw, & Ramirez-Hammond (2010) Trauma Informed Approach for the practitioners. She suggested that organisations accept that professional trauma and fatigue were *likely* to impact on practitioners as a part of their role. If this was the case, then by educating staff and providing a supportive culture, the risk could be at least acknowledged. Stevenson (2016) reports very recently that one of the key reasons for two London Boroughs to achieve outstanding Ofsted grades was due to them adopting a culture of compassion. This was largely attributed to a "strong culture of continual learning, professional accountability and responsibility," towards their staff (p1).

None of the practitioners coming from the social work or counselling professions had received any training on domestic violence as a part of their professional university education. It is important to stress at this point that the four practitioners came from different universities. This would suggest there is an element on domestic violence in practice missing from university curriculums. Given the extent of the issue as raised in Chapter One, the researcher finds this concerning. The lack of teaching in this area disturbed all of the practitioners when they entered their various roles. "It's entrenched," exclaimed Gemma, "why haven't college taught me about this," questioned Samantha. "The amount of DV I hear she continues," Tracey confirmed this feeling "they're not preparing you with the tools of the job".

This lack of awareness could have serious consequences, not only for survivors, but also for professionals. The Home Office (2011) announced that Domestic Homicide Reviews (DHRs) were to be established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act (2004). This provision came into force on 13th April 2011. Historically many agencies, similar to child deaths within the safeguarding arena, may have been working with families where a death occurs. Had they known about the domestic violence within a family and been able to share information, certain strategies could be put in place by professionals involved to reduce risk and provide support to high risk cases.

The aim of DHR's is to learn lessons, similarly to the statutory serious case reviews in a child serious injury or death. Should a domestic homicide review be called, any practitioner or agency who has had an involvement with the victim, including a counsellor in private practice could be asked to submit records and reports to the panel. The panel would be convened to make inquiries into the death. This is a serious concern to the researcher. Only

the SDVP's had received any training in domestic violence as a part of the professional training. Given the potential consequences of working with a survivor and not having the awareness that they are at risk, or indeed share information, when clients are at high risk, could have significant consequences should the practitioners be called into a statutory review process.

5.3 Evaluation of the Study.

The findings of this qualitative study were shaped by me as the researcher from the beginning. By choosing the question, designing the methodology, and my interpretation of the results, I have consciously and subconsciously driven and woven my own biases and interpretations throughout the study. However, it is due to my experience in the domestic violence sector, and more recently as a qualified counsellor, that my interest in how practitioners experience their work became of interest. How would practitioners experiencing the same phenomenon in the workplace have different or similar experiences and supportive structures?

It was the researcher's decision that a qualitative study would provide the personal subjective information that may answer the question. The researchers experience of uncoordinated and un-prioritised support in the role of a domestic violence practitioner contrasted with the experience of being committed to accessing clinical or reflective supervision as a counsellor. These experiences both influenced the area of research as well as the content of the study itself.

If I was to plan the research again I would narrow the area of interest. The interviews revealed much more information than anticipated. It felt almost disrespectful to the

participants to have to decide to limit the results of the study in order to fit within the scope of the project. Theme 2 on support and Theme 4, the impact of the work on practitioners, would make interesting and valuable studies in their own right. This would enable future research to dig deeper into the information and provide more explicit results.

I have also considered how the study may have benefitted from conducting the literature review after the interviews as opposed to before them. Researching the concepts of burnout compassion fatigue and vicarious trauma set the context for what I thought the practitioners may experience, however the actual terms were rarely used by participants. The broader description of professional fatigue and trauma adopted by this study at the beginning, in reality seems to cover the participant's experiences more accurately than any other specific term defined in the literature.

Had the literature review been conducted after the interviews, the concept of self care may have featured more prominently within Chapter 2. Self care was something that the participants felt strongly about, it generated codes that may have turned into other themes had the scope of this project allowed. A theme of Self Care may have provided useful results for readers on how the participants balanced the impact the work has on them with positive actions in order to look after themselves.

This was a small study of six participants. Braun and Clarke (2013) suggest a minimum of six participants for a small scale thematic analysis. The information from the six participants was also divided by the information from three professions. This may have significantly reduced the results, and future research may benefit from a larger project. However, even as a small project there was a multitude of information, which has provided powerful material that the

researcher has been able to present, although not as intricately as could be researched in the future.

In hindsight the interview schedule may have been structured to draw more positive experiences to the surface for participants. This may have provided an insight into more encouraging elements of the role. However, the negativity may be a reflection of why the participants chose to take part in the study. They may have had negative experiences that had not been heard previously and it was important for them to have a voice through this study.

The questions in the interview about what motivated participants to enter this line of work were intended to lift what the researcher felt may have been intense and negative experiences from participants. The participant's answers about motivation also felt negative. Most of them felt that their motivation and crucially their absolute passion for their work, had been dampened, if not vanished entirely. It seems overwhelmingly sad that practitioners who enter a profession to support positive changes for people who are vulnerable are experiencing similar feelings to clients. Not being heard, frustration at the systems they find themselves in, fear of recriminations from those in power, and overwhelmed by the sheer volume at all they have to do.

5.4 Areas of Learning and ideas for Future Research

I believe this study has illustrated several areas that would benefit from further research. As discussed above, the themes developed on support and the impact on the practitioners would be worthy of independent studies in order to explore them further. Potentially finding deeper thoughts and more experiences from practitioners in these areas could benefit those developing and looking to improve practice and reduce the impact on professionals further.

I believe that this study also demonstrates key areas of future research and learning:

1. **All participants had clear ideas on how they believe support could be put in place in order to support them in their roles.**

Future research could expand on this and explore how organisations could develop these ideas. The ideas from the participants in this present study, specifically on a peer support system or group supervision, could affect how practitioners cope with their roles. The Professional Quality of Life Scale (see Appendix Q) could be used to monitor participant's experiences and feelings around compassion satisfaction and compassion fatigue before and after implementing a peer support scheme. A project like this could offer valuable findings on how support could be improved for existing future practitioners.

2. **The therapeutic or reflective supervision that counsellors commit to accessing appeared to be defined by all practitioners as desirable and appropriate supervision.**

In practice, according to the participants interviewed, therapeutic or reflective supervision is only available to counsellors. According to Safelives and the BACP as mentioned previously clinical or reflective supervision is suggested as best practice to all practitioners listening to clients stories. This does not yet appear to be happening for the SW's or SDVP's interviewed. Further research could explore why this does not happen, in order to investigate the feasibility of if and how it could.

3. **Employers have a duty to care for their teams.**

Whilst resources are in no way limitless, there is evidence to suggest, as reported by Stevenson (2016) that creating a 'Culture of Compassion,' is possible to support staff. Further research into effective organisational support models could expand on this information.

4. **Domestic Homicide Reviews are a reality.**

Practitioners cannot prepare to work within statutory frameworks if they are not aware of them. Further studies could explore how many practitioners are actually aware of this framework. If they are not aware, how can this information be cascaded more effectively to those who may be affected professionally?

5. **All participants demonstrated that they felt unprepared for the role, both in their knowledge of domestic violence and the impact that working with survivors of domestic violence can have on them.**

There is the possibility and opportunity for academic institutions to include domestic violence and expand further on professional trauma and fatigue in their curriculums. A study intended to explore why domestic violence doesn't appear to be included on curriculums would provide interesting information which may enable institutions to make any necessary changes.

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Chapter 6

6 Conclusion and Implications

6.1 Implications

The results of this study highlight several potential implications for the stakeholders outlined in Chapter 1; managers, commissioners, practitioners and survivors. I had hoped that the practitioner's experiences would open up ideas for effective support that enabled them to feel cared for and confident, in order to carry out their role. I was delighted that ideas were plentiful, articulated, and constructed from their understanding of their role, and the impact it has on them as individuals.

All practitioners felt that a more appropriate and holistic form of supervision would be helpful. This leads me to return to how as a counsellor my thoughts around a commitment to, and provision of therapeutic or reflective supervisor widely used by counsellors could support the SW's and SDVP's. A supervisory relationship which takes into account my theoretical understanding of person-centred practice may prove useful. Rogers' (1957) 'core conditions' of genuineness empathic understanding and unconditional positive regard may enable practitioners to experience something similar to the counselling relationship.

Legal implications for stakeholders were an unexpected key finding for the researcher as a part of this study. Organisations have a duty to their staff to keep them safe. Practitioners also have a duty to keep themselves safe, and without the knowledge of DHRs they could find themselves in a professional and personal nightmare if called to a DHR panel without prior knowledge. This also leads into the consideration of the responsibility teaching institutions have in preparing their students fully for the roles that they are being trained to do.

Keeping clients safe, and watching them grow and gain confidence and control was the motivation for most of the practitioners who took part in this study. It seems that this may not be totally possible if they are not looked after themselves by managers and their structural organisations. It is also important to mention that resources and funding are diminishing. It will take an attitude of creative enthusiasm, and consistent persistence, in order for organisations to identify and make any changes they feel to be appropriate and supportive for their staff.

6.2 Reflexivity

As a counselling researcher, this is the first time I have conducted a research study, and as such the challenge of this qualitative piece of work was daunting. The idea of subjectivity being central to qualitative research was a concept I initially struggled with. How could I present an honest and open study, if I, the researcher, was to have such an influence?

"Looking through a lens of terribleness" is the poignant quote from Lucy (L49) that seemed to perfectly capture all of the practitioner's voices on how working with survivors of domestic violence can feel to them. I thought long and hard before engaging with the pain and fear that researching in the domestic violence field would inevitably bring. I have reflected on past experiences as a practitioner, the women that I have worked with, those who have survived, and those who tragically did not.

Many client's voices and cases have come back to me as I listened to the practitioners recall their stories. Listening to the participant's stories, initially at interview, but then more thoroughly through the transcription process, brought tears to my eyes and shivers down my spine as the reality of the horrors that victims have experienced were brought back to life by

practitioners. These voices being heard are due to the study being qualitative, and it shows how these individual experiences have led to a piece of work that shows patterns across the transcripts which culminated in the five themes.

New stories have now been told in this study; precious, dangerous, brave and heart-breaking stories of pain and fear, and the realisation of the responsibility I held in presenting them daunted me. Etherington (2004) discusses how our research studies are impacted and influenced by our own experiences, history and beliefs, also suggesting that this opens up opportunities for us as researchers, as well as contributing to the transparency of the study. I hope that by unveiling these stories through practitioners lived experineces there will be a value in finding better ways to support practitioners who by choice, have taken on an overwhelming role in supporting clients in trauma.

Morally and ethically, it was important to me as a researcher counsellor and individual to communicate the stories with dignity and respect, not shying away from the brutality of domestic violence, but treating them with the sensitivity honesty and integrity they deserve. As a qualified counsellor I have had to learn to be brave when working with clients, and not leap in to save them, let them take the session the way they wish it to, whilst I sit alongside them, working in partnership. This experience helped me to explore the feelings of the practitioners, trusting that they will only go where they want to during their interviews. Similarly, to the person centred practice theory when counselling clients, trusting in *the actualising tendency*, a force within us all striving towards our potential.

As a counsellor, I have been reminded of the number of clients that I work with who may be suffering violence at home, but not present as such on the counselling room. This is

something I need to remember, whilst not in a domestic violence setting, it could be easy to forget, lose that awareness over time, and miss a disclosure or the severity of risk a client maybe at.

I have been upset at my surprise of the brutality of domestic violence that the participants described. All the more shocking as I once held the role of a SDVP. I was accustomed to listening to survivors on a daily basis. Although not aware of how this may have affected me at the time, looking back, like Lucy I can see that it did, and I can see how it affected colleagues, switching off and unable to engage with clients in a way we had previously.

My role as a SDVP was dependant on hearing the stories in order to pursue civil remedies or gain protection from other agencies for my client. The extensive detail that had to be uncovered in order to compile a statement for court was always disturbing, and constantly tested by my ability to remain positive for the client whilst being subjected to so much of the pain that had been inflicted upon them. I had not considered how the story may be affecting me at the time, but the exhaustion and 'shut down' feelings described by participants were all too familiar. This has caused me concern and lead me to question if I was fulfilling the role as effectively as I would have liked to at the time.

6.3 Final words

I cannot draw this study to a close without an honest admission of the impact that this study has had on me individually, one that was truly unexpected. Towards the end of writing the report I was rundown and fell ill. It took those closest to me to see this, I did not see it happening myself. Whilst pushing myself as a practicing counsellor in addition to this role as a counselling researcher, I forgot to look after myself. There is an irony, and further learning,

that whilst I was entrenched in the stories of those who listen to trauma, I myself forgot to find an avenue to offload, and neglected to practice self care until it was too late.

In a dual role, of being counsellor and a counselling researcher, I did not see my physical and emotional health start to dip. In hindsight, knowing what I have learned through my literature review and research, maybe I could have proactively worked on the assumption that it would, and not waited until it had.

This final learning took me back to Lucy's thoughts on organisations taking a Trauma Informed approach as outlined by Ferencik, Lisw, & Ramirez-Hammond (2010). An approach that suggests responsibility of the *likelihood*, that professional trauma and fatigue will occur, is one of the most effective ways of preventing it, or spotting the signs early on. I can identify with missing the covert, or too subtle signs of professional trauma and fatigue that Lucy and Vicky talked about, and can see the value of someone else around you being aware of this too.

References

Abrahams, H. (2007). *Supporting women after domestic violence: Loss, trauma and recovery.* London: Jessica Kingsley Publishers.

Aitken, L. H., Sermeus, W., Van den Heede, K., Sloane, D. M., Busse, R.,Kutney-Lee, A. (2012). Patient safety, satisfaction, and quality of hospital care: Cross sectional surveys of nurses and patients in 12 countries in Europe and the United States. Research, *British Medical Journal*. 344e, 1717.

Babin, E. A., Palazzolo, K. E., & Rivera, K. D. (2012). Communication skills, social support, and burnout among advocates in a domestic violence agency. *Journal of Applied Communication Research,* 40 (2), 147–166.

BACP. (2016). Ethical Framework for Good Practice in Counselling and Psychotherapy. Lutterworth: UK; BACP.

BACP. (2016). Ethical framework for the Counselling professions. Lutterworth: UK: BACP.

Barak, M., Nissley, J. and Levin, A. (2001) Antecedents to retention and turnover among child welfare, social work, and other human service employees: what can we learn from past research? A review and metanalysis. *Social Service Review*. 75 (4) 625–61.

BASW. (2011). UK Supervision Policy. Retrieved from http://cdn.basw.co.uk/upload/basw_73346-6.pdf

Barak, M., Nissley, J. and Levin, A. (2001) Antecedents to retention and turnover among child welfare, social work, and other human service employees: what can we learn from past research? A review and metaanalysis. Social Service Review. 75 (4) 1-15.

Brandon, M., Belderson, P., Warren, C., Howe, D., Gardner, R., Dodsworth, J. and Black, J. (2008) *Analysing child deaths and serious injury through abuse and neglect: what can we learn? A biennial analysis of serious case reviews 2003–2005*, Research Report DCSF-RR023. London: Department for Children, Schools and Families.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3, 77-101.

Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. London: SAGE Publications

Christensen, T. M., & Kline, W. B. (2000). A qualitative investigation of the process of group supervision with group counselors. *The Journal for Specialists in Group Work,* 25(4), 376–393. doi:10.1080/01933920008411681

Collins, S. (2008). Statutory social workers: Stress, job satisfaction, coping, social support and individual differences. *British Journal of Social Work*, 38(6), 1173–1193.

Denscombe, M. (2003). *The good research guide: For small-scale social research projects* (2nd ed.). Maidenhead, England: Open University Press.

Donovan T 26, 2016 *Children's social work vacancies soared 27% in past year, government reports.* Accessed at http://www.communitycare.co.uk/2016/02/26/childrens-social-work-vacancies-soared-27-past-year-government-reports.

Etherington, K. (2004). *Becoming a Reflexive researcher: Using ourselves in research* (3rd ed.). London: Jessica Kingsley Publishers.

Ferencik, S. D., Lisw, R., & Ramirez-Hammond. (2010). Trauma-informed care best practices and protocols for Ohio's domestic violence programs Funded by: The Ohio department of mental health. Retrieved from http://www.ncdsv.org/images/ODVN_Trauma-InformedCareBestPracticesAndProtocols.pdf

Figley, C. R., & Figley. (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*. New York, NY, United States: Taylor & Francis.

Fossey, E., Harvey, C., Mcdermott, F., & Davidson, L. (2002). Understanding and evaluating qualitative research. Australian and New Zealand Journal of Psychiatry, 36(6), 717–732.

Freudenberger, N.J. (1974) Staff Burnout. *Journal of Social Issues*, 30, 159-165.

Hawkins, P.S., Shohet, R., Ryde, J., & Wilmot, J. (2012b). *Supervision on the helping professions* (4th ed.). Maidenhead, Berkshire, England: McGraw-Hill / Open University Press.

Health and Safety at Work Act 1974, c.22. Available at: http://www.legislation.gov.uk/ukpga/1974/37/contents (Accessed: 11 July 2016)

Herman, J. L. (1997). *Trauma and recovery: The aftermath of violence - from domestic abuse to political terror* (20th ed.). New York: Basic Books.

Home Office. (2011). Multi-agency statutory guidance for the conduct of domestic homicide reviews. Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/97881/DHR-guidance.pdf

HSE. (2015). Work related stress, anxiety and depression statistics in Great Britain. Retrieved from http://www.hse.gov.uk/statistics/causdis/stress/stress.pdf

Jenner, L. (2016). The high price of empathy. *Therapy Today*, 27(5), 28–30.

Kinman, G., & Grant, L. (2011). Exploring stress resilience in Trainee social workers: The role of emotional and social Competencies. British Journal of Social Work, 41(2), 261–275. doi:10.1093/bjsw/bcq088

Kinman, G., Grant, L., & Baker, S. (2013). Enhancing resilience and wellbeing in social work: An evidence-based approach. Retrieved from https://www.beds.ac.uk/__data/assets/pdf_file/0009/495288/Enhancing-Resilience-and-Wellbeing-in-Social-Work.pdf

Kapoulitsas, M. and Corcoran, T. (2014) Compassion fatigue and resilience: A qualitative analysis of social work practice. *Qualitative Social Work*, 14(1), p.86–101.

Kim, H. (2008). A longitudinal study of job resources, burnout, and turnover among social workers: implications for evidence-based organisational processes. *Dissertation Abstracts International Section A: Humanities and Social Sciences* 69(6A), 2455.

Larsen, Debra, Stamm, Beth Hudnall Trauma, recovery, and growth: Positive psychological perspectives on posttraumatic stress. Joseph, Stephen (Ed); Linley, P. Alex (Ed); pp. 275-293; Hoboken, NJ, US: John Wiley & Sons Inc; 2008. xi, 372 pp.

Local Government Association (LGA) (2009) Challenges remain in social work retention and recruitment.

Lloyd, C., King, R., & Chenoweth, L. (2002). Social work, stress and burnout: A review. *Journal of Mental Health*, 11(3), 255–265. doi:10.1080/09638230020023642

McCann, L. I., & Pearlman, L. A. (1989). Vicarious Traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress*, 3(1), 131–149.

McFadden, P., Campbell, A., Taylor, B., Derry, Ireland, N., & Queens, 2 (2014). Resilience and burnout in child protection social work: Individual and Organisational themes from a systematic literature review. *British Journal of Social Work*. doi:10.1093/bjsw/bct210

Markham, A. N. (2008). The methods, politics, and ethics of representation in online ethnography. In N. Denzin and Y. Lincoln (Eds.), *Collecting and interpreting qualitative materials*, (3rd ed.). Los Angeles, CA: SAGE Publications.

Maslach, C. (1976). Burned-out. *Human Behaviour*, 5, 16-22.

Maslach, C., Schaufeli, W. B., & Leiter, M. P. (2001). *Annu. Rev. Psychol*, 52(52), 397. Retrieved from http://www.wilmarschaufeli.nl/publications/Schaufeli/154.pdf

Newell, J. M., & McNeil, G. A. (2010). Professional burnout, vicarious trauma, secondary traumatic stress, and compassion fatigue: A review of theoretical terms, risk factors, and

preventive methods for Clinicians and researchers. *Health*, 6(2). Retrieved from http://www.iupui.edu/~mswd/S501/multimedia/word_doc/burnoutarticle.pdf

Newell, J. M., Nelson-Gardell, D., & MacNeil, G. (2015). Clinician responses to client traumas: A chronological review of constructs and terminology. *Trauma Violence Abuse*, 17(3), 306–313. doi:10.1177/1524838015584365

Norcross, J. C. (2000). Psychotherapist self-care: Practitioner-tested, research-informed strategies. *Professional Psychology: Research and Practice*, 31(6), 710–713. doi:10.1037//0735-7028.31.6.710

ONS (2015), Crime Survey England and Wales 2013-14. London: Office for National Statistics.

Rogers, C. (1951). *Client-centred Therapy: Its Current Practice, Implications and Theory.* London: Constable.

Rogers, C. (1951). *Client-centered therapy.* Boston, MA: Houghton Mifflin.

Rolls, L. & Relf, M. (2006). Bracketing interviews: addressing methodological challenges in qualitative interviewing in bereavement and palliative care. *Mortality*, 11 (3) 286-305

Sanderson, C. (2008). *Counselling survivors of domestic abuse*. Philadelphia: Jessica Kingsley Publishers, United Kingdom.

Smith, J. A. (1996). Qualitative methodology: Analysing participant's perspectives. *Current Opinion in Psychiatry*, 9(6), 417-421.

Sodeke-Gregson, E. A., Holttum, S., & Billings, J. (2013b). Compassion satisfaction, burnout, and secondary traumatic stress in UK therapists who work with adult trauma clients. , 4, . Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3877781/pdf/EJPT-4-21869.pdf

Stevenson, L. (2016, March 29). Tri-borough children's services first to get Ofsted top marks. Retrieved August 5, 2016, from Children,

http://www.communitycare.co.uk/2016/03/29/ofsted-gives-first-outstanding-grades-childrens-services-two-london-councils/

Tehrani, N. (Ed.). (2010). *Managing trauma in the workplace: Supporting workers and Organisations.* New York: Routledge

Wainwright, D. (2016, April 20). England children's social worker posts almost 20% vacant. BBC England. Retrieved from http://www.bbc.co.uk/news/uk-england-36026098

Women's Aid. (2016). Women's aid annual survey 2015 statistics. Retrieved August 11, 2016, from In focus, https://www.womensaid.org.uk/womens-aid-releases-annual-survey-2015-statistics/

Appendix A: The Bracketing Interview

I chose a phenomenological approach for my project as I hope to be able to use the participants lived experience, to explore their truth in their lives. What have they experienced in their roles of working with clients who are experiencing trauma.

The subject of my project flows from the past ten years of my professional life and this means that as a qualitative piece of work, it is necessary for me to explore my own judgements and biases in an attempt to present a valid and reflexive piece of work from any data analysed.

Lowes & Prowse (2000) suggest that it is, an illusion that researchers can remain outside of the interview process and maintain an objectivity or distance. Ahern (1999) concurs with this view however continues to suggest that if qualitative researchers bracket their potential biases they are able to provide a more transparent study. Ahern (1999) suggest that there are several ways to minimise your subjective bias. Lewis (2008) argues that it is by the very act of honesty, attempting transparency, "laying bare the researchers identificactory processes with the participant narrative" that culminates in a more truthful transparent and valid collection of data (pg. 69).

Rolls and Relf (2006) refer to a process of bracketing personal experience from the interview with participants and as part of this study I chose to participate in a bracketing interview in order to draw out my thoughts and feelings around the project. It is my hope that the bracketing interview will demonstrate validity for this project and show an awareness of how personal feelings and preconceptions could impact on the study.

Reflexivity is the realisation that I, as a researcher, am a part of the social world I am studying, bringing my own assumptions, beliefs values and biases to the process. Rolls and Relf (2006) suggest that bracketing interviews provide a valuable research-focussed relationship that adapts the skills of clinical supervision in the context of research. This parallels for me the process of this study, as I believe that my skills as a counsellor and psychotherapist will go some way to support and enable the participants during the interview. Lewis (2008) also suggests that the therapeutic process is very similar to qualitative research, requiring a "highly developed capacity for emotional engagement in the client's subjective experience" (p63).

My first question required me to talk about what had prompted this research question. After discussing the main ideas of gaining a better understanding of the support different professionals receive when working with the same phenomena and client group I started to discuss student SW's. Having spent some time working with student SW's as a practice educator I really felt that they were overwhelmed by the amount of domestic abuse they were finding and the intensity of the traumas they were listening too. I also realised that I felt the support they received was not enough, and this is something I need to be aware of and work with as objectively as I am able.

One of my bracketing questions asked me to consider my own experience of receiving support as a front line domestic abuse support worker. Straight away I could see how my positive experiences could influence my thoughts about the interview. I could also see how my negative experience could lead me to assume that this would be the case for my participants. In essence my thoughts around how to support practitioners are already embedded and an awareness around this is key if I am to remain open to new information.

I also became aware of my relatively new belief that therapeutic supervision was going to show up in the study as necessary for all practitioners if they were to receive adequate support. However, my bracketing interview suggested other methods were possible. Particularly as I talked about my passion for peer support and how a small generous team can provide valuable support in a workplace where traumatic clients stories are a major part of professional life.

In addition to my bracketing interview I monitored potential conflicts by using my research journal to note and reflect on the process and my feelings towards it. During my supervision meetings for this study I valued the role of my supervisor in challenging me to consider other perspectives and views from my own.

I hope that the variety of roles that I have been able to experience within the domestic abuse sector has given me a relatively holistic view of the professional; arena practitioners are working in. I also hope that this enabled me to approach this project with a leaning towards objectivity and a passion to find out the experiences of my participants as opposed to confirming any of my own beliefs or suspicions.

I start the project optimistically hopeful that my experience as a manager of paid and voluntary teams, a practice educator for social work students, a multi-agency trainer a support worker and a counsellor will enable me to initially take a 360-degree tour of my subject. Realistically I am also aware that each of these roles may bring another layer of bias that I will need to be aware of continually throughout the project.

Appendix B: Pilot Study

As this was my first research project I felt it necessary to conduct a pilot study. Primarily this was to generally test or have a dress rehearsal of my interview schedule. The second reason for me doing this was to ensure that my questions were understandable and made sense to a SW.

This study revolves around three different professions, a counsellor a SDVP and a SW. Out of these three roles I have never worked as a SW. I have been a practice educator for social work students in a voluntary setting. Although this work gave me enough knowledge to be aware of the potential impact students were experiencing when working with clients who are experiencing domestic violence, I was keen to ensure that my interview schedule was using the right terminology for this profession.

Braun and Clarke (2013) suggest that it is not always possible or feasible to conduct a formal piloting for a small project. However, they also say that the questions need to be meaningful to the participants, and accommodating, to different people, which suggested to me that it was necessary. It also felt ethically responsible to conduct a pilot given the subject matter of domestic abuse and trauma. A pilot study would enable me to see how my participants would react and process the questions, and if they triggered anything emotionally that I might not have expected.

I deliberately recruited a SW for the reasons set out above, and set up the interview as I had planned to for the other participants. A venue of their choice, with them having received the information sheet prior to the interview. I also used this session to have a practice run through of revisiting confidentiality and discuss consent before signing the forms. It also enabled me

to give an explanation of how I have grouped compassion fatigue, secondary trauma vicarious trauma and burnout into the umbrella phrase of professional trauma and fatigue.

Apart from slightly rewording several questions the schedule appeared to flow in the direction that I had hoped. The main changes that I made following the pilot study was to make the schedule more conversational. I had simply written the questions down in my initial schedule. I also expanded on the descriptor of professional fatigue and trauma and added a checklist of reminders.

The semi structured interview worked well as this allowed me to 'set the scene' with the question, but then follow the participant in the direction that they wanted to go, or prompt them if it felt they were swaying away from the research question.

Finally, I felt it would be a positive addition to finish the interview asking 'what motivated you' to work in the role. This had happened naturally as a conclusion to the pilot and I felt that it would be useful to formalise it as the last question in the interviews that would follow.

Appendix C: Participant Information Sheet

Participant Information Sheet

'Effectively supporting practitioners who work with survivors of domestic abuse.'

INFORMATION SHEET FOR PARTICIPANTS

Dear Participant,

My name is Sass Boucher and I am currently studying for my MSc in Counselling & Psychology at Keele University.
For my dissertation I am researching how 'Practitioners experience care and assistance specifically around the potential of professional trauma and fatigue when supporting survivors of domestic abuse'. I have previously worked in a domestic abuse setting and I am interested in the experiences of domestic abuse support practitioners, counsellors working in a domestic abuse setting and social workers in a Safeguarding team who are also working with survivors of domestic abuse.
Before you decide if you would like to take part in the study, it is important that you understand what the research is for and what you will be asked to do. Your participation is entirely voluntary. If you decide to take part, you will be given this information sheet to keep. You will also be asked to sign a consent form. You can change your mind at any time and withdraw from the study without giving a reason. You are also very welcome to phone or email me if you would like any further information.

The purpose of the research study is to examine your experiences as a practitioner who is regularly coming into contact with clients who are or have experienced domestic abuse. You listen to their stories and therefore hear them recount their trauma. I would like to ask questions about what it is like for you, your thoughts, your feelings and your experiences as a professional. The questions will examine your understanding of professional trauma and fatigue, what you may believe could help to support these issues and what your thoughts and experiences are, for you, in the work place.

You have been chosen as a potential participant because I am aware through my various professional and academic networks that you are working or have regularly worked with clients as a specialist domestic support worker, a counsellor within a domestic abuse setting or a social worker in a safeguarding team. The study will involve up to 6 participants, who will all be interviewed separately.

If you agree to take part, the interview will take approximately one hour and I will organise a time and location for the interview convenient to you. The interview will be recorded on audio tape and then transcribed onto a computer. The audio tapes will be stored in a locked secure place at all times and the computer data will also be protected. The audio tapes will be destroyed at the end of the study. The interviews will be analysed by myself, and your responses will be treated with confidentiality and anyone who takes part in the research will be identified only by a pseudonym. The final study will not contain any quotations that may enable participants to be identified. You can request a copy of the interview transcript if you wish.

The information gained from this research may offer insights into the experiences of practitioners absorbing traumatic experiences of survivors and how best to support them.

At the end of the research I will write a report and the results of the study may also lead onto further studies, professional training materials, conference presentations, published in peer reviewed journals and contribute to good practice guidelines.

Talking about your experiences may be upsetting for you. You are free to stop the interview at any time if you do not wish it to continue. If the interview upsets, you and you feel you would like some additional help and support after the interview I will provide you with organisations who can help together with their contact details. Every effort will be made to ensure that no identifiable information will be used or contained within the study.

This study has been reviewed and approved by the School of Psychology Research Ethics Committee at Keele University.

Please do not hesitate to contact me if you need further information

Thanking you in anticipation,

Yours sincerely,

Sass Boucher
email: sassboucher@hotmail.com
Tele: 07967 685 371

Appendix D: Interview Schedule

Interview Schedule

'Effectively supporting practitioners who work with survivors of domestic abuse.'

'What is your experience in the workplace, around the possibility of professional trauma and fatigue following your support of survivors of domestic abuse?'

Compassion fatigue, secondary trauma, burnout and vicarious trauma, are all terms used to describe the impact and / or the potential diagnosis of this impact for professionals working with trauma. For the purpose of this interview I shall collectively term them as professional trauma and fatigue.

- ✓ Revisit confidentiality
- ✓ Run through different roles.
- ✓ Run through the three subheadings.
- ✓ There is no right or wrong, you are the expert of your experience, consent.

Understanding of how professional trauma and fatigue could impact on you as a practitioner in your setting.

1. Can you tell me what you understand professional trauma and fatigue in a to mean?

2. Could you comment on how, in your own experience, listening to the trauma can impact on you. For example , inside and outside of work when you are working on a regular basis with victims and survivors of domestic abuse?

3. Some people suggest that professional trauma and fatigue, burnout, secondary trauma, vicarious trauma and compassion fugue can impact on you as a practitioner, do you have any experience of this?

Understanding of what is thought to prevent professional trauma and fatigue and support practitioners.

4. Promoting autonomy in practice, encouraging self-care, supervision and peer support are all ideas and interventions in practice that aim to support you as a practitioner, are you familiar with these terms?

5. The idea of "supervision" appears to mean different things to different practitioners, some practitioners have clinical supervision, other management supervision, some a mixture of both, could you tell me a little about what it means to you?

6. The term professional resilience is used more frequently within the working environment; this appears to address personal qualities or strengths that support a professional. Could you say if you have heard about professional resilience, and what that may mean for you as a practitioner?

Experience and thoughts for improvement

7. As a part of your professional training could you tell me a little bit about how working within domestic abuse and its potential to impact on you were covered?

8. As a part of your organisations induction and ongoing training, can tell me a little about how professional trauma and fatigue were considered as something you need to be aware of?

9. As mentioned earlier, promoting autonomy in practice, encouraging self-care, supervision and peer support can all be seen as qualities and support interventions that can help support you as a practitioner, do you have any experience of these that you could tell me about?

10. Could you think about a time when you may have you may have asked for support from your employer and tell me a little about that?

11. Rather than you having identified a need for support, I'd like to ask you if there was a time when your line manager identified that you may have a need for support?

12. Has there been a specific time that you have felt there was a really supportive gesture or idea on how to deal with listening to trauma or the after effects of listening to trauma from your manager or peers?

13. Could you tell me how you may try to practice self-care on a regular basis?

14. In your experience could an employer make things even better for you, either with the process you need to follow to seek support or the ways that they could support you as a practitioner who is regularly working with survivors of domestic violence and listening to their stories?

15. We've been talking a lot about how tough your role can be, and different ways you may be able to experience care and assistance within your workplace. I would be very interested to hear a little bit about what motivated you to work in this role and what continues to motivate you within this role?

16. Do you have any other questions, or is there something that you would like to add?

Appendix E: Participants Consent Form

INFORMED CONSENT TO PARTICIPATE IN RESEARCH

Title of project: ***'Effectively supporting practitioners who work with survivors of domestic abuse.'***

Researcher: Sass Boucher

I have been given the information sheet for this study and have understood an explanation of this research project. I have had an opportunity to ask questions about the study, and have them answered. I know that my participation in this study is entirely voluntary.

I understand that I can withdraw from the interview at any point, and that I am under no obligation to answer any particular questions.

- ☐ I agree to take part in this research
- ☐ I agree for the interview to be audio taped
- ☐ I agree that Sass Boucher may use the results of this study and that this may also lead onto further studies, professional training materials, conference presentations, published in peer reviewed journals and contribute to good practice guidelines.
- ☐ I am aware that the information collected in my interview will be made anonymous.
- ☐ I agree to the use of quotes
- ☐ I disagree for my quotes to be used.

Signed: **.....**

Name: **.....**
(please print clearly)

Date: **.....….**

Appendix F: Participants Debrief Information Sheet

Participant Debrief

Title of project: *'Effectively supporting practitioners who work with survivors of domestic abuse.'*

Researcher: Sass Boucher

Thank you for taking part in this study.
I shall write a transcript of our interview and then I will analyse it using Thematic Analysis to write my dissertation report.
Please contact me on w0e52@students.keele.ac.uk if you would like a copy of your transcript.
I will endeavour to maintain confidentiality throughout the study, if you request a copy of your transcript then it will be your responsibility to keep it securely or destroy it.
There is the potential for this study to trigger personal or professional memories or issues that may cause you discomfort or distress. Please find the contact details below for agencies that may be able to support you on issues around domestic violence or employment. If you feel that you have been affected by any of the issues and experiences that came up throughout the interview, then please contact the services below for further support.
Many thanks again for your time and participation,

Sass Boucher

For issues around domestic violence:
The Pathway project 24-hour helpline 01543 676800
Local employment advisory organisation
CAB 0344 441 1444

Appendix G: Lucy's Transcript – Coded Page 1

1	**Interview 1** LUCY.			
2	**Interviewer**			
3	So, we've run through the question,			
4	**L**			
5	Yup			
6	**Interviewer**			
7	And we've run through my sort of wording, visited confidentiality and the different roles, and the subject			
8	headings and there's no right or wrong, this is absolutely down to you to answer.			
9	**L**			
10	Yep			
11	**Interviewer**			
12	So, can you tell me, what you understand professional trauma and fatigue to mean?			
13	**L**		EXPERIENCE HEARING SEEING. OTHER PEOPLES STORIES. PROFOUND IMPACT.	IMPACT PROFESSIONALLY.
14	OK, I understand professional trauma and compassion fatigue, like those kinds of phrases to mean erm that the			
15	kind of the experience that first line practitioners get hearing or seeing other people's stories, and then it having			
16	a profound impact on those individuals.			
17	**Interviewer**			
18	Thank you. Could you comment on how in your own experience listening to trauma can impact on you inside, or			
19	outside of work, when you're working on a regular basis with victims and survivors.			
20	**L**		IMPACT TWO FOLD. WELLBEING. SURFACE. TRAUMATIC UPSET. LONG TERM – DON'T FEEL SURFACE FEELINGS HARDENED TO IT. DEEPER MOOD. PERCEPTION OF WORLD NEGATIVE - BAD THINGS ALWAYS HAPPEN.	IMPACT WELLBEING IMPACT PROFESSIONALLY. HARDENED PERCEPTION WORLD. BAD THINGS. NEGATIVE.
21	Yep. In my experience the way it impacts on you is kind of twofold really, I think firstly it can have an impact on			
22	your wellbeing, on, I think at first you can very much, it impacts on the surface, so you might hear something			
23	that's traumatic and feel a bit upset. But then I think what happens long term is you don't feel those surface			
24	feelings because you're so used to it, you almost become a bit hardened to it, but how it affects you on a			
25	deeper level, in terms of your mood, in terms of your perception of the world, in terms that it can become quite			
26	negative. You think that bad things are always going to happen. Like for example, standing in a supermarket and			
27	thinking that someone who says a comment to somebody and you're there thinking, like perpetrator,			

	LUCY.	TERRIBLE THINGS - FAMILY - OVERANALYSING LEAPS OF JUDGEMENT. ALWAYS IN HEAD BAD THINGS HAPPEN.	PERSONAL IMPACT.
28 29 30 31	perpetrator, and you're thinking all of these terrible things, with family members when they get into relationships. You start to think you're over analysing things and making massive leaps of judgement because you've always got in your head, these terrible things are going to happen? Feeling that all these bad things will happen, but er,		
32	**Interviewer**		
33 34 35 36 37 38 39 40 41	Would you liken that to hypervigilance? **L** Yep, yep, when you look at traditional trauma symptoms, yeah, I think you can become quite hypervigilant, definatly erm, and I think, the other side of it actually is that you can become, when it comes to how you deal with your clients, you can become, part of you can become a bit shut off, and you're not listening to them the way you should be because you actually can't deal! It's too much! So you start kind of having, this self-protect stuff comes in, where you start kind of, the shutters come down a bit, and you're not responding the way you should, or, you're sat in the office and you know you've got to ring all these people, but actually, you kind of don't want to. Because you can't deal with hearing more stuff.	HYPERVIGILANT BECOME SHUT OFF YOURE NOT LISTENING YOU CANT DEAL TOO MUCH - SELF PROTECT. SHUTTERS DOWN NOT RESPONDING TO CLIENT DONT WANT TO.	SHUT OFF RESPONSIBILITY TO CLIENT PROTECT SELF. CANT RESPOND.
42	**Interviewer**	NOT ABLE TO DO ROLE RESPONSIBILITY.	ROLE RESTRICTED
43 44 45 46 47 48 49	So to summarise that then, we're, what we're talking about is not being able to do the role? **L** Not being able to do the role, and actually the impact on your mental health and your relationships, I think it's like a 360 degree affect really. When you have to, I think you have to have some distance from it to see that, because I don't think you see it when it's happening, but I do think that's the impact of it. Yeah, I think it's almost like you have this, like you're seeing everything through a lens, like a lens of everything being terrible, a lens of terribleness.	IMPACT ON RELATIONSHIPS 360° AFFECT NEED DISTANCCE DONT SEE IT COVERT A LENS OF EVERYTHING BEING TERRIBLE.	DISTANCE. NEGATIVE SENSE OF SELF. LENS OF TERRIBLENESS.
50	**Interviewer**		
51 52 53	Thank you. So if we're moving on to what we think could prevent that, happening, promoting autonomy in practice, encouraging self-care, supervision, peer support, are all ideas and interventions in practice, that aim to support you as a practitioner. Are you familiar with those terms?		
54	**L**		

Appendix G: Lucy's Transcript – Coded Page 3

LUCY.

NOT AUTONOMY.
CERTAIN AMOUNT OF ROPE
FEEL BETTER –
A BIT OF CONTROL.

LACK OF CONTROL.

Most of them apart from the autonomy one, although I can kind of guess what that would mean, so if I just say what I think? I imagine it means they give you a certain amount of rope for you to use, and I suppose to make you feel better about things because you've got a bit of control. Would that be right

Interviewer

Yep, brilliant, yeah, thank you yeah, so it's a trust thing in enabling you to do your role in how you feel

TRUST.
PARTICULAR FEELINGS WITHIN
HERE THIS STUFF.
CANT DO ANYTHING.
ENABLE IF YOU HAVE TOOLS
DEALWITH IT – MOVEFORWARD
CHANGE POSITIVELY
DESTRUCTIVE TO M.H.
NOONE LISTENS
SOAKING IT ALL UP,

NO AUTONOMY.
HELPLESS
FRUSTRATED
NOT HEARD.
IGNORED.
INADEQUATE.
ABSORB TRAUMA

L

Yeah yeah and I do feel, I can see where that would come in because I do think there's a particular kind of feeling that comes about when you you're hearing all this stuff, but then you can't do anything about it? I think its actually a lot easier if you can say, ok, I'm hearing this, I hear what you say, here are the tools I have to help you deal with it, here's to moving you forward, and you can see things change positively, I think what is very destructive actually, for your mental health with regards to trauma is when you see it, and you actually can't do a lot. You feel like other people aren't listening to you, you feel like you're being the, in my role as IDVA and advocate as somebody, but no one cares, no one's listening, so yeah, you're soaking all this up, but it's not going anywhere, like you're just soaking it up.

Interviewer

Yes, yes, thank you. The idea of supervision appears to mean, it seems to mean lots if different things to lots of different people and actually on researching it there are lots of definitions of supervision relevant to roles and different professions, some practitioners have clinical supervision, others have management supervision some a mixture of both, could you tell me a little bit about what supervision itself means to you as a practitioner, what it meant to you, as a definition.

SUPERVISION & DEFINITIONS
WHAT SHOULD HAVE
DID HAVE.
HR BASED.
DONE SOMETHING WRONG.
NON THERAPEUTIC
CAB & MANAGEMENT.

SUPERVISION
SUPERFICIAL
HR.
REACTIVE
NOT
THERAPEUTIC
SELF DOUBT

L

I would have two definitions of that so I'd have a definition of what I would expect supervision to involve for my sector, and for the kind of work that I was doing, and I would have a definition of what I received. So what I received was very, I would say HR based very much based around have you taken annual leave, any sickness issues, any issues with your performance, more like performance revues really and is there any issues with you. Almost supervision would come a time where you think, shit, if I've done something wrong this is where I'm gonna get told off. Erm and then didn't really have a therapeutic element at all, if you talked about cases it was more along the lines of, if there's a problem with this case what's going to be done with it,

Interviewer

A practical issue with that particular case as opposed to what was happening for you

Appendix G: Lucy's Transcript – Coded Page 4

LUCY.

85	**L**			
86	Yes, what I would understand supervision to be of use for, and like in relation to trauma, but actually probably	TRAUMA		REFLECTIVE PRC CLIENT AND WORKER
87	what it actually probably should be in my opinion and from training I received whilst I was an IDVA would be	REFLECTIVE PROCESS		
88	that yes those things might be included but it would also be about looking at that reflective process, looking at	IMPACT ON CLIENT		
89	how you were impacting o clients because we as individuals bring our own stuff, and how that then reflects on	BRING STUFF - TAKE STUFF		EXCHANGE TRAUMA
90	to how you deal with a client, kind of, that that opportunity to look at things differently, but also then about	AWAY.		
91	how that client impacts on us as individuals, because as well as bringing stuff we take stuff away, and how much	OPPORTUNITY TO LOOK AT		
92	of that we are taking away with us erm and how its impacting on us, and also as an opportunity to explore that.	DIFFERENTLY. - EXPLORE		LACK OF BALANCE
93	So when I was asked about my wellbeing, or when that was part of the supervision, I actually wasn't always, but	(ARE YOU ALRIGHT '' YES)		
94	even when it was, it was a case of 'are you alright?' which I would always say 'yes' because that's the kind of	WOULDN'T RECEIVE SELF DIC.		
95	person that I am and I wouldn't perceive myself to not be all right.			
96	**Interviewer**			
97	The term professional resilience, is used more frequently it appears to address personal qualities or strengths			
98	that support a professional, can you say if you've heard about professional resilience and what that might mean			
99	for you as a practitioner?			
100	**L**	SOME MORE ABLE TO COPE THAN OTHERS.		PROFESSIONAL SOUL VS PASSION.
101	No, it's not something that I've heard of, not something that came up, I can kind of guess what they're getting	CONCERN		
102	at with that that some people are more able to cope with others, erm, but my concern with that would be, my	RESILIENCE VS PASSION ?		CYNICISM.
103	concern always with that would be that, is when you have organisations that deal with with these kinds of	RESILIENCE = GOOD REASON		
104	issues, then you have people that are very resilient or perceived as very resilient, and who then do very well,			
105	within the kind of aims and objectives of the organisation, and hits targets etc. . But sometimes that's the			
106	people who, they might be very resilient, using air quotes, but is that because they don't have the other			
107	essential elements, so, to me the passion, the care for the clients, the wanting to see change, wanting to see			
108	them move forward, actually if you don't have that you're probably going to be a lot more resilient, but does			
109	that make you a good practitioner? I would say not.			
110	**Interviewer**			
111	Brilliant, thank you. So moving on to your own sort of personal experiences and thoughts of improving the			
112	support that you might have received as a dv practitioner, as part of your professional training, both within your			
113	organisations, and we've talked about you being an IDVA so that would have been training from a national			
114	organisation, in order to equip you to deliver a professional nationally recognised role, could you tell me a little			
115	but about how you working with domestic abuse and its potential to impact on you were covered?			

Appendix G: Lucy's Transcript – Coded Page 5

LUCY.

NOT COVERED IN ORGANISATION.
CAADA – YES.
RESTTIME – LIGHT BULB MOMENT.
TOOK INFORMATION BACK ORGANISATION NOT INTERESTED. RESPONSIBILITY

RESPONSIBILITY TO WORKER. NOT TRAINING OR MANAGED WHEN DID (LIGHT BULB' realisation myself.

116 L

117 Ok, within the organisation that I worked for it was never covered at all. Within the erm training that I received I
118 received training from CAADA as it was, now saferlives, the IDVA qualification, within that we talked about
119 vicarious trauma and self-care, so that was the first time I'd really come across it, and it was quite a light bulb
120 moment for me, because I started to think, I kind of heard the theory and thought yeah that's me, like I can see
121 that in myself. I did take it back to the organisation that I worked for by term, they weren't at all interested.
122 Which was interesting in and of itself.

IDEA OF BEING WEAK.
EXPERIENCE – WEAK.
CYCLE BOOM IMPACTED.
SPEAK UP = WEAK.
NOT RESILIENT = SOMETHING WRONG WITH YOU.

EXPERIENCE PT + F = WEAK.

SELF BLAME

123 **Interviewer**

124 Erm,

125 L

126 And I think there was this kind of, when I did do that there was almost this erm, kind of thing, that this idea that
127 you're weak, that actually if you experience this kind of things you're weak, when actually what the research
128 shows and what I have personally experienced, and seen is that everybody is impacted in some way or other,
129 but this idea that if you speak up and say that somehow makes you the weaker person, It was a bit like going
130 back to that resilience stuff, you're not a resilient person, there's something wrong with you.

GIVE ONE HAND – TAKE OTHER.
TRAUMA – YOUR PROBLEM
REALLY TRAUMATIC STUFF
HOW CAN A MUMMY NOT BE IMPACTED.
YOUR RESPONSIBILITY.

131 **Interviewer**

132 It sounds like thats going to encourage fears of being able to do your own job, actually if its just you, then it's
133 you that's got the problem.

134 L

135 Yeah, yeah, like giving it to you with one hand, like you've got all if this work to do, you have to go and do all of
136 this stuff, listen to really traumatic stuff, but actually if you have a problem with that, it's your problem, and
137 there's something wrong with you. When actually in my opinion how can you how could you listen to all of that
138 stuff, be a normal human being who cares and not having an impact? Especially if you're not putting things in
139 place to deal with it.

140 **Interviewer**

141 Thank you, so to summarise, what you're saying is that the, your awareness around vicarious trauma, was only
142 because you did the IDVA training?

143 L

Appendix G: Lucy's Transcript – Coded Page 6

LUCY.

LIGHT BULB -SCARY
CAN SEE MYSELF.

AWARENESS
RECOGNITION.
SCARY.

144 Yes, and that was really interesting for me because it was a real light bulb moment where I went, "I can see
145 myself in this, it's quite scary."

146 **Interviewer**

147 How long had you been practising in that role before you had that training?

148 **L**

149 Quite a long time, like I think it was maybe a year, two years because I was an unqualified IDVA for quite a
150 while, and previous to that I'd done refuge work, where you're hearing all the same kind of stuff, to be perfectly
151 honest and generic outreach work which again, you're not working with the proportion of high risk clients but
152 you're still hearing terrible things.

VARIETY OF ROLES.
REFUGE OUTREACH
HIGH RISK.
HEARING TERRIBLE THINGS

153 **Interviewer**

154 And in refuge in my experience you're actually trapped with that more, in an outreach appointment you'll be
155 going in for an hour, whereas in the refuge environment you're working all the time with that going on all
156 around you,

157 **L**

158 And my experience of that in refuge actually was that people who'd worked in refuge long term became very
159 erm detached from the women I would say. Maybe, I mean I'm drawing my own conclusions here but
160 potentially I don't know whether it's because they became overloaded, with the whole compassion fatigue idea,
161 and therefore they had to detach themselves, and I've seen myself do that at different periods in my career, but
162 I wonder if that's what some of that was about, because going in when I first started at refuge, you'd feel that
163 people were quite hard,

REFUGE DETACHED FROM WOMEN.
OVERLOADED. COMPASSION FATIGUE - DETACHED
HARD. DEHUMANIZED

DETACH
OVERLOADED
HARD.
FATIGUE.
DEHUMANIZED

164 **Interviewer**

165 Hardened to it?

166 **L**

167 Yeah.

HARDENED

HARDENED.

168 **Interviewer**

169 So a part of your professional training we've covered that bit, as part of the organisations initial induction and
170 their ongoing training could you tell me, as part of induction and ongoing training could you tell me if
171 professional trauma and fatigue were considered as something that you needed to be aware of?

Appendix G: Lucy's Transcript – Coded Page 7

LUCY.

172	L		NOT COVERED FROWNED UPON	
173	They were not in anyway, and like I said it was almost kind of frowned upon. Like there was something wrong		SOMETIMES WORDS WITH YOU.	RESPONSIBILITY TO STAFF.
174	with you if you. I remember taking that information back and it was almost as if this information, what's this,		IF STRUGGLING - ITS YOU.	
175	we don't have this. His idea that if you're struggling with it this is something intrinsic to you, not because of the		NO RESPONSIBILITY.	
176	work were asking you to do.			
177	**Interviewer**			
178	So, as mentioned earlier, we talked about promoting autonomy in practice, encouraging self-care, supervision,			REGULAR SUPERVISION SUPPORT.
179	peer support, can all be seen as qualities and support that could help you as a practitioner, do you have any			
180	experience of these, that we haven't covered before, that you wanted to tell me about?			
181	L		NOT A LOT EXPERIENCE NOT OFFERED.	
182	I don't think I've got a lot of experience of them, erm, because they weren't offered, erm I think I know what		THE SUPERVISION NOT THERE FOR TRAUMA WORK.	
183	they should look like, but I don't think that I have much experience of the no. Like I said previously about			
184	supervision that was never the kind of supervision that was useful about trauma or compassion fatigue point of			
185	view, it was the kind of supervision that was useful from a HR point of view.			
186	**Interviewer**			
187	That's fine thank you. Can you think of a time that you might have asked for support, from your employer o line			UNAWARE OF IMPACT.
188	manager?			
189	L		DIDN'T ASK.	
190	No, I didn't, and I think I would have never realised at the time, that there was an issue. Because I think that half		DIDN'T SEE AN ISSUE.	COPE - .
191	the point of a lot of these things whether your talking about vicarious trauma, or direct trauma, you don't see it		COPE - DO YOUR BEST.	DISTANCE TO SEE IT.
192	as an issue at the time. Because you're dealing with it you're coping with it, and you're doing the best that you		STEP BACK -	
193	can, and that's part of the problem, and then when you step back from it you either completely crash or you		CRASH YOU RECOVER.	UNAWARENESS.
194	recover, I think that those are the points at which you go, "wow, ok that was a problem."			
195	**Interviewer**			
196	Interestingly that seems to parallel with some victim's experiences, they're not actually aware of what domestic			
197	violence is at times they're not aware that there support that they can access,			
198	L			

Appendix G: Lucy's Transcript – Coded Page 8

LUCY.

199	Yeah, its why within DV psychoeducational works so well, talking to people about power and control, talking to	PSYCHOEDUCATIONAL – GOOD.		AWARENESS
200	people about how these dynamics work, how someone is like "oh god that's me" like the vicarious trauma stuff,	('THATS ME'		RECOGNITION
201	"oh yes that's me" and actually if you're not being told if you're not able to, erm, if it's not being recognised,	HUMAN NATURE TO THINK		SELF DOUBT.
202	everyone around you is going, "there's nothing here for you to be worrying about, you should be able to deal	OTHERS ARE LAZY!T.		
203	with this" then its human nature to think everyone else must be right, there's something wrong with me. It's	SOMETHING WRONG WITH ME.		
204	nothing to do with this work or job, almost victim blaming,			
205	**Interviewer**			
206	So as opposed to some support that you might have asked for, rather than you having identified that need for			
207	support, was there a time when your line manager ever identified a need for support.			
208	**L**			
209	I think that there were clear indicators, but it was never recognised, no.	INDICATORS NOT NOTICED.		NOT RECOGNISED
210	**Interviewer**			
211	OK thank you			
212	**L**	RESISTANT.		RESISTANT.
213	And I think I would have been fairly resistant, because I think that the culture of the organisation and the idea	CULTURAL –		RESPONSIBLE
214	that it was your fault, if someone were to then recognise it, because of that culture it would have felt like a	YOUR FAULT.		
215	negative thing. It would have felt like you're not coping, you're not doing very well, which then as somebody	NEGATIVE – NOT COPING		NEGATIVE-COPING
216	who always wants to achieve, that would not sit well with me.	NOT SIT WELL WITH ME.		
217	**Interviewer**			
218	Thank you. Has there been a specific time where you felt there really was a supportive gesture or idea on when			
219	you're listening to trauma, or the after effects of listening to trauma, from your manager or your peers or your			
220	training, is there anything you did feel worked or could work for you?			
221	**L**	LEARNING ABOUT PTF.		
222	I've never really, I never really experienced I wouldn't say a positive coping mechanism as such, erm because	SHIT DOWN.		AWARENESS
223	none of it was available, however, er, I think as I've previously mentioned, learning about vicarious trauma in			LEARNING.
224	itself s I said before the kind of psychoeducational side of that was really useful for me, because in the short	('IT'S MAKES SENSE')		
225	term at least, until it was shot down, it felt like "oh ok, this makes a bit of sense" and I think having an	AWARENESS		
226	awareness means you can regulate yourself and you can start and look at ways that you as an individual can	SELF CARE AS AN		
227	kind of mitigate for that, and just bring your self-awareness to it. Whereas when you're not self-aware there's	INDIVIDUAL.		

LUCY.

nothing you can do about it. It's just not in your sphere of thought, it's just not what you're doing, whereas I think when you're in the kind of when I was aware, though because it wasn't taken seriously by other people and the culture of the organisation it didn't make a massive impact but it still had an impact because its still there in my head, and I was still at times thinking, for example when I was in a supermarket and a bloke was saying something, I was thinking maybe this is me. Maybe this isn't about the person, Maybe the way they picked those beans up wasn't that bad. Maybe you I shouldn't be damning them to hell, just yet.

REGULATE SELF.
WASN'T TAKEN SERIOUSLY.
CULTURE.
IN MY HEAD.
MAYBE THIS IS ME.

SELF AWARENESS
CULTURE ORGANISATION
RECOGNITION.

Interviewer

Could you tell me how you might try to practice self-care on a regular basis?

L

Within that role I don't think I did practice self-care, because I didn't realise the importance, it wasn't felt as important by anybody else, and erm I think little things that might have, or now that I think are really important like erm taking the time or something after a difficult appointment having the ability to be able to reflect on that with somebody, having a bit of timeout after an incident that's difficult and making sure that you sit and just have a cup of tea and chat to somebody, erm and having a sort of debrief from it. Making sure that you do things like taking breaks, making sure that you aren't working ridiculous hours, making sure that you take a break at lunch for example, and aren't just going going going going, they are all things that I think are important now, but I think it would have been perceived in the work place where I worked previously that it would have been a weakness if I were to have done these things, and I therefore felt they were weaknesses. That was my perception as well because that was the culture I was within. So if I had stopped and said "er I'm going to take this much time to have my lunch and sit away from everybody else, and you know, refresh my brain, erm I feel that would have been like, "er what's she doing, lazy!" Actually probably would have been a lot more productive, because you're not just working yourself into the ground you're taking the time, and I know it's going off track a little bit but when you look at all the recent research into mindfulness and meditations how it effects our brain, how it functions how it grows how it changes, all that makes a lot of sense, sometimes doing nothing is just as important as ding something, but I don't think that that is appreciated.

DONT THINK I DID PRACTICE SELF CARE.
NOT IMPORTANT
ABILTY TO REFLECT.
TIMEOUT.
DIFFICULT INCIDENT
RIDICULOUS HOURS.
WEAKNESSES – CULTURE
LAZY.
TAKE TIME.
IT EFFECTS OUR BRAIN.

RECOGNISE SELF CARE.
CONSTANTLY ABSENT.

Interviewer.

Brilliant, thank you. I know that this is a bit of a magic wand question but in your experience was there anything that your employers could do that would make things better for you, either with the process that you needed to follow to seek help, or which clearly you weren't even aware was an issue at that point, but if there was a process that you needed to follow to seek the support, or there were actually ways to provide that support?

L

	LUCY.		RESPONSIBILITY
259	Yes, I think there something wrong within that question, because I don't think it should be about seeking	NOT SEEK MANAGED IDENTIFY.	ORGANISATION AND SELF.
260	support I think it should be about managers identifying that there's an issue, erm and drawing that out, Just like	AS WITH CLIENT - DRAW OUT.	
261	you would with a client, you wouldn't go to somebody who you think is experiencing domestic abuse because	SEE IT IN STAFF.	REGISTRATION
262	all the signs are there and '"you ok,?" and they say "Yes," and you went "all right then that's fine" I mean that	WHAT IS GOING ON.	
263	would be the classic, I mean I don't know what happens why we can't see that with staff? Erm so to me that	TECHNIQUES - STRATEGIES	TRAUMA INFORMED
264	should be about teasing it out of people, finding what is going on for them, but also primarily in answer to the	TRAUMA INFORMED.	
265	second bit of the question is in building all of those techniques, all of those strategies into how teams work and	SUPERVISION - POSITIVE.	
266	how they're managed, so kits not about, oh this is elf care, or this is to stop trauma, actually it should be a		
267	trauma informed approach, not just for clients but also for staff. So that all these things are looked at at every		
268	stage, so you're having kind of the space built into the diary for team building stuff and team support and that's		
269	given importance. You're encouraging and potentially making people take bits of time for themselves to take		
270	breaks. You are making sure that supervision is a positive time, and if people want to talk about it or not quite		
271	frankly your diving into how the cases are impacting on them and how they are impacting on the cases. And		
272	you're not just allowing people to get out of it by going "oh I'm all right". So actually it doesn't become about		
273	somebody putting their hand up and going "I'm the weak person" it comes back as a weakness in not doing all		
274	of these things were asking you to do.		
275	**Interviewer**		
276	That's coming across as almost a cultural		
277	**L**		
278	It's a cultural thing.	BAD NOT TO TAKE TIME.	PRODUCTIVITY.
279	Yes, it's bad to not take time, it's not good, and I think we always, I think its become about a productivity focus,	PRODUCTIVITY FOCUS.	
280	so we have to do do do do do, and I think generally, in life we're seeing that that's a problem and if were talking	PROBLEM NORMAL JOB →	
281	about it being a problem for someone sitting in an office to do that, how much of a problem is it for someone	PROBLEM WORKING WITH TRAUMA.	TRAUMA INFORMED
282	hearing traumatic experiences time after time after time. And if we want to look at the quality of interventions	TRAUMA INFORMED GOOD INTERVENTION.	
283	for domestic abuse victims then we need to make sure that our staff is happy and stable and as emotionally		
284	stable as possible, and I think if you do that then you'll have good interventions.		
285	**Interviewer**		
286	You used the phrase Trauma Informed which I'm coming across a lot in my research, which actually could really		
287	counter that negative culture couldn't it, that were coming at it from an informed position?		
288	**L**		

	LUCY.		
289 290 291 292 293 294 295 296	Yes, but also there's this idea that Trauma Informed is for our client, all of these things are for our clients, and yes clearly when you are working with people who are traumatised you want to implement best practice, and evidence based interventions, but actually you should want to do that for your staff as well. Even if it's coming from the completely most selfish perspective that you want the best out of them I mean for your clients. Purely economically. It makes more sense, somebody working through their lunch, listening to awful things and not telling anybody, not reflecting on it, not having the space to think about it, not having a supportive team around them, they're going to crash and burn, or, become massively ineffective, which is then not going to help you achieve what you want to achieve.	TRAUMA INFORMED STAFF. CLIENT – WORKER. BEST PRACTICE. BEST OUT OF STAFF LISTENING TO AWFUL THINGS CRASH + BURN INEFFECTIVE	VICIOUS CIRCLE. CRASH + BURN. INEFFECTIVE.
297 298 299 300 301 302 303 304 305 306 307	**Interviewer** Thank you. So we've been talking a lot about how tough that role is, and different ways that you may, or may not experience the care and assistance that you need to work effectively, so I'd be really interested to know what motivated you to work in the role, and what continued to motivate you in the role? **L** Mmm, I mean I think the thing that always motivates me was the ability to see people change, the ability more than anything to see people gain self-esteem and gain control of their lives. I came as a social work student, so I got to see that in a refuge environment, and I just really enjoyed that, and I enjoyed the fact that I could be part of the process, and I erm, and that's something that has the followed me throughout my career, and I want to support women to achieve and feel better in themselves and not stuck in cycles of negative behaviour and negative consequence. That's what I enjoy about it.	MOTIVATED TO SEE CHANGE. GAIN SELF ESTEEM + CONTROL PART OF THE PROCESS. ACHIEVE BETTER-FEEL BETTER. NOT STUCK IN CYCLE	SEE CHANGE GAIN CONTROL EMPOWER.
308 309 310 311 312 313 314 315 316	**Interviewer** And that's interesting listening to you say that it feels like another parallel between the manager and practitioner role and the practitioner client relationship because as a manager what you would like to see as a culture is that a member of that team you're encouraged to move forward, equipped and strong to deal with **L** And achieve more, achieve more, you would want to see your staff moving on, actually in a weird way because you want people to get bigger and better and stringer and you want to have those skills in your team, and if someone's overloaded they don't have the ability to do that. **Interviewer**	ACHIEVE – SEE STAFF DEVELOP. OVERLOADED.	SUPPORTIVE CULTURE LOOK AFTER YOURSELF

LUCY.

317 So is there anything that you'd like to add, because it's not a totally structured interview schedule, I know that
318 recently you're going to be moving into a role that you're managing a team so that your sort of changing roles
319 at quite

320 **L**

321 A pace

322 **Interviewer**

323 Yes, absolutely, so in the role as a practitioner or in the role as a new manager taking on a team of practitioner
324 is there anything that you would like to add, that you, feel would be useful to this particular study?

325 **L**

326 I just think fully integrated support really, having fully integrated support for everything that you do, and
327 creating a culture within teams that actually like I said, the culture is that you look after yourself and that we
328 will support you to do that, and we will expect you to do that, and that is primary, rather than, it be this kid of
329 ide that you must, like I've experienced, that it's your responsibility took after yourself, so if you're not looking
330 after yourself you're at fault, but were not going to give you any time or space or support to do that and it's
331 going to be your fault if you fail. So I think making sure that all of the things that we've talked about,
332 supervision, clinical supervision where possible and appropriate, giving people autonomy some sense of control
333 in their jobs, giving people the space and time for team building and really like meaningful structured team
334 support, not just be sitting in an office and chat but proper meaningful support erm, all of these things to be
335 integrated into how staff are treated and how this works, so it's a part of it from the beginning, base up and it's
336 an expectation, that's what I would like to see, and I think that's what people need.

337 **Interviewer**

338 Brilliant, thank you very much.

SUPPORT FOR STAFF
FULLY INTEGRATED.
CULTURAL.
WE WILL SUPPORT YOU.
BALANCE OF RESPONSIBILITY
CLINICAL SUPERVISION.
MEANINGFUL.
FROM THE BASE UP.

CULTURAL SUPPORT
BALANCE RESPONSIBILITY.
BASE UP.

Appendix H: Table of Codes

Vicky - DV	Samantha - C	Rachel - C	Gemma - SW	Tracy - SW	Lucy - DV
Impact individually	Not let go	Impact individually	Horrific situations	Exhausted	Responsibility to staff
Hardened	Not switch off	Immersed in trauma	Impact professionally values	Zap energy	Trauma Informed
Desensitised	Not leave at work	Draining	Impact personally	Impact personal - mum	Impact personally
Absorb trauma	Lingers beyond session	Heart breaking stories	Fall to pieces	Impact professionally	Impact professionally
No balance	Part of me	Exhausting mentally	Responsibility to client	Work life balance?	Non reflective
Feed up hearing	Responsibility to client	Responsibility client safety	Responsibility to manager	Part of job	Lack of control
Immune to detail	Responsibility to client	Respect client	Responsibility to peers	Resigned to it	negative
Emotionally exhausted	Clinical supervision great	Overwhelmed	frustration	Accepted it	Shut off
Isolated	Reflective	Frustrated client	anxiety	pressure	hardened
Isolated	Experienced supervisor	Resilience client	frustration	High risk DV	detached
Gradual impact	Victim worry	Supervision emotionally protects	feel like failed	Extreme abuse	Hardened
To the core	Instant supervision	No closure	dangerous	Men!	detached
Helpless	High risk	Fearful for client	Professional conscience	Challenge your views	Negative sense of self
Values life	Limited sessions	Peer support beneficial	Truth clients	treadmill	Absorb trauma
Values men	Rape	Instant support	burnout	Non reflective	Frustrated supervision
Values suicide	Frightened	Not feeling judged as practitioner	Not reflective	Non reflective	Lack of balance
Responsibility client	Lots of support	Reflective – self aware	No time to reflect	Tread mill	Supervision superficial
Responsibility client	Lots of support	Keep self-safe	sceptical	Lack of understanding with professionals	Thoughts not feelings
Who am I	How do I feel?	Group supervision	cynical	awareness	Resilience vs passion

		share experience			
Lost objectivity	Resilience – aware	Encourage autonomy	consuming	Lack of awareness dv	cynical
Need clinical; supervision	Autonomy	Supervision superficial	Supervision routine superficial	children	dehumanized
Ignored	Confidence	Preparation for client issues	Peer support great	Awful situations	Lightbulb awareness around PTF
Good practice?	Preventative not curative	Clients confused	Resilience – how do you know	Caseload impossible	overloaded
Not prepared	Supervision lip service	Counselling at right time	Resilience personal / professional	tragic	fatigue
Not aware enough	Part of the team	Personal experience	It's your job	Thoughts not feelings as practitioner	Weak if have a problem
Peer support good	Interested in me	Not seen as coping	Part of your role	Detached / empathy	Embarrassed can't cope
Management defensive	Limit work	Clinical / reflective supervision essential	unprepared	Hardened / time to leave	Self-doubt
Parallel client relationship	Battle hardened		Accountability life / death	Horrific stories	cultural
Supervision lip service	Man hater		desensitized	What about me	Blame self
Autonomy	Drip drip drip trauma		Live and breathe it	Cant empathise	Cultural blame
Trust	Desensitised		Access counselling self-refer	dehumanised	responsibility
Cultural	Heard it before		Am I doing a good job?	Frustration system	Ignored - what about me
Trauma informed	Clients stop being individual		Supervision fear of judged	Not considered as staff	
Respect us	Self-care essential			Wellbeing????	
Make a difference				isolation	
What about me				No one understands the work	
Self-care self-taught				burnout	
				Self-doubt	

				ignored	
				What about me	
				Cultural attitude	
				No resources	
				Do job or not	
				Micromanaged	
				unprepared	

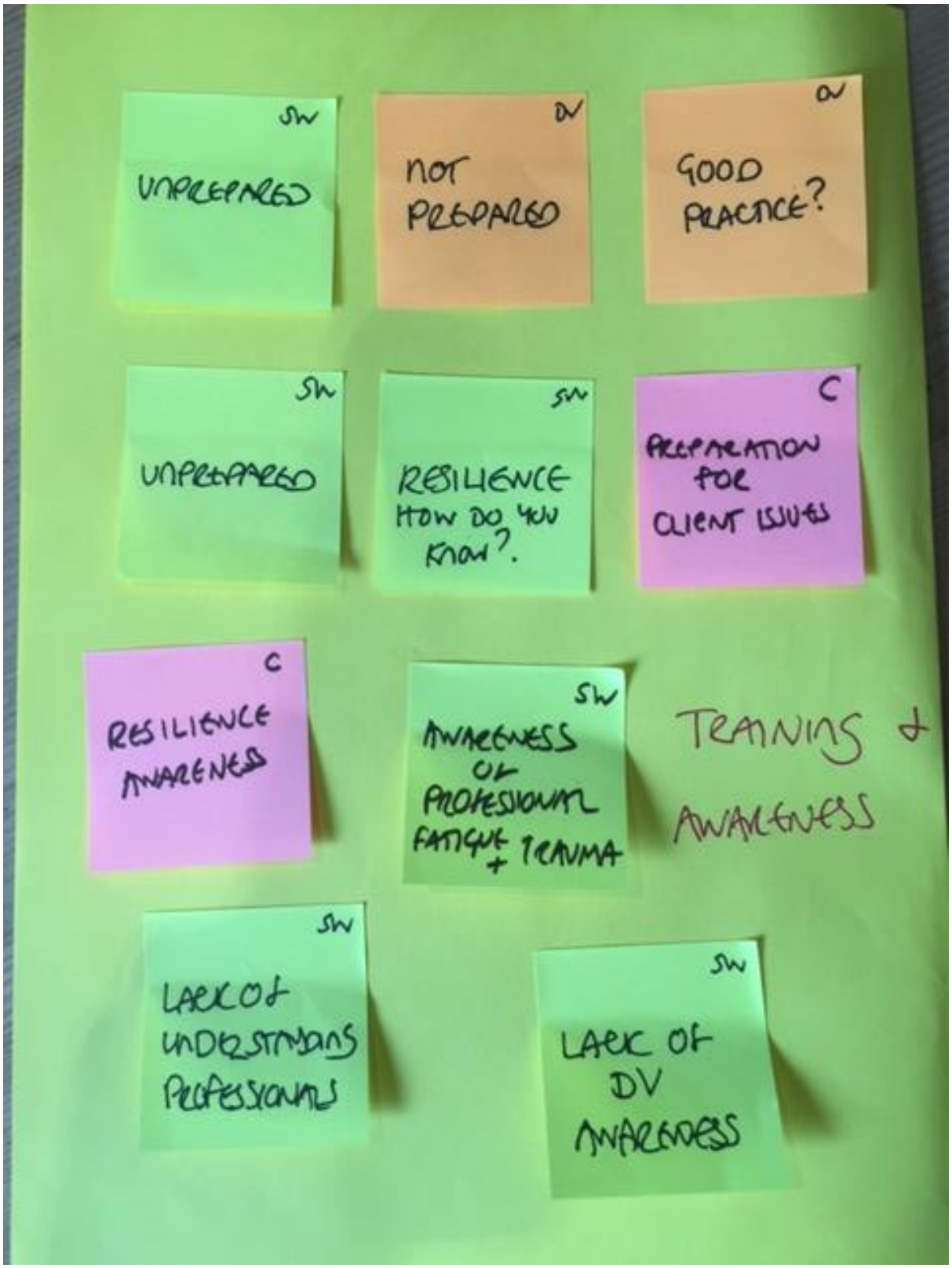
Appendix I: Theme 1 – The Brutality of Domestic Violence

Appendix J: Theme 2 – Support, The Good and the Bad

Appendix K: Theme 3 – The Weight of Responsibility

Appendix L: Theme 4 – The Impact, Professionally and Personally

Appendix M: Theme 5 – Training and Awareness



Appendix N: Project Plan

Project Plan

Please read the Guidance Document in the SPEC Space on the KLE before attempting the Project Plan. Submissions will be rejected if any formatting employed below (except space allocated to answers) is changed or the two A4 pages limit is exceeded.

Please complete the top row in the table below and tick the appropriate 2rd row box to identify your degree course.

Student: Sarah Boucher		Supervisor: Dr. Mark Trueman		Date: 18th January 2016
BSc Psychology: Final Year Project	BSc Psychology-Major: Mini-Project	MSc Psychology: Dissertation	MSc Psychology: Research Apprenticeship	MSc Counselling ✓

1) Provisional project title:

'How do members of the helping professions experience organisational support and cope with their work when supporting victims of domestic violence?

2) Study aim:

To explore members of the helping professions experience and awareness of the potential impact of listening to trauma when supporting victims of domestic violence.
To explore the different ways agencies, support their staff in this area of work.
To explore the contrast between counselling supervision and management supervision and how this may support staff.
To identify any key interventions that professionals find supportive.

I am aware of the difference in organisational support for professions in different sectors. I am particularly interested in themes that may emerge cross discipline that professionals feel make a difference in their wellbeing whilst working within a traumatic arena.

3) Who will participate in the research and exactly how will they be contacted and recruited?

Approximately 6 professionals, 2 counsellors, 2 social workers, 2 domestic violence support workers.
I will contact and recruit participants through my existing professional network.

4) Describe the methodological approach to be applied and also outline any stimuli and apparatus, or other materials (e.g., neuropsychological tests, questionnaires, interview schedules) to be used:

A qualitative study, I will record and analyse semi structured interviews, working from an interview schedule in order to try and gather experiential data.

Questions I am to include

1. Could you comment on how listening to trauma can impact on your own wellbeing?
2. Can you tell me a little more about your experience of any impact on your wellbeing by working intensely with victims of DV trauma?
3. Where may there be support available for you if you identify this as a need?
4. In your experience what is adequate support and what does it involve?
5. Could you tell me how you may be able to practice self-care?
6. What does the term 'Wounded Healer' mean to you and do you identify with this?

5) Account of the Research Design:

This will be a qualitative study, semi structured interviews on a one to one basis.
I will aim to ask open ended questions to encourage the participants to explore their experiences.
I will record the interviews, and then transcribe them.
I will keep a reflexive journal.

1

6) Account of the Research Procedure:

I will design and produce an information sheet for potential participants in order for them to have clear information about the project its aim, procedure, how the data may be used in order to enable participants to feel confident in the process and be able to consider informed consent.
The data will be recorded during the one to one interviews. I will communicate individually with participants prior to the session to arrange a mutually suitable and safe venue. I anticipate this to either be at the participant's place of work or their home. I am aware participants may feel less open to communicate if they are in their place of work given the subject matter. Given geography the university is not likely to be a practical venue.
I will facilitate a debrief session with the participants.

7) Data analytic techniques to be applied. NB. A full specification required in undergraduate Posters:
I will use thematic analysis (Braun & Clarke, 2013) in order to code and then search for themes from the transcribed interviews.

8) Data management plan – please outline: [a] procedures to protect the confidentiality and anonymity of participants and their data during the research, [b] the data to be stored, who will have access, where it will be stored and for how long, and [c] the measures to be applied to ensure data security and what will happen to the data when the project is complete:

A. I will provide a consent form to explain the project, its aims, and the type of data I am looking for. I will explain that some quotes maybe used, and that I may use data from the project to use for further articles or research. Having taken into account the BACP ethical research guidelines I hope that this will, provide enough information to gain informed consent. I will confirm my intentions to create confidentiality and anonymity for the participants using pseudonyms which will be used from the start.
B. I shall confirm that only myself and my supervisor will have access to this data. Recordings and transcripts will be anonymised and stored on a password protected computer.
C. I shall confirm with the participants that the raw data will be destroyed upon completion of the award.

9) Research should avoid causing distress, but if the study may cause discomfort or unsettle participants, then please list the specific advisory or counselling services with the full contact information to be provided in the study debrief. Please provide a very short list of highly pertinent organisations/services.

There is the potential for this study to trigger personal or professional memories or incidents that may trigger discomfort or distress.
I shall include contact details for local agencies to support memories around domestic violence to access support on the initial information sheet for participants and at the debrief. I shall provide details for local advisory centres should issues around employment arise on the initial information sheet and at the debrief.

For issues around domestic violence the local specialist is:
The Pathway project 24-hour helpline 01543 676800

Local employment advisory organisation
CAB 0344 441 1444

Reference
Clarke, V., & Braun, V. (2013). *Successful qualitative research: A practical guide for beginners*. London: Sage Publications.

Appendix O: Ethics Committee Checklist

PSYCHOLOGY STUDENT PROJECT ETHICS COMMITTEE (SPEC) CHECKLIST

Please read the Guidance document in the SPEC Space on the KLE before attempting the Ethics Checklist.

NB. The Ethics Checklist submissions will be rejected if any of the formatting employed below is altered.

APPROVED 2/2/16

Please complete the top 2 rows in the table below and tick the appropriate 3rd row box to identify your degree course.

Student: SARAH BOUCHER		**Supervisor:** Dr. MARK. TRUEMAN		**Date:** 20/1/16
Brief title of study: PROFESSIONALS EXPERIENCE OF COPING WITH TRAUMA WHEN WORKING WITH DOMESTIC ABUSE				
BSc Psychology: Final Year Project	**BSc Psychology- Major: Mini-Project**	**MSc Psychology: Dissertation**	**MSc Psychology: Research Apprenticeship**	**MSc Counselling Psychology** ✓

Please complete the form below by circling the YES or NO responses, and submit to the School of Psychology Research Ethics Committee via the School of Psychology Office. Where **bold** responses are circled, please provide explanatory information (appropriately labelled with question & part) on a separate sheet. Please be aware the Psychology SPEC may request further information.

1. Prior ethical approval.

A) Has this research project received approval already from another research ethics committee?

YES (NO) If **YES**, please provide details

2. Informed consent.

A) Will the researcher inform participants of all aspects of the research, particularly those with negative consequences, which might be expected to influence willingness to participate?

(YES) **NO** If **NO**, please explain

B) Will the researcher ensure participants know their right to withdraw themselves and their data from the study without providing a reason?

(YES) **NO** If **NO**, please explain

C) The data anonymization procedures applied can make it impossible to identify a participant's data. If data will be anonymized, will the researcher ensure participants know the latest point at which a request to withdraw their data will be successful?

(YES) **NO** N/A If **NO**, please explain

D) Research Governance regulations require a researcher to keep a verifiable record of participants' informed consent. (Standard informed consent verification record forms are available in the SPEC Space on the KLE.) Will such a record be kept?

(YES) **NO** If **NO**, please explain

E) Deceiving participants should be avoided, but may be necessary. (NB. Omitting information irrelevant to participants' willingness to engage in research is not deception.) When deceiving participants, a researcher must: (i) determine no alternative procedures avoiding deception are available, (ii) consult with informed but disinterested advisors on how the deception will be received and (iii) ensure participants are debriefed as soon as possible. Will all of this be done?

YES **NO** (N/A) If **NO**, please explain

3. Confidentiality

A) Are you conducting a counselling self-assessment study?

YES → Then please tick this box ☐ and move straight to Question 6.

NO → Then please continue answering the Questions below.

E) Is the research recruiting participants who are or have received clinical psychological, psychiatric or medical treatment for problems which are the research focus (e.g., recruiting depressed / previously depressed people to examine depression)?

YES (NO) If **YES**, please explain

6. De-briefing.

A) Will participants be de-briefed to ensure the study purpose is appreciated and to monitor possible misconceptions or negative effects?

(YES) **NO** If **NO**, please explain

B) Will counselling or advisory arrangements be needed for participants who are distressed or who might seek advice?

(**YES**) NO If **YES**, please explain

PLEASE SEE ATTACHED NOTES

7. Procedures.

If not already addressed, please identify and explain the ethical issues arising from any of the following:

(i) Recall of confidential or upsetting memories PLEASE SEE ATTACHED NOTES .
(ii) Reporting or discussing confidential or upsetting topics
iii) Presenting unpleasant, emotionally evocative or loud stimuli
iv) Psychophysiological measures
v) Tasks with an extremely high failure rate
vi) Tasks which might threaten safety if an accident occurred
vii) Tasks which might harm or distress participants in a vulnerable state (e.g. anxious, bereaved, depressed)
viii) Tasks involving deprivation or restriction (e.g. food or sleep)
ix) Procedures from which participants might not feel free to withdraw
x) Procedures in which participants subsequently might regret taking part
xi) Procedures which might provoke inter-personal or inter-group conflict

8. Other ethical issues.

Are there any other ethical issues raised by the research?

YES (NO) If **YES**, please explain

9. Health and Safety

It is your responsibility to take any necessary steps to minimise health & safety risks (e.g. meeting research participants outside the School of Psychology, lone working after office hours in the School of Psychology) arising from the research proposed.

Staff Signature: Mark Tamm

Student Signature:

(Dr A Rutherford, October 2015)

Sarah Boucher

January 2016

Psychology Student Project Ethics Committee (SPEC) Checklist

Additional Information for the checklist.

Note 6B & 7

There is the potential for this study to trigger personal or professional memories or incidents that may trigger discomfort or distress.

I shall include contact details for local agencies to support memories around domestic violence to access support. I shall provide details for local advisory centres should issues around employment arise.

I have included these contact details in my project plan.

Appendix P: Safelives Guidance

Clinical supervision guidance
For domestic abuse services

The Leading Lights programme requires that services provide for the clinical supervision of front line domestic and sexual abuse workers. This guidance provides a brief overview of clinical supervision.

Safe Lives recommends that agencies provide one to one clinical supervision (as defined below) on a monthly basis. However, recognising that this is often new to services and that there are budget implications,[1] the minimum to meet the standard would be the provision of group clinical supervision on a quarterly basis.

Definition

Clinical supervision is defined by the Department of Health as "a formal process for professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex situations. It is central to the process of learning and to the scope of the expansion of practice and should be seen as a means of encouraging self-assessment, analytical and reflective skill."[2] An addition description is that "clinical supervision focuses on the development of the supervisee specifically as an interpersonally effective clinician."[3]

Clinical supervision in practice

Clinical supervision sessions are designed to provide a safe space in which the supervisee can discuss their personal or emotional responses to any traumatic or difficult cases. Alongside a range of other practical measures (see below), clinical supervision should be provided to frontline staff to ensure their emotional and psychological wellbeing and to help prevent emotional depletion or 'burnout'.

Clinical supervision should be carried out by a qualified person who is external to the service. The supervisee should not be accountable operationally or professionally to the supervisor. Clinical supervision notes may be stored by the practitioner/supervisor in an off-site facility. However, the incident of clinical supervision should be recorded and logged, and these details can be stored in personnel files.

Services should be explicit about the limits to confidentiality specific to supervisees undergoing clinical supervision. Supervisees should be made aware of how and when their supervision notes might be disclosed to their superiors at work. Supervision contracts for clinical supervision should specify the minimum standard of provision, and recourse to more clinical supervision should be provided if workers feel in need of more comprehensive emotional and psychological support.

The principles of clinical supervision

Clinical supervision should be undertaken within a culture of learning and should:

- Support and enhance practice for the benefit of clients
- Develop practice reflection skills to narrow the gap between theory and practice

[1] Cost of providing clinical supervision ranges from £15-£50 an hour. Therefore quarterly group supervision for two hours could cost as little as £280 a year.
[2] Department of Health (1993)
3 (Hart 1982)

- Involve a qualified supervisor and practitioner or group of practitioners reflecting on and critically evaluating practice
- Be distinct from formal line management supervision and appraisal
- Be planned and systematic and conducted within agreed boundaries
- Be explicit about the public and confidential elements of the process
- Involve all individuals in the service, signed up to by staff and supported and resourced by management
- Be developed in partnership with managers and practitioners
- Be supported by appropriate resources (time, training, replacement staff)
- Facilitate practitioner access to their chosen model of supervision, as appropriate[4]

A wider support framework[5]

In addition to the provision of clinical supervision, it is also important that domestic abuse services:

- Have a comprehensive case management and review framework
- Have line management supervision
- Ensure workers have reasonable caseloads and holiday allowances

Services can also foster open communication among workers through:

- Establishing a group debriefing procedure for especially challenging cases
- Creating opportunities for social interaction between workers
- Ensuring a supportive workplace culture in which staff are encouraged to provide peer support.

Services can also work towards building a less stressful work environment through:

- Prioritising the physical and psychological wellbeing of staff
- Providing a comfortable rest area set apart from client areas
- Rotating different tasks to prevent burnout - ensuring diverse caseloads for each IDVA

The importance of clinical supervision

Clinical supervision is necessary to ensure the emotional and psychological wellbeing of staff and allows them to explore the client/worker relationship in more depth whilst remaining an effective practitioner.

"Given the reality of IDVA work, providing clinical supervision indicates a commitment to addressing the stress and potential long-term health consequences associated with working as an IDVA. Those supervising IDVAs should not be presumed to be willing or able to provide this type of support in addition to their other responsibilities. Furthermore, we must not forget that some supervisors carry their own caseloads and cannot be reasonably expected to provide their own clinical support."[6]

Legal context:

- Health and Safety at Work Act 1974 – an employer must do everything reasonably practicable to provide a safe and healthy workplace with adequate welfare facilities.
- 'Common law': all employers have a duty of care imposed on them to protect their employees.
- Under existing health and safety legislation employers have a duty to undertake risk assessments and manage activities to reduce the incidence of stress at work.

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[4] *A Guide to Implementing Clinical Supervision* CPD37 (Revised September 2005 6). The Chartered Society of Physiotherapy.
[5] Tony Morrison (2005). Staff Supervision in Social Care, revised ed.
Providing Effective Supervision (2007), Skills for Care
Zoe Morrison (Sep 2007). 'Feeling heavy'i: Vicarious Trauma and other Issues Facing those who Work in the Sexual Assault Field (Australian Centre for the Study of Sexual Assault - ACSSA Wrap No. 4)
[6] Robinson, A. (2006) Independent Domestic Violence Advisors: *A process evaluation*.

- Changes to the Disability Discrimination Act 1995 in December 2005: mental illness no longer has to be a clinically recognised condition to be covered. So 'anxiety', 'stress' and 'depression' may be sufficient to qualify a person as disabled.

Considerations for not providing clinical supervision

Not providing adequate support for your staff could result in:

- Staff off on long term sick
- High staff turnover
- Potential legal action from staff

Resourcing clinical supervision

Services may wish to consider:

- Whether or not they would like to provide group clinical supervision or one-to-one sessions
- What other supportive practices they can build to complement (but not replace) the provision of clinical supervision, e.g. group debriefing, regular team meetings, celebration of success, case file reviews.

Your service will be best able to design clinical supervision arrangements tailored to your specific situation. You may wish to consider:

- A mandatory or 'opt out' process - 'opt in' arrangements for clinical supervision are rarely accessed by staff.
- Carried out by someone external to the service and to whom the IDVAs are not answerable professionally.

The cost of clinical supervision

Typical hourly rate for clinical supervision	£35-£70 per hour
Quarterly group supervision @ 2 hours per session	£100 - £140 (group numbers may be restricted)
Annual cost of quarterly group supervision @ 2 hours per session	£400 - £560

Where it is not possible to access financial resource, other creative options should be explored:

- You could contact a local university to see if newly qualified practitioners would be available at reduced rate.
- You could come to an arrangement with another agency where skills are shared, e.g. a qualified person from another agency could provide your service with clinical supervision and your service could provide that agency with some team training.
- A qualified professional from another agency could provide this service on a 'voluntary basis'.
- Small local grants could be sought to provide clinical supervision.

Appendix Q: Professional Quality of Life Scale

PROFESSIONAL QUALITY OF LIFE SCALE (PROQOL)

COMPASSION SATISFACTION AND COMPASSION FATIGUE
(PROQOL) VERSION 5 (2009)

When you *[help]* people you have direct contact with their lives. As you may have found, your compassion for those you *[help]* can affect you in positive and negative ways. Below are some-questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the last 30 days.

1=Never	2=Rarely	3=Sometimes	4=Often	5=Very Often

_____ 1. I am happy.
_____ 2. I am preoccupied with more than one person I *[help]*.
_____ 3. I get satisfaction from being able to *[help]* people.
_____ 4. I feel connected to others.
_____ 5. I jump or am startled by unexpected sounds.
_____ 6. I feel invigorated after working with those I *[help]*.
_____ 7. I find it difficult to separate my personal life from my life as a *[helper]*.
_____ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I *[help]*.
_____ 9. I think that I might have been affected by the traumatic stress of those I *[help]*.
_____ 10. I feel trapped by my job as a *[helper]*.
_____ 11. Because of my *[helping]*, I have felt "on edge" about various things.
_____ 12. I like my work as a *[helper]*.
_____ 13. I feel depressed because of the traumatic experiences of the people I *[help]*.
_____ 14. I feel as though I am experiencing the trauma of someone I have *[helped]*.
_____ 15. I have beliefs that sustain me.
_____ 16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
_____ 17. I am the person I always wanted to be.
_____ 18. My work makes me feel satisfied.
_____ 19. I feel worn out because of my work as a *[helper]*.
_____ 20. I have happy thoughts and feelings about those I *[help]* and how I could help them.
_____ 21. I feel overwhelmed because my case [work] load seems endless.
_____ 22. I believe I can make a difference through my work.
_____ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.
_____ 24. I am proud of what I can do to *[help]*.
_____ 25. As a result of my *[helping]*, I have intrusive, frightening thoughts.
_____ 26. I feel "bogged down" by the system.
_____ 27. I have thoughts that I am a "success" as a *[helper]*.
_____ 28. I can't recall important parts of my work with trauma victims.
_____ 29. I am a very caring person.
_____ 30. I am happy that I chose to do this work.

YOUR SCORES ON THE PROQOL: PROFESSIONAL QUALITY OF LIFE SCREENING

Based on your responses, place your personal scores below. If you have any concerns, you should discuss them with a physical or mental health care professional.

Compassion Satisfaction _____

Compassion satisfaction is about the pleasure you derive from being able to do your work well. For example, you may feel like it is a pleasure to help others through your work. You may feel positively about your colleagues or your ability to contribute to the work setting or even the greater good of society. Higher scores on this scale represent a greater satisfaction related to your ability to be an effective caregiver in your job.

The average score is 50 (SD 10; alpha scale reliability .88). About 25% of people score higher than 57 and about 25% of people score below 43. If you are in the higher range, you probably derive a good deal of professional satisfaction from your position. If your scores are below 40, you may either find problems with your job, or there may be some other reason—for example, you might derive your satisfaction from activities other than your job.

Burnout_____

Most people have an intuitive idea of what burnout is. From the research perspective, burnout is one of the elements of Compassion Fatigue (CF). It is associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively. These negative feelings usually have a gradual onset. They can reflect the feeling that your efforts make no difference, or they can be associated with a very high workload or a non-supportive work environment. Higher scores on this scale mean that you are at higher risk for burnout.

The average score on the burnout scale is 50 (SD 10; alpha scale reliability .75). About 25% of people score above 57 and about 25% of people score below 43. If your score is below 43, this probably reflects positive feelings about your ability to be effective in your work. If you score above 57 you may wish to think about what at work makes you feel like you are not effective in your position. Your score may reflect your mood; perhaps you were having a "bad day" or are in need of some time off. If the high score persists or if it is reflective of other worries, it may be a cause for concern.

Secondary Traumatic Stress_____

The second component of Compassion Fatigue (CF) is secondary traumatic stress (STS). It is about your work related, secondary exposure to extremely or traumatically stressful events. Developing problems due to exposure to other's trauma is somewhat rare but does happen to many people who care for those who have experienced extremely or traumatically stressful events. For example, you may repeatedly hear stories about the traumatic things that happen to other people, commonly called Vicarious Traumatization. If your work puts you directly in the path of danger, for example, field work in a war or area of civil violence, this is not secondary exposure; your exposure is primary. However, if you are exposed to others' traumatic events as a result of your work, for example, as a therapist or an emergency worker, this is secondary exposure. The symptoms of STS are usually rapid in onset and associated with a particular event. They may include being afraid, having difficulty sleeping, having images of the upsetting event pop into your mind, or avoiding things that remind you of the event.

The average score on this scale is 50 (SD 10; alpha scale reliability .81). About 25% of people score below 43 and about 25% of people score above 57. If your score is above 57, you may want to take some time to think about what at work may be frightening to you or if there is some other reason for the elevated score. While higher scores do not mean that you do have a problem, they are an indication that you may want to examine how you feel about your work and your work environment. You may wish to discuss this with your supervisor, a colleague, or a health care professional.

WHAT IS MY SCORE AND WHAT DOES IT MEAN?

In this section, you will score your test so you understand the interpretation for you. To find your score on **each section,** total the questions listed on the left and then find your score in the table on the right of the section.

Compassion Satisfaction Scale

Copy your rating on each of these questions on to this table and add them up. When you have added then up you can find your score on the table to the right.

3. ____
6. ____
12. ____
16. ____
18. ____
20. ____
22. ____
24. ____
27. ____
30. ____

Total: ____

The sum of my Compassion Satisfaction questions is	So My Score Equals	And my Compassion Satisfaction level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

Burnout Scale

On the burnout scale you will need to take an extra step. Starred items are "reverse scored." If you scored the item 1, write a 5 beside it. The reason we ask you to reverse the scores is because scientifically the measure works better when these questions are asked in a positive way though they can tell us more about their negative form. For example, question 1. "I am happy" tells us more about the effects of helping when you are *not* happy so you reverse the score

You Wrote	Change to
	5
2	4
3	3
4	2
5	1

*1. ____ = ____
*4. ____ = ____
8. ____
10. ____
*15. ____ = ____
*17. ____ = ____
19. ____
21. ____
26. ____
*29. ____ = ____

Total: ____

The sum of my Burnout Questions is	So my score equals	And my Burnout level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

Secondary Traumatic Stress Scale

Just like you did on Compassion Satisfaction, copy your rating on each of these questions on to this table and add them up. When you have added then up you can find your score on the table to the right.

2. ____
5. ____
7. ____
9. ____
11. ____
13. ____
14. ____
23. ____
25. ____
28. ____

Total: ____

The sum of my Secondary Trauma questions is	So My Score Equals	And my Secondary Traumatic Stress level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High