An Interpretative Phenomenological Analysis of Counselling Psychology Trainees' Experiences of Working with Adult Survivors of Childhood Sexual Abuse

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A Thesis submitted in partial fulfilment of the requirements of

London Metropolitan University for the degree of

Professional Doctorate in Counselling Psychology

September 2015

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Acknowledgements

I would like to express my gratitude to all the people who have supported me through the undertaking of this research.

Thank you to my family for their positive reinforcement and patience throughout the process, particularly my Mother for all her belief, encouragement and practical support throughout. Thank you to my husband, David for being infinitely supportive in every way possible.

I wish to thank my research supervisor, Dr Joanna Pashdag, for her encouragement in getting this research off the ground and her invaluable input throughout the project.

Finally, a big thank you to the six counselling psychology trainees who gave up their time and generously shared their experiences with me.

Abbreviations

CBT	Cognitive Behavioural Therapy
CSA	Childhood Sexual Abuse
DA	Discourse Analysis
EMDR	Eye movement Desensitization and Reprocessing Therapy
IAPT	Improving Access to Psychological Therapies
IPA	Interpretative Phenomenological Analysis
NHS	National Health Service
NICE	National Institute for Clinical Excellence

Abstract

Background: In view of the estimation that around one fifth of individuals abused in childhood will develop psychological difficulties which require professional input there is a high chance that counselling psychology trainees will encounter adult survivors in their practice. Counselling psychology trainees are continuously faced with philosophical and practical challenges when they seek to integrate psychological models into their practice. The critical literature review discusses the contentions regarding the most appropriate therapeutic approach when working with this client group, alongside maintaining the focus of therapeutic relationship. The review also explores the risk to clients of re-traumatisation through poorly conducted therapeutic interventions. In addition, potential risks to trainees have also been discussed such as difficult affective reactions or vicarious traumatisation.

Aims: A lack of research was identified with regards to exploration of trainees' internal experiences of working with this client group leading to the research question: How do counselling psychology trainees experience working with adult survivors of childhood sexual abuse?

Methodology: Semi-structured interviews were conducted with six trainee counselling psychologists enrolled on BPS Accredited Counselling Psychology Doctoral courses, who had experience of working with adult survivors of CSA. The transcripts of the interviews were analysed using Interpretative Phenomenological Analysis (IPA).

Results: From the analysis the following three key super-ordinate themes were developed: balancing the power dynamic in therapeutic relationship; management of

vicarious emotional state of self; questioning competent versus incompetent self as therapist.

Findings: The study identified clinical implications to develop further understanding and requirements for trainee counselling psychologists in relation the superordinate themes. Furthermore, an important limitation from the study was identified with regards to the inclusion of only one male participant. This highlighted the issue of gender differences between client and therapist; however, it underlined an important area requiring further study.

Introduction

2.1 Overview

The aim of the research is to undertake an Interpretative Phenomenological Analysis (IPA) to explore counselling psychology trainees' experiences of working with adult survivors of childhood sexual abuse (CSA). The following introduction outlines the relevance to counselling psychology, provides an overview of the incidence, prevalence and the psychological impact on survivors of CSA in adulthood. In addition, a critical review of the existing literature has been undertaken regarding the variation in therapeutic approaches and presenting integrative challenges for counselling psychology trainees. The emotional effect on professionals when working with this client group has also been discussed. The rationale and aims of the current study are presented, including the decision to implement an IPA approach.

2.2 Relevance to counselling psychology

Within the field of Counselling Psychology it is widely accepted that effective clinical practice is established through the strength of therapeutic relationship (Horvath & Symonds, 1991; Martin, Garske & Davis, 2000; Woskett, 1999). The self-reflective focus in counselling psychology training through personal therapy and supervision promotes deeper understanding of the processes occurring within the therapeutic relationship (Woolfe, Strawbridge, Douglas & Dryden, 2010). This is considered to be a fundamental component of therapeutic work with adult survivors of CSA (Chouliara, Karatzias, Scott-Brien, Macdonald, MacArthur & Frazer, 2011; Chouliara,

Karatzias, Scott-Brien, Macdonald, MacArthur & Frazer, 2012; Davies & Frawley, 1994; Middle & Kennerley, 2001; Olio & Cornell, 1993; Sanderson, 2006).

Focus on specific intervention is often influenced by diagnostic criteria (Holmes, 2002). However, in view of the complex psychological sequelae with which survivors present, specific diagnostic labels may not be fully encapsulating of an individual's difficulties (Putnam, 2003). Therefore, counselling psychologists' attention to the therapeutic relationship as an alternative to diagnostic criteria is of further relevance with this client group (Fairfax, 2008).

Counselling psychology encapsulates a holistic approach with origins in phenomenological, existential, psychodynamic and humanistic paradigms, emphasising a search for meaning and understanding of the individual (Woolfe et al., 2010). This pluralistic stance is congruent with the integrative approach recommended in therapeutic work with survivors of CSA (Briere, 2002; Olio & Cornell, 1993; Sanderson, 2006). Equally, counselling psychology's philosophical foundations support the underpinnings of qualitative research (Larsson, Brooks, Loewenthal, 2012), with a mutual focus on individual meaning making with a constructionist view of reality (Willig, 2013).

As counselling psychology trainees work in a range of clinical settings offering therapeutic work, as is required to meet the standards for Doctoral Programmes (British Psychological Society, 2014), they are likely to encounter service users with a history of CSA within their training placements. Providing trainees' with a voice to

share their experiences and challenges of working with this potentially complex client group could offer further understanding of the management of this process.

2.3 Definitions of childhood sexual abuse

The World Health Organisation (WHO) (1999) offers a comprehensive definition of Child Sexual Abuse:

"Child sexual abuse is the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violate the laws or social taboos of society. Child sexual abuse is evidenced by this activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person. This may include but is not limited to: The inducement or coercion of a child to engage in any unlawful sexual activity; the exploitative use of child in prostitution or other unlawful sexual practices; the exploitative use of children in pornographic performances and materials." (p.13)

A more recent, although rudimentary definition has been offered by the National Society for the Prevention of Cruelty to Children (NSPCC) (2011) stating Child Sexual Abuse as, "Persuading or forcing a child to take part in sexual activities, or encouraging a child to behave in sexually inappropriate ways." (p. 1.)

Burke-Draucker and Martsolf (2006) make the distinction between "survivor" and "victim." They refer to an adult who has been abused as a child as a "survivor" to avoid connotations with the label of "victim." However, when they refer to the client

as a child experiencing the abuse they use the term “victim” in order to emphasise the child’s inability to consent to the sexual abuse. This helpful distinction in terminology has been adopted by counselling psychologists and other professions. The term survivor will be used in reference to adults who experienced abuse throughout the present research study.

2.4 Estimates of incidence, prevalence and effects

Incidence

The National Association for People Abused in Childhood (NAPAC) and the National Society for the Prevention of Cruelty to Children (NSPCC) reported a 200% increase in calls to their adult helpline since 2012 compared with that of the previous year, which they linked to recent high profile childhood sexual abuse cases in the media (NAPAC, 2014). NAPAC state the media coverage has consequently resulted in higher number of adult survivors seeking support from services. This increases the prospect of professionals, including counselling psychology trainees, encountering more adult survivors of CSA within the wide range of services they work who are signposted for further help.

In the year 2014, the number of childhood sexual abuse cases reported to the police increased 60% compared with 2011. Travis (2015) stated 8,892 cases were reported to the police in 2014 compared to 5,557 in 2011, which was also linked to the growing awareness raised by the media.

Prevalence

Radford, Corral, Bradley, Fisher, Basset et al. (2011) undertook a study in the UK which indicated from a sample of 1,761 young adults aged between 18-24 that almost a quarter experienced sexual abuse (including contact and non-contact) by an adult or by a peer during childhood. Pereda, Guilera, Forns and Gomez-Benito (2009) undertook a review of 39 international epidemiological studies which focused on the prevalence of CSA. Pereda et al.'s study concluded overall the most commonly reported prevalence rate for boys is below 10% (indicated in 57.50% of studies), whereas the prevalence for girls was found to be between 10-20% (indicated in over 35.71% of studies). Pereda et al. stated overall almost 30% of studies reported childhood sexual abuse prevalence rates to be above 30%. As up to one fifth of adult survivors may go on to develop serious psychopathology (Browne & Finkelhor, 1986; Putnam, 2003), the implications for professionals, including counselling psychologists, offering therapy are significant.

Long-term effects

The literature suggests that CSA survivors can present with a wide spectrum of long-term psychological difficulties, including depression, anxiety, poor self-esteem, difficulty in trusting others, emotional regulation difficulties, eating disorders, substance abuse, feelings of isolation and stigma, and post-traumatic stress disorder (Beitchman, Zucker, Hood, DaCosta, Akman et al, 1992; Brown & Anderson, 1991; Browne & Finkelhor, 1986; Bryer, Nelson, Miller & Krol, 1987; Cahill, Llewelyn & Pearson, 1991; Finkelhor, 1990; Flett, Kazantzis, Long, MacDonald, Millar et al., 2012; Katerndahl, Burge, & Kellogg, 2005; Putnam, 2003; Rowan & Foy, 1993).

While the relationship between childhood sexual abuse and psychopathology in adult life has been well established, a recent study by Bak-Klimek, Karatzias, Elliott, Campbell, Pugh et al. (2014) attempted to further understand the relationship between psychopathology and sexual abuse characteristics e.g. age at onset, frequency of assaults, number of perpetrators and their relationship to the victim. The study consisted of a sample of 149 survivors of CSA who had been invited to attend a specialist psychotherapy service. A strong link was indicated between elevated psychopathology, particularly depression; however, none of the examined sexual abuse characteristics significantly predicted severity of psychopathology. The authors concluded that the results suggest CSA effects may be dependent on factors which are not necessarily related to the nature of sexual abuse. They hypothesise factors such as poor family relationships and management of disclosure could further contribute to the development of severe psychopathology.

The field of Counselling Psychology has a complex relationship with the diagnostic labels aforementioned due to the conflict between professional usage to provide a shared understanding versus maintaining philosophical values of non-pathologising individuals (Larsson, Brooks & Lowenthal, 2012). However, within research purposes symptomatology is often categorised within such frameworks from which to derive empirical findings (Larsson et al., 2012). CSA has been particularly linked to the diagnoses of Post-traumatic Stress Disorder (PTSD) and Borderline Personality Disorder (BPD) (Putnam, 2003). However, BPD is considered a particularly contentious diagnosis (Kendall, 2002; Kreger, 2015; Lewis & Grenyer, 2009; Skodol & Bender, 2003). For instance, there is debate in relation to gender, as literature indicates three times more women are diagnosed with BPD compared to men, which

has raised questions around sampling or diagnostic bias (Skodol & Bender, 2003). However, it has been argued by Kendall (2002) that based on a sample of the general population, BPD appears equal across gender. Kendall highlights the debate around gender to be fuelled by stereotypes toward women and misdiagnosis. Individuals are regularly diagnosed with other mental health problems such as, bipolar disorder, substance misuse, depression, anxiety and PTSD, which makes BPD difficult to diagnose with certainty (Kendall, 2002).

The controversy surrounding BPD and Complex PTSD has been longstanding due to the strong links demonstrated between BPD and early traumatic experiences (Lewis & Grenyer, 2009). The following section, therefore, provides a more in depth critique of the relationship between PTSD and BPD in relation to childhood sexual abuse.

2.4.1 Childhood sexual abuse relationship to PTSD and BPD

A number of researchers have suggested that post-traumatic stress disorder (PTSD) most appropriately encapsulates this complex symptomatology present in survivors of CSA and therefore informs treatment protocol (Foa & Kozak, 1986; Greenwald & Leitenberg, 1990; Rodriguez & Vande Kemp, 1998; Wolfe, Gentile & Wolfe, 1989). Rowan and Foy (1993) stress that conceptualisation of the long-term effects of CSA within a PTSD framework is consistent with research for other forms of traumatic abuse, for example, rape and domestic violence. Furthermore, Herman (1997) asserted that CSA is in keeping with the symptoms of Complex Post Traumatic Stress Disorder (C-PTSD). However, it should be noted that this has not been established as a diagnosis in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5).

Some researchers argue that PTSD is an incomplete explanation as it does not fully abridge the difficulties that some CSA survivors experience in areas such as relationships, sexual intercourse and suicidal ideation (Finkelhor, 1987; Kuyken; 1995). A study undertaken by Widom (1999) investigated the extent to which childhood abuse and neglect increase a person's risk for PTSD. Widom's sample consisted of childhood abuse victims who had experienced physical, sexual or neglectful abuse and whose cases were processed through the criminal justice system. The individuals were then traced and interviewed blind to the purpose of the study. Widom's study offered a relatively large sample size to provide sufficient statistical power, as of the 676 participants 96 were adult survivors of CSA. The findings concluded that approximately 37.5% of adult survivors of CSA met diagnostic criteria for PTSD. Although Widom's study indicates that CSA is a statistically significant predictor for PTSD in adulthood ($p<0.001$), it also demonstrates that almost two thirds of survivors do not meet criteria for PTSD.

Nevertheless, the only official clinical guidance in the UK for practitioners, including counselling psychologists, working with adult survivors of CSA is outlined within the National Institute for Health and Care Excellence (NICE) guidelines (2005) for PTSD. This would indicate there is no clinical guidance for working with the high number of CSA survivors who experience psychological distress, but do not meet criteria for PTSD. Furthermore, the NICE guidelines for PTSD only provide a general review of the evidence for treating PTSD; they do not offer individualised guidelines for working with survivors of CSA. However, a recent study by Ehring, Welboren, Morina, Wicherts, Freitag et al. (2014) undertook a meta-analysis exclusively

evaluating the efficacy of psychological therapy interventions for adult survivors of CSA who met criteria for PTSD. The researchers concluded that trauma-focused treatments were more efficacious than non trauma-focused interventions. Furthermore, they indicated individual therapy to be more effective than standalone group treatment. However, there appeared to be a number of limitations to the findings, in particular, with regards to variation in methodology in the studies reviewed in the meta-analysis. In addition, there appeared a significant bias in the meta-analysis toward trauma-focused CBT/EMDR treatment as 10 of the studies included were of this approach versus only 6 studies which were deemed non trauma-focused treatment and varied in approach. Moreover, the study did not disclose the estimated prevalence of PTSD in adult survivors of CSA. The paper did not, therefore, consider the provision of treatment options for survivors of CSA who do not experience symptoms of PTSD.

PTSD from childhood sexual abuse has also been suggested to have a relationship with the development of Borderline Personality Disorder (BPD) in adulthood (McClean & Gallop, 2003; Minzenberg, Poole, & Vinogradov, 2008; Stalker & Davies, 1995). Nonetheless, BPD is considered by some to be contentious due to lack of clarity regarding the diagnostic label (Pilgrim, 2007). However, Fonagy, Luyten and Strathearn (2011) discuss the neurological underpinnings of BPD being a result of childhood trauma, such as CSA. They assert that the activation of the attachment system under stress can result in disruption of mentalisation processes required to acknowledge the thoughts, feelings and position of another. This difficulty in differentiating one's own mental state from another's can lead to affect

dysregulation, inner pain, use of maladaptive coping strategies, substance misuse, self-harm and/or hypersexuality (Fonagy et al., 2011).

The impact of childhood sexual abuse on adult attachment due to damage to the neuro-cognitive processes has been growing over the last 20 years (Minzenberg et al., 2008; Siegel, 1999; Stalker & Davies, 1995). However, a meta review of the literature evaluating effect size of the relationship between CSA and BPD by Fossati, Madeddu and Maffeifor (1999) did not find CSA to be a causal antecedent. Therefore, it could be argued that although it is widely considered that CSA has a neurobiological impact on attachment organisation, this does not necessarily result in development of BPD. Searching for an understanding of a client's early attachment experiences, rather than focusing on diagnosis, is considered to inform counselling psychologists' practice as a helpful way to view the therapeutic relationship (Larsson, et al., 2012).

Sanderson (2006) has asserted that survivors of CSA's attachment related difficulties can result in individuals shifting from the position of seeking formation of an attachment with another to fear of forming an attachment due to risk of feeling overpowered or re-abused. She indicates this to be an important consideration of practitioners in the complex dynamics of working with survivors of CSA.

2.5 Critical review of the literature

The wide variation of difficulties with which adult survivors of CSA present poses a question for therapists as to which treatment is the most effective (Chahal, 2013). The philosophy within the counselling psychology profession is to integrate

approaches based on individual need (Woolfe et al., 2010). However when faced with the complexity an individual with a history of CSA might experience, trainees are often left with a sense of uncertainty with regards to therapeutic approach (Chahal, 2013). Counselling Psychology British Psychological Society (BPS) Accredited Training courses require trainees to be competent in at least two or three approaches to therapy, promoting a pluralistic approach to training which can be a challenge for trainees to achieve with survivors of CSA (Chahal, 2013). This is of concern according to Newgent, Fender-Scarr and Bromley (2002) who argue that implementation of inappropriate treatment with this client group can result in more damage through re-traumatisation.

The following aspect of the literature review, therefore, critiques and explores integration of therapeutic approaches for CSA.

2.5.1 Treatment for survivors of childhood sexual abuse

NICE guidelines appear to have conflated treatment for survivors of CSA within the PTSD guidelines without further consideration of the additional complexity of issues these individuals often present with (Putnam, 2003). Irrespective of the causation of an individual's PTSD, NICE conclude that trauma-focused cognitive behavioural therapy (TF-CBT) and Eye Movement Desensitization and Reprocessing therapy (EMDR) are the recommended treatments. NICE state that these treatments were demonstrated to have the largest empirical database using the required methodological criteria for inclusion by NICE.

Briere (1987) was one of the first to assert that treatment for adult survivors of CSA could benefit from techniques used to treat post-traumatic stress among client populations such as rape victims or war veterans. Briere also stated that cognitive therapy could be helpful to address issues such as low self-esteem, guilt and distrust, which he stated are common features in survivors of CSA. Notably, since that time, there has been an increase in the empirical based literature using Randomised Control Trials (RCTs) advocating trauma-focused cognitive behavioural therapy (TF-CBT) for survivors of CSA (Cohen, Deblinger, Mannarino & Steer, 2004; Cloitre, Stovall-McClough, Nooner, Zorbas, Cherry et al., 2010; McDonagh, Friedman, McHugo, Ford, Sengupta, et al., 2005; Resick, Nishith & Griffin, 2003).

This evidence base has given CBT a strong foothold in providing treatment for survivors of CSA. However, when compared with other treatments CBT has not conclusively been found more or less effective (McDonagh et al., 2005; Foa, Rothbaum, Riggs & Murdock, 1991). Therefore, counselling psychologists integrating CBT into their practice should be aware that although RCTs have demonstrated CBT can affect symptom change, counselling and psychodynamic therapies when subjected to such empirical research methods have also been shown to be effective (Foa et al., 1991; Price et al., 2004).

Nevertheless, some of the literature guides based on CBT offer helpful guidance to professionals. Herman's (1997) book was considered to be a ground-breaking guide for clinicians working with more complex PTSD when it was originally published in 1992 (Hopper, 2012). Herman, a psychiatrist and researcher, focuses on a range of complex trauma within her work, in particular, trauma resultant from CSA. Herman

discusses varying treatment approaches and presents a helpful chapter on, “A Healing Relationship” (Herman, 1997, p.133), which focuses on the importance of therapeutic relationship. In addition to stressing the importance of the therapeutic relationship in the early stages of working with survivors of trauma, Herman also recommends cognitive and/or behavioural strategies, particularly to manage self-destructive behaviours.

Herman’s (1997) work has informed Smucker and Dancu’s (1999/2005) guide for clinicians which largely concentrates on imagery re-scripting through imaginal exposure and cognitive restructuring to challenge maladaptive schemas. The authors aim to outline a potential step by step short-term treatment for survivors of CSA. Their book also builds on previous research by Smucker, Foa and Niederee (1995) who undertook a study on imagery re-scripting for survivors of CSA experiencing PTSD and supported it to be effective. While the authors’ guide offers some useful tools in challenging a survivor’s negative view of themselves, they do not consider difficulties that may arise during therapy in building a therapeutic relationship. This is considered to be of pertinent importance with this client group who have difficulties trusting others (e.g. Knight, 2009; McGregor, Thomas & Read, 2008; Middle & Kennerley, 2001; Olio & Cornell, 1993). If counselling psychology trainees were to attempt to integrate Smucker and Dancu’s techniques without having developed trust and rapport with the client they could face difficulties in engaging the client to implement the techniques (Knight, 2009). Another difficulty in undertaking CBT approaches is the risk of re-traumatisation through imaginal exposure (Durosaro, Ajiboye, Olawuyi & Adbanke, 2012).

While it must be acknowledged that the growing body of literature supporting TF-CBT is continuously emerging, it could be argued that its success is as a result of using empirically based research methods to illustrate its effectiveness. This is also probable in the evidence base for EMDR, developed by Shapiro (1989). Shapiro and Forrest (1997) further developed an EMDR manual which summarises the efficacy of the approach is supported by randomised and non-randomised control trials. In relation to the evidence base for EMDR with adult survivors of CSA, Edmond, Rubin and Wambach (1999) undertook an RCT which found it to be clinically significant at reducing psychological distress in survivors. However, the authors noted it was not found to be more effective than routine individual treatment. Indeed, Shapiro (1995) intended for EMDR to be used in conjunction with other therapeutic intervention. Consequently, integrative therapists, including counselling psychologists, incorporating EMDR into their practice should consider the importance of using it concurrently with other approaches. Overall, when compared with other interventions, there was limited evidence that TF-CBT or EMDR were significantly more effective than other supportive/non directive therapies, such as counselling and psychodynamic therapies (Burke-Draucker & Martsolf, 2006). Furthermore, a recent pilot study by Brotto, Seal and Rellini (2012) has indicated a mindfulness-based approach to be more effective than CBT for women with a history of childhood sexual abuse who were experiencing sexual difficulties.

Burke-Draucker and Martsolf (2006) state that some counsellors would argue that CSA survivors should be seen by an expert sexual abuse therapist. Nevertheless, they highlight that due to the large numbers of individuals that seek counselling with a history of CSA, it would not therefore be feasible for each of these individuals to

see a specialist therapist. They emphasise that counsellors should develop the necessary skills to work with this population due to the unique and complex nature of their difficulties and offer specific therapeutic techniques for practitioners to implement. However, one of the drawbacks of their text is the lack of clarity in managing the dissociation, which survivors of CSA are at risk of experiencing when discussing traumatic memories (Briere, 1987; Ginzburg, Koopman, Butler, Palesh, Kraemer et al., 2006; Lev-Wiesel, 2008; Price, 2007).

Burke-Draucker, Martsolf, Roller, Knapik, Ross et al. (2011) have since developed further guidance in working with CSA to aid clinicians. The authors have devised a theoretical CSA Healing Model which incorporates the multifaceted and dynamic process of healing across the lifespan. A constructivist grounded theory method was implemented to develop themes related to healing. This was undertaken from a large project already in progress on sexual violence throughout the lifespan, which included a sample of 48 women and 47 men who had experienced childhood sexual abuse. During semi-structured, open-ended interviews, they were asked to describe their experiences of healing from childhood sexual abuse. Frameworks were developed to encapsulate life patterns, which included, parenting experiences, disclosures about sexual violence, spirituality, and altruism. A theoretical model was devised incorporating four stages of healing that practitioners working with CSA should consider. This involved working with clients in relation to, grappling with the meaning of the CSA, figuring out its meaning, tackling its effects, and laying claim to their lives. Burke-Draucker et al. assert the model is fluid and that survivors will move throughout this process across the lifespan. Their findings provide clinicians with a helpful insight into the complexity of healing.

Hall and Hall (2011) have also provided further implications for working with adult survivors of CSA. They place emphasis on the therapeutic alliance and empowering the client; however, they state that there is no one model recommended for counselling survivors. This prompts an additional critique of the NICE guidance due to the absence of acknowledgement toward the therapeutic alliance in treatment, which has been demonstrated to be fundamental when working with clients, particularly with survivors of CSA (Chouliara et al., 2011; Chouliara, et al., 2012; Davies & Frawley, 1994; Edwards & Lambie, 2009; Middle & Kennerley, 2001; Olio & Cornell, 1993; Sanderson, 2006).

Guidance has also been compiled for professionals from a contemporary psychoanalytic perspective for adult survivors of CSA by Davies and Frawley (1994), which focuses on a relational model for trauma. This model helps to guide understanding and development of the therapeutic relationship. Davies and Frawley believe the therapeutic relationship to be a central part of re-enactment which requires the therapist to use the concept of transference and countertransference to reflect with the client on the processes that have occurred between them. As counselling psychologists place emphasis on the importance of the therapeutic process, Davies and Frawley provide a helpful framework within which to conceptualise this.

Furthermore, the authors devote a chapter of their book to address dissociation which they believe to be an important adaptive defence and mode of communication (Davies & Frawley, 1994). They place emphasis on working with dissociation in the

session and the interaction with the therapeutic relationship, which could be deemed a useful tool for counselling psychologists in training. However, Briere (2002) stated that it can be dangerous for a client to markedly dissociate within therapy due to risk of re-traumatisation and recommend a level of intensity control. Should re-traumatisation occur, this could be damaging to the therapeutic relationship (Briere, 2002; Olio & Cornell, 1993).

Olio and Cornell (1993) affirm the therapeutic relationship to be the foundation regardless of therapeutic approach when working with survivors of CSA. They discuss the requirement to balance the transferential dynamics of the relationship in order to facilitate integration of self for the survivor. They emphasise this provides a reparative function through the establishment of trust. They critique traditional methods of therapy which promote neutrality and therapeutic distance when working with survivors for fear of further re-traumatisation. However, they also assert that implementation of practical techniques prior to having built a strong therapeutic foundation could also result in client disengagement.

The review introduces the range of therapeutic options when working with survivors and is by no means exhaustive. This highlights the challenging aspects for counselling psychology trainees attempting to integrate approaches due to the concern regarding what is helpful or damaging to clients. Evidently, the therapeutic relationship is deemed of paramount importance regardless of approach (Olio & Cornell, 1993; Sanderson, 2006). This is further advocated by service-users themselves as discussed in more depth in the following section (Chouliara et al.,

2011; Chouliara et al., 2012; Hall & Hall, 2011; Davies & Frawley, 1994; Middle & Kennerley, 2001; Olio & Cornell, 1993; Sanderson, 2006).

2.5.2 Service user related research

The importance of the therapeutic relationship for survivors of CSA was considered to be highly significant within a service user related literature review (Chouliara et al., 2012). The researchers outlined a number of limitations from the literature reviewed, such as variation of recruitment and methodological approach, inadequate information in relation to typology of CSA, lack of clarity regarding treatment duration, frequency and modality, and critique of rigour or robustness due to poor transparency from a number of studies. However, the systematic analysis by Chouliara et al. provided a number of interesting findings for practice and future research. In addition to highlighting the key function of the therapeutic relationship, Chouliara et al. illustrate the challenges for professionals in maintaining this with survivors of CSA. Consequently, they advocate relational models of training and practice for professionals working in the area of CSA. Chouliara et al. report development of relational theory could benefit therapists to utilise supervision effectively to explore issues of power in the relationship or identify and manage signs of vicarious traumatisation. They illustrate a lack of CSA focussed training in general on curriculums of psychology and psychotherapy training courses and emphasise a need for further research into professionals experience within the field.

One of the service user studies reviewed by Chouliara et al. (2012) was undertaken by Middle and Kennerley (2001). They implemented a grounded theory investigation

into whether service users with a history of CSA and service users with no history of CSA differed in their view of the therapeutic relationship. It should be noted that both groups were treated with a CBT approach. Service users in the CSA group were found to place greater emphasis on the interpersonal qualities of the therapist, such as trust, integrity and empowerment, whilst the non CSA group stressed therapeutic techniques and progress in therapy. The importance service users placed on the relationship should be of note to counselling psychology trainees who may be focused on implementing a textbook manualised approach rather than tending to the therapeutic relationship.

A subsequent qualitative service user study by McGregor, Thomas and Read (2006) explored what survivors of CSA found helpful and unhelpful in building a therapeutic relationship, although no therapeutic modality was specified, which could be considered a limitation. The authors highlighted five key issues for therapists which emerged, including: 1) information about therapy should be provided from the outset; 2) clients need to be consulted over the structure, pace and focus of therapy; 3) all mental health workers should have training to be able to listen to experiences of CSA and assess and address the effects or refer on when necessary; 4) simply listening to, understanding and normalising CSA experiences and effects can be effective; 5) therapists who work with interpersonal trauma must be aware of the potential for distancing and intrusive errors. Examples of errors of intrusion were described as when therapists provided unsolicited personal information, whereas errors of distancing were considered to occur when therapists refused to disclose information, failed to provide empathy, did not appear genuine or offer unconditional positive regard (Weiss, 2011).

The therapeutic errors raised by service users could have a particularly damaging impact on survivors of CSA in relation to re-triggering of traumatic experiences. The following section further outlines factors which are considered to increase the risk of re-traumatisation.

2.5.2.1 Re-traumatisation risk factors

The question of whether counselling can be re-traumatising within the field of trauma is of increasing debate. Novice therapists who have not received specialist training in working with adult survivors of CSA are considered to be at risk of causing further damage to the client (Briere, 2002; Sanderson, 2006; Baynard & Williams, 2007).

Sanderson's (2006) text uses an integrative framework across humanistic and psychodynamic conceptualisation to present a comprehensive guide for practitioners working with CSA. The guide recommends professionals to remain mindful of aspects of practice which could be damaging for survivors, such as competency level, management of disclosure, dissociation and pacing of therapy.

Pinker (2010) asserts that strong research evidence shows that encouraging individuals to talk about difficult experiences is not helpful and can exacerbate trauma. However, this does not appear a robust argument as the evidence the article referred to was based on research by Wessely and Deahl (2003) who demonstrated psychological debriefing to be unhelpful. This is a significant limitation of Pinker's article as psychological debriefing is usually offered as a one off session following a traumatic event and would therefore not be comparable with counselling,

which is generally a moderate to long-term process with CSA survivors (Hall & Hall, 2011).

Poor management of disclosure is considered to be a risk factor for re-traumatisation (Chouliara et al., 2012; Chouliara et al., 2014; Draucker, Martsolf, Cook, Ross, Warner-Stidham, 2010). Browne and Finkelhor (1987) asserted that childhood management of disclosure has a significant impact on recovery. They indicated that if a child is believed and supported through the process this considerably improves their ability to cope with the abuse. However, if a child's disclosure is invalidated and they feel unable to disclose for fear of being believed or due to embarrassment this can hold lasting negative psychological consequences (Barker-Collo & Read, 2003; Browne & Finkelhor, 1986; Linehan, 1993). If disclosure in adulthood to professionals is also insensitively managed, it can be reinforcing of earlier experiences (McGregor, Gautam, Glover & Julich, 2013; Read, Hammersley & Rudegeair, 2007; Roberts, Reardon, & Rosenfeld, 1999). Furthermore, as a result of disclosure, survivors are at risk of re-triggering traumatic memories which have been repressed, causing higher levels of emotional distress requiring containment (Davies & Frawley, 2003).

Briere (2002) states it is important not to flood the survivor with traumatic memories, through pacing the retrieval to minimise destabilisation. Evoking traumatic memories can result in dissociation which Briere stresses should be carefully handled due to the risk of re-traumatisation. This concurs with McGregor et al.'s (2006) service-user related research which also identified the importance of pacing to manage emotional

distress. Sanderson (2006) further affirms the danger of leaving a client to feel further victimised during dissociation.

2.5.3 Integrative challenges for counselling psychology trainees

The therapeutic relationship is also considered to be of central importance to counselling psychologists in all fields (Division of Counselling Psychology, 2007). However, attempting the balance of relational work with integration of other psychological models when working with survivors of CSA has been highlighted as a particular challenge for counselling psychology trainees (Chahal, 2013).

This signifies a historical struggle within the profession, in its attempt to combine phenomenological models of practice with the traditional scientific psychology paradigm. Indeed, Shorrock (2011) evaluates a number of the philosophical challenges counselling psychologists face as they seek to integrate psychological models. Shorrock postulates that the rise of humanism challenged positivistic and empirical stances within the profession of psychology.

In order to integrate evidence based models of practice, counselling psychologists attempt to straddle this gap between the empiricist stance adopted by the Behaviourist paradigm and constructivist approaches favoured by psychoanalytical and psychodynamic approaches (van Scoyoc, 2010). Van Scoyoc stated that empiricists dismissed constructivist approaches as "untestable" or "unfalsifiable" and consequently not scientifically robust. She highlighted that the humanistic postmodern paradigm shift in the mid-twentieth century moved toward the contrasting view that “objective reality” and “ultimate truth” are not viable. Van

Scoyoc states that counselling psychologists continue to be challenged by the integrating the divergent approaches.

Chahal (2013) notes the difficulty for trainees attempting to embody a humanistic and existential phenomenological approach whilst embracing and integrating different models of therapy from an empirical stance such as CBT. However, Chahal's paper theoretically discusses the move toward embracing a CBT-informed practice rather than a CBT-led perspective. The paper explores this in the context of working with adult survivors of CSA due to the recommendation for implementing an integrative approach with this client group (Chahal, 2013). The article underlines the challenge of integrating CBT-informed practice with survivors whilst maintaining the therapeutic relationship. The theoretical discussion she introduces could benefit from further phenomenological investigation around the experiences of trainees attempting to integrate approach with this complex client group to explore her theoretical suppositions.

2.5.4 Affective reactions and vicarious traumatisation

The complexity of attempting to hold and facilitate the therapeutic relationship with adult survivors of childhood sexual abuse can have a profound impact on the trainee therapist (Chahal, 2013). Although there appears to have been no research specifically into the psychological impact of working with survivors of CSA on counselling psychology trainees, studies have demonstrated that therapists in general working with survivors of CSA can experience difficult affective reactions (Knight, 1997) and are at risk of vicarious traumatisation (Adams & Riggs, 2008; Brady, Guy, Poelstra & Brokaw, 1999; Chouliara, Hutchison & Karatzias, 2009).

A quantitative study undertaken by Adams and Riggs (2008) explored vicarious traumatisation in trainee therapists. However, this was not specific to adult survivors of childhood sexual abuse and participants were comprised of clinical and counselling psychology trainees. Their findings did conclude that trainees who had experienced a history of interpersonal trauma themselves, such as trauma of a sexual nature, would be at higher risk to vicarious re-traumatisation. However, conclusions as to whether working with adult survivors of childhood sexual abuse poses a more significant risk to vicarious traumatisation could not be drawn. A further phase of qualitative exploration could have been a beneficial to provide richer data regarding trainees' perceived experience of vicarious traumatisation and their management process of this.

A qualitative study undertaken by Harrison and Westwood (2009) attempted to explore how professionals working with traumatised clients manage vicarious traumatisation. The main conclusions from their findings were in relation to ethical considerations for professionals with regards to managing vicarious traumatisation. The researchers concluded that the ethical responsibility should be shared by employers, educators, professional bodies and individual practitioners to address management of the problem. In addition, the researchers placed emphasis on engagement of empathy as a protective factor for practitioners from vicarious traumatisation. However, the study did not differentiate between childhood sexual abuse trauma and other traumatic experiences. Therefore, implications in relation to whether any further considerations would be required when working with this population were not able to be drawn.

Chouliara et al. (2009) evaluated ten studies varying in methodology in relation to vicarious traumatisation in professionals working with adult survivors of sexual violence and CSA. Overall, Chouliara et al. found that professionals working in this field were at risk of vicarious traumatisation or negative affect; however, this was not deemed to be more likely with this group than with survivors of other types of trauma. The researchers cited a number of methodological problems across the studies reviewed, including poor response rates, inadequate control for confounding factors or comparative groups and a lack of clarity in definition of vicarious traumatisation. They affirmed a need for additional exploration into this area before conclusions could be established.

Working with complex client groups in general can evoke difficult affective reactions in therapists (Adams & Riggs, 2008; Brady, Guy, Poelstra & Brokaw, 1999; Chouliara, et al., 2009; Knight, 1997). How therapists understand and manage this internal experience is a multifaceted process (Maunders, 2010). According to Grant (2006), the greater complexity of the case, the more difficult developing awareness of this internal process is considered to be, particularly for trainee therapists. However, internalising the process can provide a way for trainees to manage difficult interactions with clients; this is considered to enhance therapeutic outcome (Grant, 2006).

Few investigations have examined internal experiences of professionals. Chouliara et al. (2009) undertook a combined study into talking therapy for adult survivors of CSA, exploring service user and professionals' perspectives. As part of the study

the researchers identified a theme regarding professionals experiencing distressing affective reactions when hearing and managing disclosures. An additional theme proposed that dealing with child protection issues could also trigger distressing emotional experiences. However, the research reported that there were limitations due to variation in level of clinical experience, training and supervision arrangements. Furthermore, although the findings provided useful practical recommendations in relation to working with survivors, there was little focus on the affective reactions or vicarious traumatisation experiences of professionals.

There appears to be a significant dearth of literature in this area, particularly in relation to trainee therapists' internal experiences of working with complex presentations. One previous study has explored American trainee therapists' internal experiences as phenomena that occur during process of therapy (Melton, Nofzinger-Collins, Wynne & Susman, 2005). The qualitative approach involved four counselling psychologists reviewing the audio transcripts of eight trainees using the methodology of Inner Experience Recording Booklet (IERB). Four predominant affective themes were identified, including anger/frustration, disappointment/regret, anxiety/fear, and happiness/excitement. Nonetheless, there were a number of limitations to the study. Firstly, the client interactions were simulated and the inner experiences were therefore not representative of process within authentic client sessions. Consequently, client presentation was more straightforward and affect was not captured with regards to challenging or complex clients. Secondly, there was no reflexivity offered from the reviewers, whose interpretation of the trainees' experiences produced the themes from the IERBs. Lastly, through implementation of this process the researchers appeared to disparage the trainees' own ability to

reflect on session process with a client, instead resorting to using reviewers and the use of mock clients. Consequently, the findings concluded further research is required to explore the process of managing strong affect in a genuine client session.

Given the strong affective reactions working with complex clients such as adult survivors of childhood sexual abuse can evoke (Beitchman, Zucker, Hood, DaCosta, Akman et al, 1992; Brown & Anderson, 1991; Browne & Finkelhor, 1986; Bryer, Nelson, Miller & Krol, 1987; Cahill, Llewelyn & Pearson, 1991; Finkelhor, 1990; Katerndahl, Burge, & Kellogg, 2005; Putnam, 2003; Rowan & Foy, 1993), and the increased likelihood of this being a challenge for trainees (Grant, 2006), exploration of trainees' internal experiences with this client group could enhance understanding and management of this process.

2.6 Summary of the critical literature review

The introduction to this study discusses the increasing number of childhood sexual abuse cases reported in recent years due to increase media coverage (NAPAC, 2014). In view of the estimation that around one fifth of individuals abused in childhood will develop psychological difficulties which require professional input (Radford et al., 2011), there is a high chance that counselling psychology trainees will encounter adult survivors in their practice. However, there is contention with regard to the most appropriate therapeutic approach and challenges with integration of models whilst maintaining the focus of therapeutic relationship (Chahal, 2013), which is considered paramount when working with this client group (Chouliara et al. 2012). Furthermore, the review explores the risk to clients of re-traumatisation

through poorly conducted therapeutic interventions (Briere, 2002; Sanderson, 2006). In addition to the risk of harm to clients, the potential risks to therapists working in the field as a result of challenging affective reactions or vicarious traumatisation were also reviewed. A lack of research was identified with regards to exploration of trainees' internal experiences of working with this client group.

2.7 Research question and aims

The research aims to undertake an Interpretative Phenomenological Analysis to explore how trainee counselling psychologists make sense of their internal experiences. This could provide an important understanding of the therapeutic process when working with this client group.

The following question has consequently been derived following a review of the literature:

How do counselling psychology trainees experience working with adult survivors of childhood sexual abuse?

3. Methodology

3.0 Methodology

This section explains the rationale for the chosen method, describes participant recruitment, data collection and analysis. Methodology refers to the approach adopted towards studying a particular research topic and is informed by the epistemological position.

3.1 Qualitative Methodology

Qualitative methodologies aim to understand and represent the lived experience of individuals and are exploratory in nature (Elliott, Fischer & Rennie, 1999). This was felt to be the optimum methodological approach with which to explore counselling psychology trainees' experiences of working with survivors of CSA. Exploring meaning of individual experiences based as closely as possible on their perspective provides an enhanced psychological understanding (Elliott et al.,1999; Smith, 1996) A further advantage of such an approach is that it allows for the emergence of unanticipated findings (Barker, Pistrang & Elliott, 2002).

Other prevalent qualitative methods such as grounded theory, narrative analysis and discourse analysis were considered and will be discussed. However, it was concluded that Interpretative Phenomenological Analysis (IPA) (e.g. Smith & Osborn, 2003; Smith, Flowers & Larkin, 2009) was the most favourable for this particular research.

3.2 Principles of Interpretative Phenomenological Analysis

IPA aims to undertake a detailed exploration of how individuals construct meaning through their lived social and personal world to an experience or event (Smith & Osborn, 2003). Smith, Flowers and Larkin (2009) state that IPA has been informed by three key areas of epistemology: phenomenology, hermeneutics and idiography and as a result is social constructionist in its philosophical stance. The following section outlines the three main principles of IPA and their relevance within this research project.

Smith et al. (2009) assert that phenomenology is a philosophical approach to understanding experience. They emphasise that from a psychological perspective, phenomenology provides a rich source of ideas about exploring and understanding lived experience. Consequently, Smith et al. stress that our understanding of others' perception of meaning is an interpretative process. Smith and Osborn (2003) highlight that IPA dissents from attempting to produce an objective statement. They assert that a significant feature of IPA is the requirement for the researcher to take an active role in the process of sense making and interpreting the participants' meaning.

Moreover, IPA's phenomenological approach has been shown to be helpful with under-researched populations and phenomena by virtue of its exploratory nature and the emphasis on how people attribute meaning to their experiences (Smith et al., 2009). This was believed to be of particular relevance for this research because of the dearth of literature in this area.

IPA involves merging the vital components of hermeneutics and phenomenology to provide meaning to an individual's lived experiences (Smith et al., 2009). Hermeneutics is the second main theoretical component of IPA and is concerned with the theory of interpretation (Smith et al., 2009). Smith et al. propose that IPA is phenomenological by seeking to get as close as possible to the individual's experience. However, the approach recognises this is subsequently interpretive. They describe how the hermeneutic circle holds particular relevance to IPA due to the process being iterative in its nature. This fits with the methodological approach undertaken in this study which, in line with IPA, was concerned with the relationship between the part and the whole. In order to understand the part, it was necessary to look at the whole and this was required conversely. Therefore, understanding of the text required moving back and forth through different parts of the data at different levels as advocated by Smith et al.

The third influential factor on IPA is its idiographic nature. It does not aim to make sweeping generalisations about larger populations; instead it arrives cautiously at general statements and only following the in-depth analysis of individual cases (Smith & Osborn, 2003; Smith et al., 2009). This is consistent with the present study which was concerned with enabling each individual to make sense of what they found to be challenging and helpful in their experience of working with adult survivors of CSA. Smith et al. believe the idiographic approach of IPA enables the synthesis of multiple studies from single cases to develop phenomenologically informed models. This understanding would thereby enhance counselling psychologists' and other professionals' theoretical knowledge to inform their therapeutic practice.

3.2.1 Why not other qualitative methodologies?

There are a large number of qualitative approaches available to researchers (Willig, 2013). Three in particular were thoroughly considered in the developmental phase of the research as possible alternatives to IPA due to their similar epistemological positioning. A rationale is presented in this section as to why IPA was selected over grounded theory, discourse analysis or narrative analysis.

Grounded theory is considered to be oriented towards building a theory or explanatory model of basic social processes (Starks & Brown Trinidad, 2007). Due to the sociological focus of grounded theory it was consequently deemed less suitable for this study, which is concerned with individual experience. It was felt that IPA provided a more congruent method with this study's research aim, as it offered an opportunity to examine in detail each individual's lived experience (Smith et al., 2009). Furthermore, the sociological stance of grounded theory draws on themes within a larger sample to support wider theoretical explanations (Willig, 2013). IPA is considered a more psychological approach (Willig), concerned with giving detailed individual experience from a smaller sample (Smith et al., 2009). This too was believed to be more in keeping with this study's aims.

Discourse analysis (DA) aims to understand how people use language to construct and negotiate knowledge (Starks & Brown Trinidad, 2007). DA focuses on how people use language to construct social reality, however, is critical of the cognitive paradigm (Starks & Brown Trinidad, 2007). Conversely, Smith et al. argue if cognition is considered as a complex nuanced process of sense and meaning-making, it holds a significant position for IPA, in addition to focusing on the use of

language. Interpreting these two factors was considered to be of central importance to this research project. Therefore, it was believed that IPA was a more appropriate method.

Narrative analysis entails the way in which individuals construct their own self-accounts through the creation and use of stories to interpret the world (Burck, 2005). Smith et al. (2009) discuss how this approach can share commonalities with IPA given its social constructionist, meaning-making process. However, they highlight that narrative analysis is only one method of sense-making. It was, therefore, felt that IPA could include participants' narrative in the process, without being restricted to only this focus (Smith et al., 2009).

3.3 Epistemological position

Hofer and Pintrich (2002) assert that, "As a philosophical enterprise epistemology is concerned with the origin, nature, limits, methods and justification of human knowledge" (p.4).

The humanistic philosophy underlying counselling psychology respects individual difference and values the internal subjective of both the psychologist and client (Woolfe, Strawbridge, Douglas & Dryden, 2010). Consequently, the discipline has moved away from psychology's earlier traditional positivist-empiricist model which strived to find objectivity and truth, toward a postmodern pluralistic stance (Woolfe et al., 2010). Woolfe et al. refer more commonly to this position as social constructionism, through which knowledge is constructed socially, historically, culturally and linguistically. It has been widely regarded that IPA can be approached

from this epistemological position (Smith & Osborne, 2003). Therefore, researchers are less likely to be concerned with evaluating their work according to an objective viewpoint (Madill, Jordan & Shirley, 2000). Indeed, the researcher is believed to inevitably bring their own assumptions and understandings, which will shape how the research is carried out (Smith et al., 2009). Consequently, to ensure a rigorous and robust research project, engagement in reflexivity is considered to be fundamental for a researcher (Willig, 2013).

3.4 Reflexivity and quality

Finlay (2003) asserts that we cannot remove ourselves out of the research process as our findings are based on our own beliefs and assumptions. In congruence with the methodological approach of IPA, our experience cannot be understood without identifying our own suppositions (Smith et al., 2009). It has been proposed that through the process of becoming aware of our preconceptions we can attempt to filter these from the phenomenon being explored (Willig, 2013).

The notion of reflexivity is described by Willig, (2013) as consisting of two types of reflexivity: personal reflexivity and epistemological reflexivity. Willig (2013) states, personal reflexivity requires reflecting on how our own values and life experiences impact on the research process and how the research affects us as a person and as a researcher. Epistemological reflexivity is regarded as encouraging one to reflect on the assumptions made during the course of the research and the implications for the research findings (Willig, 2013). Willig poses questions such as:

“How has the research question defined and limited what can be found? How has the design of the study and the method of analysis constructed the data and the findings? How could the research question have been investigated differently? To what extent would this have given rise to a different understanding of the phenomenon under investigation?” (Willig, 2001, p.10).

The following section will explore the personal and epistemological reflexive position of the researcher. The epistemological questions above as proposed by Willig (2001) will be further reflected upon within the concluding chapter of the research.

3.4.1 Reflexive statement

This statement aims to offer transparency in relation to my personal and epistemological reflexive stance. I am a white Northern Irish 32 year old female, who has lived in various places in the UK, Channel Islands and New Zealand over the last 10 years where I have worked in range of mental health services.

My original interest in this topic was further developed whilst working within an Improving Access to Psychological Therapies (IAPT) service in London which primarily offered Cognitive Behavioural Therapy (CBT). The political climate at that time was resulting in major upheaval of the delivery of psychological therapies services, with a focus on providing time-limited, evidence based treatments, recommended within National Institute for Clinical Excellence (NICE) guidelines. It struck me at the time of working within that particular service that there appeared to be anxiety regarding the complexity of working with adult survivors of CSA. This resulted in service-users being referred elsewhere as they were considered not

appropriate for that service. There was often contention around which service was best placed to provide therapy for adult survivors of CSA. The issue highlighted to me that service-users often had to reiterate their experience of abuse to a number of different professionals. My concern was this could damage service-users' trust in professionals, instilling the belief that their problem is too "complex" and reinforcing feelings of shame and rejection from someone in whom they have confided. However, the experience left me with a sense of anxiety in relation to the complexity of working with this client group.

On commencement of my training, I was aware counselling psychology trainees work in a wide range of placements and I would, therefore, be likely to encounter survivors of CSA. I was subsequently concerned that when working with this client group I would reinforce harm by replicating the systemic message they would be too complex to work with. Discussions with my peers in training enabled me to become increasingly aware that they shared these apprehensions when working with the complexity of CSA. As a consequence, I was curious to further understand trainees' experiences of what was helpful or unhelpful in their work with this client group. I wanted to enhance my knowledge about the complex nuanced process involved in working with this client group as a trainee counselling psychologist.

I consider my epistemological position to lean towards the social constructivist standpoint. Although I feel quantitative approaches are valuable for certain types of research where things are considered "measurable," I believe that human experience is individual and I therefore support the qualitative view of searching for meaning in detail from an individual's experience (Smith et al., 2009; Willig, 2013). I

am critical of the stance whereby randomised control trials are considered to be the paramount research method used to develop treatment guidance for mental problems as recommended by NICE. As a result my chosen methodological approach reflects this. I have selected an Interpretative Phenomenological Analysis as I felt this would offer an opportunity to explore individuals' experiences of working with adult survivors of CSA.

My own theoretical orientation is integrative and stems from a wide range of paradigms, including psychodynamic, cognitive behavioural, systemic, feminist and narrative approaches. Drawing upon these various theories during the meaning-making process will have influenced my analysis. My own similarity to the participants as a trainee counselling psychologist has helped me to identify with them; however, it was essential for me to be aware of my own preconceptions of working with this client group. It is important to note that these findings are based on an interaction between the participants and me; consequently, these would be expected to vary if replicated by another researcher.

3.4.2 The independent audit

The appropriateness of using the criteria for validity applied to quantitative research has been questioned with regard to qualitative research (Kvale, 1996). Nonetheless, validity and quality are important constructs of IPA. Smith et al. (2009) promote the independent audit as one way to evaluate validity in qualitative research. They recommend keeping a paper trail so the process could be tracked from initial proposal to final report. This research project therefore, provides, a portfolio of material including the initial research proposal, amended proposal, an interview

schedule, audio recordings, annotated transcripts, tables of themes and the final report. This aims to ensure quality and transparency of the research process.

3.5 Procedure and Data Collection

Smith et al. (2009) recommend that an IPA study obtains data from semi-structured interviews which enables participants to describe their experience in detail. This section discusses the procedures involved in recruiting the participants, devising the semi-structured interview and ethical considerations.

3.5.1 Participant recruitment

Participants were selected in line with the principles of IPA, firstly regarding the insight they offered into the phenomenon under investigation and secondly to provide a homogenous sample (Smith et al., 2009). Smith and Osborn (2003) suggest that five to six participants is a suitable number for a study using IPA. The aim, therefore, was to recruit a minimum of six to eight participants for this study to account for any participant who requested to withdraw.

University Course Directors of British Psychological Society (BPS) Accredited Counselling Psychology Doctorates were asked to forward information sheets regarding the study to current trainees on the course. Potential participants were provided with the researcher's contact details to use if they were willing to take part in the study.

3.5.2 Inclusion and exclusion criteria

Participants had to be currently enrolled on a BPS Accredited Counselling Psychology training course to increase the homogeneity of the sample. Consequently, participants were fluent in English, which is a criterion for accredited BPS courses. This was considered important due to qualitative research relying heavily on language.

The exclusion criterion that individuals on my training course should not be invited to take part was introduced, as it was felt that there might be an ethical concern should my peers feel obliged to take part.

Participants were not asked directly if they had experienced abuse themselves. This was not stated as an exclusion criterion, as it was considered this would enrich the data if participants attributed meaning to this experience.

3.5.3 Sample

Six participants were recruited in total which was considered a sufficient number to provide rich data. The participants were from a range of five different training courses. These have not been mentioned in the participant description table to protect confidentiality. An overview of the participants' demographics and their stage of training has been illustrated in Table 1. This has not been outlined in the usual description of the sample by detailing each participant individually as it was deemed they would be at risk of being identifiable.

Table 1. **Participant information and characteristics**	
Gender	One male and five females
Age	Late twenties to early forties
Nationality	One Irish, two British, one Greek, one Croatian and one Swedish
Stage of training	Two were in second year and four were in final year
Placement setting	Three were based in third sector counselling organisations, two were in long term psychodynamic placements, one was in a specialist sexual abuse trauma placement and one was in IAPT placement.

3.5.4 Ethical considerations

Research ethics approval was obtained from London Metropolitan University's Research Ethics Review Panel (Appendix 1). Prior to deciding whether to take part the potential participants were given an information sheet providing details about the study (Appendix 2). Once they had decided to participate they were asked to sign a consent form which confirmed confidentiality and their anonymity (Appendix 3). The British Psychological Society's guidelines on the use and retention of data were adhered to.

The interviews were recorded by a digital voice recorder and transferred to a password protected memory stick, which is kept in a locked cabinet in the researcher's work office. The transcribed interviews were encrypted and also stored on the memory stick. The researcher is the only person who had access to the data and a password was required to access the data. The data was anonymised to protect the identity of the participants.

Due to the personal nature of the interviews, there was a possibility that participants could have found some of the questions distressing. They were free to decline any questions without any negative consequences and the intention was to remind them of this if at any point they appeared to be having difficulty. They were also reminded that the interview could be stopped at any point and they could withdraw from the study with no reason required. Apart from advising them to consult with their supervisor, it was also suggested that if they experienced any distress they should avail of their university counselling service or their therapist if they had one. A distress protocol was in place to be followed if necessary (Appendix 4). A debrief sheet was also provided outlining sources of support (Appendix 5).

There was a small possibility that the researcher could become distressed whilst listening to the content of the interviewees' material in this study. Any issues that emerged would have been discussed with the research supervisor. Consideration was also given to the potential risk of the researcher travelling to a venue of the participant's choice. Therefore, another individual known to the researcher was always notified of the researcher's whereabouts and the expected duration of the interview.

3.5.5 Semi-structured interviews

A semi-structured interview schedule was developed (Appendix 6), which was relevant to the study aims. This was informed by relevant literature, discussions in supervision, and guidance on interview development sought through published guidelines (e.g. Smith & Osborn, 2003) and attending a Division of Counselling

Psychology Training on IPA. The schedule was used flexibly, in order to allow probing of unanticipated areas that emerged.

Participants could choose where and how they wanted the interview to take place, provided this was a confidential and quiet space. Following each interview, a reflective diary was used to record reflections on the interview and any issues around content and process, aimed at increasing researcher reflexivity.

3.5.6 Data analysis

Smith et al.'s (2009) steps for IPA analysis were followed. The interviews were audio recorded and transcribed verbatim. Step one and two were merged, which consisted of reading and re-reading the transcript several times and coding in a free textual analysis. The aim of this initial noting is to produce a detailed set of notes on the data. This level of analysis was broken down into three discrete processes with differing focuses as recommended by Smith et al. The first process involved descriptive comments which included focusing on the content of what the participant said by noting down key words, phrases or explanations. The second process suggested concentration on linguistic comments. This required focusing on the participant's specific use of language, which is often interrelated and can provide further content and meaning. The third process attended to conceptual comments, which involved moving to a more interpretative level. This required exploring the participants' overarching understanding of the phenomena being discussed.

Smith et al.'s (2009) third step of analysis is developing emergent themes (see example transcript appendix 7). This involved a move to working from the initial

noting rather than the transcript. They state that development of emergent themes requires an attempt to create a complex statement that concisely captures what was important from the initial noting. These themes are expected to reflect the original words of the participants, alongside the analyst's interpretation. The initial process of noting developing themes was informed by repetition of participant's narrative; however, this was not the sole method of developing a theme. This stage required working from initial notings rather than with the transcript. In addition to initial notings made on the transcript, field notes were also kept in the form of reflective research journal to assist the analysis. This process enhanced the rigour of the analysis through reflexivity (Burgess, 1991). Furthermore, field notes were able to be re-examined along with initial notings to enable the researcher to reflect when deriving the themes. As recommended by Pietkiewicz and Smith (2012), coining a theme was done by formulating a concise phrase at a slightly higher level of abstraction through psychological conceptualisation. This required engaging in an approach coined as "Focusing," which Gendlin (1996) describes as the process whereby one uses their felt sense to phenomenologically make sense of a fieldwork experience. Gendlin stated that focusing can be a useful innovative approach to phenomenological research as it encourages engaging with implicit material. This method supports the double hermeneutic circle advocated by Smith et al. Focusing was further integrated into the remainder of the interpretative analysis phase.

The fourth step of analysis searched for specific connections between themes, which is referred to as abstraction and subsumption (Smith et al., 2009). Abstraction identifies patterns between emergent themes to develop a sense of higher order themes known as 'super-ordinate' themes. Subsumption is similar to abstraction but

in this case an emergent theme itself becomes a superordinate theme as it draws together related themes (see appendix 8 for example). The process was repeated for each case. Once each transcript had been analysed and a table of themes produced for all of them, the next step involved looking for patterns across cases (see appendix 9 for emergent themes table across participants). This entailed identifying higher order themes which more than one participant shared. The final result of this process showed connections for the group as a whole.

3.6 Summary

The methodology chapter has included establishing the grounds for undertaking a qualitative approach, namely IPA. The explanation as to why IPA was considered to be the most appropriate method over other qualitative methodologies was illustrated. The epistemological position of the researcher and reflexive statement were included to provide transparency and improve the rigor of the research. Lastly, the research design and implementation was outlined to enable step by step clarification of the research process undertaken.

4. Analysis

4.1 Overview of chapter

This chapter outlines the results from the interpretative phenomenological analysis of counselling psychology trainees' experiences of working with adult survivors of childhood sexual abuse. The following three key super-ordinate themes were developed:

1. Balancing the power dynamic in therapeutic relationship
2. Management of vicarious emotional state of self
3. Questioning competent versus incompetent self as therapist

Table 2presents a master table of super-ordinate themes and subordinate themes. Each super-ordinate and subordinate theme has been expanded upon in this chapter, using verbatim examples from each participant and written up in narrative form. It is recognised that the themes are a subjective interpretation, therefore, other researchers may have identified alternative themes from the participants' narrative. Furthermore, the themes are not necessarily considered independent from one another as naturally they share commonalities. The verbatim excerpts also demonstrate interrelation across themes. However, the participants' extracts were chosen if they were interpreted to be the most appropriate example to support the theme.

In presenting the verbatim extracts some minor changes have been made to improve readability. Minor hesitations, word repetitions and utterances such as "ahh" have

been removed unless deemed relevant. Dotted lines within brackets (...) indicate material that is missing. Material added to explain what a participant is referring to has been presented within square brackets. Dotted lines at the beginning or end of an extract indicate that the person was talking prior to or after the extract. All identifying information has been removed or changed. Alias names have been used to protect the anonymity of participants.

4.2 Table 2. Master table of Super-ordinate and Subordinate Themes

Themes	Quotes from interviews	Page/Line
Superordinate theme: 1. *Balancing the power dynamic in therapeutic relationship*		
1.1 Transferential role dynamics	John: "…I fear at times that I might become a person that they sort of displace their experience on to and we can't park it..." Nicola: "…The dynamics that can often be recreated like the triangle of abuse..." Jill: "…Feeling a bit under pressure with clients to then do something…"	7.10 14.11 5.17
1.1.1 Role of gender in the therapeutic relationship	John: "…I'm curious about the difference between men and women, working with men and women…" Laura: "[as a female]… Like working with male clients, really going into physiology about maybe arousal and explaining why they might have had…they might have been aroused…"	10.32 6.3
1.2 Developing a safe therapeutic foundation	Jill: "…There was a genuine sort of closeness and trust in our relationship and then all of my clients went back to it and spoke about it more…" Laura: "…Really attending to therapeutic relationship because a lot of things come up about trust and betrayal…" Nicola: "I feel that I'm providing a very unique and special space for them to be able to explore that… safely…"	2.11 4.1 2.12
1.3 Empowerment of client through therapeutic relationship	Kate: "…There was a lot of relationships in her life where she had no power, no say (…) having more of an equal relationship was kind of good for both of us..." Sarah: "…the relationship was important in the therapy we did, we just figured out the kind of relationship that to let the client have a voice and to listen to the client……" Nicola: "…The more we convey that to our clients and convey the message that it's possible to stay and persevere and to cope with it..."	3.20 10.5 9.4
1.4 Pacing therapy - support	Laura: "…Making sure it's facilitative	3.29

versus challenge	for the client but also doesn't make them feel more different or more alone than they might already feel." Jill: "When to back off and when to sort of offer that opportunity to really go somewhere that's really painful and that everybody's idea of really painful is different." Sarah: "…You have to think about how ready a person is. I'm not sure how she would take it if we had started something like that."	 6.36 8.17
Superordinate theme: 2. *Management of vicarious emotional state of self*		
2.1 Therapist vicarious emotional state	Jill: "…The way it is when you work with these issues, that actually they're very intense physically and it's anxiety provoking." Sarah: "…And actually I think I got a bit dissociated, so that actually surprised me." John: "It affects me… it can also make me feel very angry..."	10.15 4.26 6.27
2.2 Managing emotional state of self through self-care	Jill: "…This is going to be my job, I need to take better care of myself…" Laura: "I guess there's like a kind of physiological basis to a lot of… I found, working with trauma, that, I don't know you need to look after yourself more." Nicola: "…what I found really helpful is keeping a journal and just being able to let all my thoughts and feelings out…	12.9 15.18 13.11
2.3 Supervisory relationship to manage emotional state	Jill: "I think it's been helpful when I've had really supportive supervision…" Sarah: "…So and to really use supervision to talk about your feelings, and don't get confused about your own feelings in this instance..." Laura: "…Supervision was probably the most helpful thing because that helped me track my own responses, and also stay more attuned with the client..."	14.9 9.4 5.28
Superordinate theme: 3. *Questioning of competent versus incompetent self as therapist*		
3.1 Questioning of the self as inadequate	Kate: "You worry, are you going to be able to cope, whether you will be able to help and affect change, you know	5.3

	it's such a long term ingrained issue." John: "…I was telling them I couldn't do it, they wanted to stretch me…." Sarah: "…I'm not so sure about going into detail about what happened [with client], I'm not so sure about that. I think it might be opening too much..."	 10.6 7.12
3.2 Self-empowerment through choice	John: "…I'm in a new placement and I said no… this going to cause her more harm… it was actually well received, phew!" Kate: "…Maybe you should consider whether it is for you..." Laura: "…Important thing to think about, that it will affect you."	2.17 9.5 14.18
3.3 Enablement through self-directed learning	Nicola: "…I also feel that the literature can be quite helpful..." Laura: "I think it would just be having a good working knowledge of the area and trauma itself..." Kate: "...To do as much reading as you can…"	13.27 10.15 8.26
3.4 Facilitative versus non facilitative learning environment	John: "…As… a trainee psychologist, on the training course, the reflexivity has given me a way to tap into feelings in the relationship with the other person…" Nicola: "…I find that it would be important to have an experiential shared space..." Jill: "…Or to even somewhere along the training someone to have mentioned the words like vicarious trauma..."	12.1 11.24 16.19

4.3 Balancing the power dynamic of therapeutic relationship

This superordinate theme was distinctly interpreted across the participants. All alluded to the importance of the therapeutic relationship with adult survivors of childhood sexual abuse. They discussed the significance of developing a trusting, safe relationship; however, participants acknowledged the complex role dynamics which occurred within the relationship. Participants described balancing components

of the relationship such as emotional containment whilst ensuring validation of client experience, managing re-enactments of client's external relationships, attending to systemic re-occurrences of abuse through the relationship and the pacing of therapy. The following subordinate themes have been outlined in further detail using participant examples to illustrate interpretation of the superordinate theme: Balancing the power dynamic of the therapeutic relationship.

4.3.1 Transferential role dynamics

Each of the participants discussed transferential roles. An example by Nicola described this in terms of the "triangle of abuse." The following excerpt illustrates her struggle with balancing the power dynamic when re-enactments of the triangle of abuse occur:

> *…The dynamics that can often be recreated like the triangle of abuse, I think that really resonates with me, this concept. Because I often find myself feeling like, 'Oh, what am I doing, am I doing the right thing, I'm useless, what can I really offer to that person, oh my God am I harming them?' So these are two reactions that are I think are quite relevant to the client's past, feeling helpless and overwhelmed and feeling maybe let down by other people who in their immediate family who were maybe in the position of a parent or someone who should protect them (…) so my feelings of not being good enough and not knowing what to do could be related to that. And also my feelings of having to tread carefully or not do any mistake could also be as a result of some kind of transference like the abuser, me becoming the abuser in some way (Nicola).*

This excerpt has been interpreted as Nicola demonstrating countertransference of feeling vulnerable herself, by stating that she is not good enough and feeling "useless," which could be understood as a projection of disempowerment from her client(s). Furthermore, her fear of being placed in the role of the abuser could also be understood through projective identification from her client evoking feelings of her being in a powerful role as the therapist whom the client identifies as a protector with the potential to cause harm. The first transferential role dynamic described illustrates the powerful role the client plays in therapeutic relationship in projecting feelings of a vulnerable self. The second interpretation from the excerpt highlights the powerful role the therapist could be deemed to hold in the therapeutic relationship.

A further example of transferential role dynamics was noted by Sarah who described feelings of a maternal role toward one of her clients, as illustrated in the following excerpt:

> *…She was 61 years old but she behaved quite like a child, very vulnerable and I do feel I felt like a mother, you know, those things. So I remember that I was thinking about her when I came home sometimes, "I hope she's okay."* (Sarah)

This highlights another powerful projection from the client to be protected and cared for resulting in the projective identification of maternal role for Sarah. It would

appear Sarah continued to harbour concern for her client out of sessions, which could be interpreted as the role of maternal preoccupation.

Jill discusses the projection of vulnerability apparent from this client group. She alludes to a sense of fragility from clients when sharing their experience as demonstrated in the following citation:

> *…And because of the actual content and what we were talking about, it's a really vulnerable side to this person. We are all vulnerable, but something about that, sharing with someone their experiences of being a child; that whole vulnerability and powerlessness that they experience (…) We were just talking about a stressful situation at work, all of a sudden [when client discusses sexual abuse] my experience of my client is very different, and now this person here is so much more fragile. And I guess feeling more responsible toward them, then feeling more anxious about that. (Jill)*

Jill's example continues to emphasise the power the client holds in projecting a sense of vulnerability, evoking a feeling of role responsibility from the therapist. Jill describes the consequent anxiety of being placed in this role.

4.3.1.1 Role of gender in the therapeutic relationship

Gender was interpreted as a subordinate theme of the transferential roles. It was not present for all of the participants; however, it was understood to be a highly distinctive theme within John's experience working as a man with female survivors of childhood sexual abuse. As such, it was interpreted as an important standalone role

dynamic which could merit further research investigation. John emphasised curiosity around the issue of how females who have experienced CSA perceive male therapists. In addition, he raised concerns about male therapists being vulnerable to accusations of abuse or that could be interpreted as abusive when in a position of power. The following example from John illustrates his experience with this:

> *As a man, I can tell immediately the way you respond [the client] there is a risk of being open to being abused because you're reacting. Straight away you've got to have boundaries but you don't know what they are anymore, so as a man I would think immediately you're vulnerable. And we really need to work on it and better understand boundaries. (John)*

John's description demonstrates the vulnerability he feels as a male therapist to being perceived in the abuser role. John also highlights how important he feels clear boundaries are in mediating the power dynamics between a male therapist and a female client.

An additional illustration of gender impacting on the therapeutic relationship was highlighted by Laura in relation to a female therapist working with male clients. The following excerpt was interpreted as Laura feeling anxious or shameful in asking male clients about their arousal during their abusive experience, prior to her developing knowledge and skills in working with this group.

> *…I hadn't really thought about, like working with male clients, really going into physiology about maybe arousal and explaining why they might have had…*

they might have been aroused or they might have even ejaculated and things like that, like I need to think about how I can ask… (Laura)

4.3.2 Developing a safe therapeutic foundation

It was interpreted that the powerful transferential role dynamics contribute to a need for the participants to develop a safe therapeutic foundation. The main processes of this subordinate theme included developing trust in the relationship, offering a safe space, management of disclosure, providing emotional containment and validating the client's experience. It was understood from the participants' narratives that this client group often had ongoing systemic or relational abuse experiences throughout their lives. Therefore, it was interpreted that these processes offered a reparative function through the therapeutic relationship. The most prominent of these themes appeared to be developing trust as illustrated in the following excerpt by Sarah:

So the beginning was very much to make her feel comfortable and safe, for many, many sessions actually. So it was a very slow process. She had quite a lot of defence mechanisms. She had one where she just talked at you. She just talked and talked and when you tried to ask something that was more personal or how she felt, she kept talking or change the subject about something else. So it was quite a long period with just trying to make her feel that she could actually trust me. I felt (…) that was what the whole process was about that she could actually start talking to someone and trust someone else…(Sarah)

Sarah's experience of her client offering her no space in the room through talking could be interpreted as a powerful defence mechanism from the client to dominate the space. In Sarah's experience, it would appear building a trusting relationship promoted equality in the power dynamic of the relationship, allowing the client to soften her defences.

Jill also emphasised the concept that through developing trust, clients will lower their defence mechanisms enabling openness. She stated:

> *…There was a genuine sort of closeness and trust in our relationship. And then all of my clients sort of went back to it and spoke about it more [the abuse]. (Jill)*

Jill's experience of building genuine trust in the relationship could be interpreted as further demonstration of balancing the power dynamic to facilitate the openness in the relationship. Nicola emphasised this through the importance of developing trust by offering a safe space for clients:

> *I think the challenging part of this work is I'm aware that I'm providing a space that is unique in the sense that maybe many of the clients haven't had the chance explore and disclose (…) to someone. (Nicola)*

Nicola's reference to managing disclosure appeared to be another important aspect of developing a safe foundation in the therapeutic relationship. Participants indicated that they felt an expectation to manage disclosure with sensitivity. This was

particularly evident if a client had a negative experience of disclosing to others in the past which may have been shaming or replicating of abuse through not being believed or being passed on to other services. The following excerpt from Laura demonstrates this:

> *…Because, especially with older survivors, the way that some of them… their disclosures have been treated and when they were children and older… was really horrendous… (Laura)*

Following on from 'management of disclosure' another theme was interpreted from participants in relation to providing emotional containment. Balancing the dynamic of providing emotional containment, whilst also working through the experience with the client was interpreted as a challenge for many of the participants. The excerpt below is an interpretation of Kate's illustration of this with a client she described as being very emotionally uncontained who was verbally aggressive toward her and others:

> *…Obviously she was like that with me in the room, not trusting me at all (…) so I actually ended up having to end with her (…) I had to be like this isn't going to work. You don't seem to be ready to properly engage… (Kate)*

This challenge of engaging in therapy with clients who are finding it difficult to contain their external emotional state could further be interpreted as the difficult balance of power dynamic between client and therapist.

Jill goes on to discuss the sense of feeling a metaphorical pressure to physically contain her clients' emotions:

> *…This idea that you somehow that you hold people's and contain people's emotions; although you kind of do (…) but I'm trying to find a way to put it into words. But it's something really physical. (Jill)*

The physical sense that Jill describes could be interpreted as a projection from the client toward the therapist to contain the emotional process to provide the client with a sense of a safe foundation. This could also be understood as the client's need for validation of their emotional experience. Participants expressed that this client group often had experienced an invalidating environment due to the abusive nature of their childhood. The following example from Sarah could be interpreted as validating a client through liberation of blame from her childhood experience:

> *…Because when she came I think she had no self-worth really, and it was kind of all taken away from her, from her childhood abuse, and then the rest of life had gone by and I just try to make her understand that she has no blame… (Sarah)*

This illustrates Sarah's attempt at relieving her client of self-blame through acknowledgment of the client's invalidating childhood environment, which had resulted in feelings of disempowerment and low self-worth for her client. This could be understood as an example of the powerful reparative tool the therapeutic

relationship offers through validation of the client having no blame in their experience.

4.3.3 Empowerment of client through therapeutic relationship

All of the participants alluded to this subordinate theme to help promote equality and empowerment of the client through the relationship. This held further significance for participants when discussing clients who were continuing to feel disempowered through recurrent systemic abusive patterns. Kate illustrated an example of this with a client who was involved with social services care:

> *I suppose there was lot of relationships in her life where she had no power, no say and you know kind of with social work and that she was very being told what, so you know having more of an equal relationship was kind of good for both of us… (Kate)*

An additional theme of empowerment of the client was raised by John, who illustrated through his experience the importance of giving the client the choice of therapist, particularly when considering the male/female dyad:

> *…If I asked for a female (…) and they changed her to a man and said it would be good for me without it being asked [John's tone expresses anger]… I couldn't have worked with her… (John)*

John's reference to providing the client with a choice to therapist was interpreted as an empowering opportunity for the client to have a voice in the process of choosing

with whom to develop a therapeutic relationship. This was interpreted as providing an opportunity to the client to balance the power dynamic from point of engagement by offering empowerment of choice within the service to minimise replication of an abusive or powerful system.

A further theme within Laura's experience was interpreted as an empowerment of the client enablement through practical techniques:

> *…I really think one of the most important things that trainees need to know and be able to explain really well is how trauma affects people psychologically and physiologically and everything because then you can make sense of a lot of things and you can normalise or explain or explore… (Laura)*

Laura's example of explaining to clients how the brain processes trauma was understood as an important way to empower the survivor with knowledge to make sense of their difficulties. This was also interpreted as significant in balancing the power dynamic in the relationship by collaboratively working with the client to share knowledge.

4.3.4 Pacing the therapy – support versus challenge

A prevalent theme interpreted from most of the participants was the importance of managing the pace of the therapeutic process. This concept builds upon the theme of 'Developing a safe therapeutic foundation,' as participants indicated that clients often presented with trust difficulties. Therefore, it was deemed important to gauge the amount of challenge or exploration a client could take versus the amount of

support they required. An excerpt from Sarah demonstrates her experience of pacing therapy gently:

> *…And I had to be very observant I think… I mean not to push… I think what is needed is a slow, slow process; I think sometimes when you start pushing too quickly to get some sort of cure or whatever it's… I think this client anyway was very, very slow process, because of all the defences she had built up… (Sarah)*

This example could be interpreted as an illustration of the therapist managing the power dynamic in therapeutic relationship. In Sarah's experience it would appear if she had forced her client into deeper exploration or therapeutic work too quickly she would have been met with powerful defences from her client.

Another illustration of this was provided by Jill in relation to questioning the therapist need for enquiry versus the benefit to the client:

> *…And I think working with childhood trauma like that, that you very quickly realise that it's not always appropriate to do that sometimes you kind of having to just let things settle in the room and to know that… So trying to judge when to lead something and when to pick it up. When is somebody ready to really look? It helped me to ask myself more often is this client ready to look at this? Or is this thinking it's my job to do this with them… (Jill)*

This excerpt from Jill was interpreted as the therapeutic balance of support versus challenge with this vulnerable client group due to their childhood trauma. There is a sense that Jill feels the need to be more tentative due to feeling anxious about pushing the client into territory they do not yet feel ready to explore.

Nicola accentuates the need for pacing therapy due to the nature of the traumatic experience of childhood sexual abuse:

> *I'm aware that I need to tread careful. You know but it's a very sad sort of territory, very sad sort of landscape to explore (…) Because it's a story that I sense that needs to be heard, that wants to be heard, wants to be shared, but the same time it feels very fragile very sensitive, very raw.*

Nicola's excerpt refers to the requirement to 'tread carefully' whilst also highlighting the client's need to share their story. This offers another opportunity for interpretation of the importance of pacing therapy to empower the client to open up in their own time without feeling pressured from the therapist. The need to pace therapy has been interpreted from the participants as an important factor in not replicating abusive dynamics by the therapist dominating the space.

An example provided by John openly alerts to the difficulties he experienced that can arise if a therapist does not clarify and pace therapy collaboratively with the client:

> *In my experience, I have to keep in mind and be very very careful of what they mean or what I think they mean. If I'm starting down a dark track thinking I*

know what I'm in for, I thought I knew but I've no idea, I mean it can cause a rupture… (John)

John's narrative was illustrative of a therapeutic rupture which could occur if an interpretation is offered to a client when the relationship has not yet been established or if the client is not ready to tolerate that extent of challenge.

4.4 Management of the vicarious emotional self

All of the participants discussed the affect which was triggered within the self while undertaking therapeutic work with adult survivors of CSA. The emotional states described by participants were interpreted as being vicarious given the parallels with the emotional experiences expressed by the participants' clients. The intensity of the vicarious emotional state varied by participant; some were believed to have experienced vicarious traumatisation. The participants' identification of their affect state was interpreted within the theme of 'Therapist's vicarious emotional state.' Subsequently, two further themes emerged in relation to managing their vicarious emotional state through self-care and the use of the supervisory relationship.

4.4.1 Therapist's vicarious emotional state

Sarah's described feeling detached emotionally from her client's experience. In the following excerpt Sarah attempts to make sense of the emotional process she was experiencing in the room with her client.

It's not that I don't feel empathetic, but I mean much more emotionally, I thought it was going to have a much bigger impact on me. And actually I think

I got a bit dissociated, so that actually surprised me (…) [given] the horrible things she said and stuff… (Sarah)

This reaction from Sarah was interpreted as a result of vicarious traumatisation. Sarah indicated her emotional reaction was to dissociate in order to manage the 'horrible things' described by her client. Laura also discussed this vicarious emotional state which was also understood as vicarious traumatisation:

…There was a tendency to not want to think about it or to maybe feel disgusted or kind of… almost a bit spaced out because once I stared feeling a bit numb when someone's talking so I had to think what's going on because obviously I didn't want to listen to some of things... (Laura)

This excerpt suggests that the client's description of the abuse was unbearable for Laura to endure and consequently she experienced a dissociative reaction. This has been interpreted as a further example of vicarious traumatisation akin to the dissociation to which she referred her client had experienced during the intolerable experience of the abuse.

Laura went on to link this to another vicarious emotion in relation to disgust.

In terms of the process issues (…) to maybe feel disgusted… (Laura)

Disgust was also considered a vicarious emotion as participants' clients also identified with this affective state toward their own experience of CSA. Kate made further reference to managing feelings of disgust:

> *…If you end up not bringing up things because you feel uncomfortable or you might portray some disgust or something, not at the client but at the experience… (Kate)*

Kate's excerpt also suggests the possibility of experiencing shame. Shame was interpreted as vicarious given the recurrent theme which participants illustrated in relation to clients' feeling shameful of their abusive experience, as the following example from Nicola highlights:

> *…It's something that can often be associated with secrecy and shame… (Nicola)*

Nicola offers further exploration of how vicarious shame can be distressing as a trainee:

> *…The shame is a big part of the process of working through this trauma, and being in the presence of someone who is living that experience in the present can be quite overwhelming and quite powerful. (...) It evokes feelings of shame, just to run away from it and hide, but it's about staying there, and unpacking the experience. (Nicola)*

This statement from Nicola was understood as a vicarious reaction within the therapist in relation to shame, evoking feelings of wanting to avoid exploring the experience with the client.

Jill provided a poignant illustration of the physical anxiety she experienced when undertaking work with survivors of CSA, stating:

> *It's quite a physical experience (…) when you work with these issues, that actually they're very intense physically and it's anxiety provoking. (Jill)*

The excerpt was interpreted as a vicarious physical reaction, as often participants described clients' physical manifestations of anxiety or distress when recalling their abusive experience.

Another physical fight or flight response experienced was highlighted by John in relation to anger.

> *It can also make me feel very angry. But I'm aware of this… so I have to be very careful about it. (John)*

John's example presents the concept of vicarious anger. In a further excerpt from John he demonstrates anger toward systems which concealed or failed to protect people from abusive experiences:

So what makes me angry, really angry, is that this is childhood abuse, an adverse serious crime, but sadly there's systems around and organisations hiding it (…) we're here to protect children and nourish them keep up society and, that's not what I see and that really makes me angry. And I have to measure that with the work involved. (John)

This feeling of vicarious anger or bewilderment toward systems failing to protect survivors was also interpreted from Laura who stated:

…I guess it can really challenge your view of the world and so I think there's different ways that it can affect you and some are maybe harder to talk about… (Laura)

This was regarded a vicarious emotional state as participants often reported clients felt anger toward others or organisational systems, due to believing they were complicit in allowing the abuse to occur.

4.4.2 Managing emotional state of self through self-care

This presented as one of the most common themes across the participants. Self-care appeared to be highly significant for trainees when working with this group. This provided an important function for participants to manage their vicarious emotional states.

Jill highlighted various practical skills that were of importance to her in managing her self-care, particularly when linked to the physical distress she discussed. These

included skills such as exercise and meditation as ways to develop compassion for the self, which she felt were of particular benefit:

> *If I've had a really intense session with someone and there's been a lot of difficult material that has come up… sometimes a client will talk about something and (…) it's hard to hear. (…) It's amazing how I started to take some of these things on; almost like absorbing them… So I would say without a doubt it would be meditating (…) doing yoga (…) going for a run because you can get it out physically and that's really great as well. But something about doing more meditative stuff (…) feels really compassionate towards myself and leaves me a really compassionate space for other people… (Jill)*

Jill's experience was understood as an example of managing the difficult vicarious emotional reactions within the self, through the use of practical strategies, particularly to cope with the physical manifestation of distress. Jill also mentioned other techniques such as writing process notes after the session:

> *I think, after a session (…) when someone's spent most of the session talking about sexual abuse and afterwards I've really felt quite drained, and it has actually been important to then go and write my notes. And I find that really helpful to kind of put all that emotion somewhere (…) that's sort of symbolic. (Jill)*

The use of writing as a technique to externally process emotional state was also used in another medium by Nicola, in the form of keeping a journal:

Personally, what I found really helpful is keeping a journal and just being able to let all my thoughts and feelings out… (Nicola)

Jill and Nicola's excerpts were interpreted as the need to be relieved of the distressing emotional state of the self through the writing process which provided a form of physical expulsion.

Managing the traumatic physiological effect of working with adult survivors of CSA was also highlighted through Laura's experience:

…I guess there's like a kind of physiological basis to a lot of… I found, working with trauma, that, I don't know you might feel like you need to comfort you or look after yourself more afterwards but, yeah… (Laura)

Laura's excerpt was thought to be an example of the importance for physical self-soothing given the vicarious emotional distress that participants reported to feel physically draining.

John also discussed the importance of finding a way to manage his vicarious emotional state, particularly in relation to anger:

Somewhere I can go and offload, especially about my own anger (…) personal therapy.

The use of personal therapy was referenced by several participants as a significant mechanism for self-care of their emotional state. This appeared to offer participants a method to process the distressing vicarious emotional state. Nicola also highlighted:

> *…And of course personal therapy (…) I think I wouldn't be able to do this job if I haven't done my own therapy. (Nicola)*

Nicola made reference to the importance of personal therapy again toward the latter stage of the interview, stating:

> *…In our own personal therapy, you know have that shared area and space where we can begin to understand to experience these things. (Nicola)*

This excerpt was also interpreted as an example of the recurrence of the vicarious emotional state out of the session with the client, albeit within a containing environment to process one's own emotional experience.

The need to manage the vicarious emotional self also appeared to have a systemic effect on others such as the therapist and other individuals close to the trainees in their lives. For instance, Laura described the vicarious impact on her own sexual relationship which resulted in her needing to self-reflect with her partner about the effect of the work on her:

…I guess that's one of things that I at least felt I had to talk to my partner about. (Laura)

This was interpreted as managing self-care through self-reflection of her emotional state and also by sharing with her partner the vicarious traumatic effects on her libido to understand the impact on their relationship.

4.4.3 Supervisory relationship to manage emotional state

The use of the supervisory relationship to manage vicarious emotions was an additional substantial theme that emerged from participants. Sarah, for example, described using supervision as a space to explore her feelings of dissociation:

My biggest fear was the feeling that I felt like, 'Why am I so dissociated with my feelings?' So and to really use the supervision to make sure that you talk about your feelings and don't get confused about your own feelings in this instance. Because I felt 'What's wrong with me?' (…) You need someone to kind of discuss these feelings around. And it's okay to have all these feelings… (Sarah)

This excerpt highlights the facets of supervision that were of particular help to Sarah in managing the guilt of feeling dissociated. It was understood that through the normalisation of her emotional experience Sarah was able to process her affect. This could be interpreted as a mirroring of the therapeutic relationship, as Sarah cited normalising her client's emotional process regarding her experience of CSA as a fundamental component of the therapeutic work.

Kate discussed the importance of this when managing the vicarious emotions attached to the graphic description of abuse from the client:

> *…Obviously supervision during that time was important and helped with the more graphic things during that time, that were playing on your mind a little bit more. (Kate)*

The supervisory relationship appeared to enable Kate to manage the distressing images. It was interpreted that without this opportunity to process such images, there was potential for her to have experienced vicarious traumatisation.

The following passage from Nicola further illustrates the importance of the supervisory relationship to manage her emotional state:

> *I think that supervision definitely has a place to gain that third perspective, being able to step back and see things from a distance, because sometimes I find that I am very involved and emotionally very involved and that can make it very difficult to think. (Nicola)*

Nicola described experiencing an emotional thinking block when working with this client group, which could be understood as a further vicarious process on which supervision provided her with a space to reflect. Moreover, supervision was deemed to offer emotional containment of the distress reported by participants. For example,

Jill stated the importance of having a positively reinforcing supervisory space to nourish and manage the emotional self:

> *…And what has been helpful is when I've had supervision that's been really about building my confidence and actually giving me positive feedback. Because it is something that I naturally am anxious about doing it wrong anyway… (Jill)*

This excerpt has been understood as the supervisory relationship providing containment for Jill's anxiety through encouragement. Laura concurred with the concept that supervision should be a supportive environment. The subsequent citation from Laura reinforces the containing functions of supervision in her experience:

> *…So supervision was probably the most helpful thing because that helped me track my own responses, make sense of what was going on, and also stay more attuned with the client… (Laura)*

Laura's reference to 'tracking her own responses' further supported the concept of supervisory relationship providing space to reflect and manage the vicarious emotional self.

John's experience of supervision was interpreted as illustrative of disappointment when supervision does not offer management of the emotional self:

Even in supervision it can be shied away from, it's a bit of a shame really, it's like what are all these feelings saying? I mean, inside, that's meaningful and it clearly impacts on the work. As a practitioner, I'm feeling that, I'm not saying take the power out of it but let's use it. Personally I think it helps... (John)

John's excerpt demonstrates the difficulty he experienced when the supervisory relationship did not address or 'shied away from' managing the emotional self. It has been interpreted that he felt this experience was inhibiting of reflection on his emotional self. John implies by making sense of what his feelings are saying in supervision this could be helpful and meaningful to the work with the client.

4.5 Questioning of competent versus incompetent self as therapist

Working with survivors of CSA appeared to evoke questioning of the self across all participants. They each discussed the process of questioning the self as inadequate and moving toward enablement of the self. Participants shared a sense of being overwhelmed by the complexity of the client group. This feeling, alongside their self-perceived lack of experience, was interpreted as self-doubt in their ability to effect change. A further theme emerged in relation to participants' feelings of empowerment by having a choice in working with this client group and also through development of knowledge. They each discussed facilitative ways in which this was acquired.

4.5.1 Questioning of the self as inadequate

This was a prevailing theme across the participants who each alluded to feelings of inadequacy, particularly in the initial stages of working with survivors of CSA.

Kate illustrated an example of feeling highly anxious when one of her clients disclosed childhood sexual abuse in the early stages of her training:

> *…She was only my third ever client. Within the first two sessions she then said, "and I experienced sexual abuse as a child," and I thought uh oh. She had a lot of counselling experience before so she kind of knew the drill, in some ways and she knew all the confidentiality talk, it was quite challenging some of the things she was telling me… (Kate)*

This excerpt has been interpreted as Kate questioning her competency on the disclosure of CSA from the client. Kate's expression of her internal thinking process: 'Uh oh,' when her client reported abuse was indicative of her feeling unable to cope with the disclosure. Kate offers further exploration of her feelings of inadequacy:

> *There was always a sense of anxiety when the client comes in and you know the issue is more complex to work with, you worry are you going to be able to cope, whether you will be able to help and effect change, you know it's such a long term ingrained issue, there is that anxiety that means it will affect you that bit more… (Kate)*

Kate's questioning of her ability to cope continues to emphasise her questioning of the self as inadequate. She then discusses the impact this appears to have on the client, as Kate chooses to end the therapy:

> *So I actually ended up having to end with her, which is not something I've ever really, I mean we only had six sessions, I had to be like this isn't going to work...*

Kate discussed the client not being ready to change; however, this abrupt termination of therapy could also be interpreted as Kate's questioning of feeling incompetent versus the client's readiness. The example Kate provides could also be deemed a potentially harmful experience for the client through reinforcement of rejection due to the disclosure of CSA appearing unbearable for the other. Kate emphasised the client was struggling with trust issues; the experience could, therefore, be interpreted as further damaging the client's ability to trust in the other. The risk of harm to the client if a therapist is inadequately skilled versus the potential harm to the client by ending abruptly was identified as an ethical dilemma. Another ethical dilemma raised by Kate was managing the legal responsibility, which provoked additional feelings of inadequacy:

> *…Be clear that you will have to report something if they do say the abuser's name or something…*

Nicola also referred to the ethical dilemma of self-competency:

…I would be filled with thoughts about dilemmas about how I would be able to hold the experience, where to start from, how to be, all these very fundamental questions. Whether what I would offer would be good enough… (Nicola)

The extract was interpreted as a clear example of Nicola's questioning of her own ability to work with this group at the outset. The following excerpt from Laura also explores feelings of inadequacy in the early stages of working with this client group:

…I guess one of things is our own process of maybe listening to things, maybe shocking things or distressing things. So, I think that's one thing that I maybe struggled with, especially in the beginning… (Laura)

Laura's reflection was understood as the significant emotional process which working with survivors of CSA evokes, due to the 'shocking' nature of the abuse. The emotional process was reported by all participants as being more complex when working with abuse issues; it has, therefore, been interpreted as a substantial contributing factor toward their questioning of self-competency. The excerpt below from Jill displays the anxiety that can result in feelings of inadequate self:

…Maybe because I still have the anxiety about, you know, doing this kind of work that maybe I feel anxious about it. Or whether that's just the way it is when you work with these issues… (Jill)

Jill's extract was interpreted as self-doubt in working with abuse issues. Jill continues to discuss the feelings of anxiety associated with responsibility toward the client which was interpreted as evoking feelings of incompetency in managing this process.

Sarah also expressed uncertainty in relation to her competency regarding exploration of the client's experience:

> *I'm not so sure about going into detail about what happened, I'm not sure about that. I think it might be opening too much. I'm not sure if you are able to go there or how it would turn out. (Sarah)*

This was understood as Sarah's questioning of self with regards to her ability to manage the client's emotional state should it become challenging.

4.5.2 Self-empowerment through choice

Several participants indicated that having a choice about whether to work with the complexity of this client group was empowering. This was interpreted as a reflection on participants' own recognition of their self-competency and ability level. In John's case, as described in the passage below, had he disrespected the client's gender preference of therapist, this could have resulted in him feeling inadequate as the client had requested a female. John explained that he was anxious about raising the issue with his supervisor:

So I asked my supervisor why I had been allocated… I'm in a new placement and I said no… this is going to cause her more harm… anyway it was actually really well received. (John)

It was interpreted through John's expression that he felt empowered to have a choice in working with this client. He felt uncertain about working with her as she had requested a female; he expressed relief when his and the client's choice were respected. John additionally discussed at a later point having the choice to only work with a small number of clients who have experienced abuse:

…The first thing I learnt, I'd only one or two people with sexual abuse but I couldn't work in a service where there were many, it's too involved for me, so one or two clients but I wouldn't work with more than that. (John)

This is further illustration of John feeling empowered by having the ability to choose the number of clients he felt was manageable. Kate also highlighted the importance of the individual's consideration as to having a choice in working with survivors of CSA:

I suppose competency as well, I suppose if you were feeling upset or squeamish you don't want to hear about client's particular traumatic experiences, so maybe you should consider whether it is for you, because you have to be able to adjust to that. (Kate)

The extract from Kate emphasises that one should carefully consider working with CSA; this has been understood as empowering the self through recognition of competency.

4.5.3 Enablement through self-directed learning

Engaging in self-directed learning to empower the competent self was a substantial theme which emerged from all participants. This was interpreted as the process of participants moving from uncertainty re the competent self to enablement of self.

The following excerpt from Nicola indicated that she experienced a sense of empowerment through the normalisation process which self-directed learning provided:

> *And I also feel that the literature can be quite helpful (…) the psychodynamic literature has offered quite a lot on the subject and I find that when I read case studies and I read about the therapists' dilemmas and countertransference reactions and things like that it makes me feel that I'm less alone (…) it normalises the reactions. (Nicola)*

Laura's citation below also promotes enablement through self-directed learning. However, she refers to the concept of normalisation not only being helpful to the therapist but also to the client. This consequently enables the trainee therapist to feel more competent in their approach with the client:

…I really think one of the most important things that trainees need to know and be able to explain really well is how trauma affects people psychologically and physiologically and everything because then you can make sense of a lot of things and you can normalise or explain or explore and I think if you have that really solid base, then it… you feel less overwhelmed in sessions because you can think about what's going on and you're able to put in place, like grounding techniques or things like that… And, I guess, address things more openly. (Laura)

Laura's self-directed learning about trauma reactions and therapeutic techniques enabled her to feel and demonstrate competency with her clients. This was interpreted as containment of the emotional self through development of practical skills and knowledge.

An additional underlying theme which was considered within this subordinate theme was in relation to prevalence. It was interpreted that participants were empowered by acknowledgement of prevalence rates of CSA. Nearly all of the participants referred to the importance of recognising prevalence rates of survivors, as highlighted by Laura:

Survivors are everywhere. So, I think just even just having an awareness of how prevalent it is, I think is a great starting point and especially how highly correlated it is with so many other, I don't know psychiatric disorders or emotional wellbeing or whatever they refer to. I think that's important. (Laura)

It was understood that the consideration of prevalence was important for participants as they wanted to be prepared for the prospect of working with survivors of CSA and understand the links to mental health difficulties.

Nicola further underlines in her experience why developing knowledge of prevalence is important:

> *…It also affects so many of our clients and just realising how common it is, not only from my own experience of the clients that have told that I've worked with but you know comparing with them other people in my cohort, and it's very often the root of many difficulties that we work with. (Nicola)*

Nicola's reference to CSA being 'the root of many difficulties that we work with' was interpreted as her developing a deeper awareness of clients' difficulties through acknowledgment of this.

4.5.4 Facilitative versus non-facilitative learning environment

This theme within this superordinate theme emerged from all participants across core learning environments. These included the training environment, the team in which the participant worked and the supervision environment as an educative space. The supervisory relationship has already been discussed in relation to managing and providing emotional containment within the previous superordinate theme. However, an additional function was interpreted regarding supervision offering a facilitative educational space. As such, it was considered under the

present superordinate theme, as a way of enabling participants to progress to the competent self.

Facilitative and non-facilitative aspects of the training environment were presented by most participants. John felt the training offered a reflexive environment which was facilitative in working with survivors of CSA:

> *…So I guess what has helped has been the reflexive bit and the reflexive part of the course… (John)*

However, he criticised the lack of specific training stating:

> *I'm curious about how do people respond or how one should respond…There's not much training, well on my course anyway. (John)*

The desire for further training around working with adult survivors of CSA was emphasised by several participants. Nicola discussed the benefit she believed experiential work could offer:

> *…I find that it would be important to have an experiential shared space in which we can learn to – not learn but experience these challenges and emotions in the presence of each other. Rather than having to feel that it's just something that we just have to deal with individually, in our own personal therapy, you know we have that shared space where we can begin to understand and to experience these things. (Nicola)*

The above excerpt was an illustration of Nicola's training environment lacking in opportunity for experiential work. As a consequence trainees may keep their feelings hidden, which was interpreted as metaphorically symbolic of the secrecy that is often associated with CSA.

Sarah also implied a need for further experiential work on the course:

> *…We didn't have much [on the training course], so I think definitely we should have more and really looking through different approaches you could use that quickly (…) it was very kind of short and to have maybe had some workshops on it so one to one or group workshops (…), so I think that was generally lacking… (Sarah)*

This was understood as further discontent regarding preparation from the training course in relation to working with survivors of CSA. As a result this was interpreted as leaving Sarah feeling less competent as a therapist.

This dissatisfaction toward the preparation from training was also noted by Jill who expressed a desire for more understanding of issues such as vicarious traumatisation:

> *…Then you actually start working and sexual abuse comes up. Something that's that traumatic, anything that traumatic comes up but there's no mention of it at all [on the training course]. I think that maybe that is why it is so de-*

skilling (sic) and then you start questioning, "Oh, I'm not ready to do this job yet. I can't believe they've give me a placement here. Did they not know I don't know what I'm doing." (…) Or even somewhere along the training someone to have mentioned the words like vicarious trauma… (Jill)

Jill's example of feeling 'de-skilled' and ill equipped by her training course to manage traumatic issues such as CSA has been interpreted as leaving her feeling somewhat fraudulent in the early stages of her practice. This was linked to Jill's high anxiety levels about her ability to practise competently.

Several trainees felt that facilitation of their competent self was nurtured more through the team environment within which they work. John stated:

…I'm curious how they relate to me now and how I relate to them, in a team who is very open, who is open to me questioning and it's very healthy… (John)

This was interpreted as facilitative for John to be able to reflect on his client work within an open team. Laura also stressed the importance of working in a supportive team environment within this area:

…And I think the context that I worked in was really supportive (…) I think working in that environment where we could talk quite openly about things and I found that quite containing, yeah, and I thought that was good... (Laura)

Laura's reference to containment was understood as an important function the team provided. This appeared to enable Laura to be reflective and open about her own process while undertaking work with survivors of CSA. Laura also discussed the facilitative environment of supervision to enhance practical knowledge:

I think I had really good supervision in my placement and there's a lot of practical things that I needed to know about , like grounding, especially with some parts of the session (…) So, there's a lot of practical things that I need to know and be aware of… (Laura)

Supervision as an educational forum for Laura was deemed an important factor in the development toward the competent self.

5. Discussion

5.1 Overview

The aim of this qualitative analysis was to gain a detailed understanding of counselling psychology trainees' experiences of working with adult survivors of childhood sexual abuse. This was undertaken through analysis of six semi-structured interviews using an Interpretative Phenomenological Analysis (IPA). Few qualitative studies have examined trainees' experiences of working with this client group. The current study was anticipated to expand on the limited existing knowledge base in this area. The main research question was:

How do counselling psychology trainees experience working with adult survivors of childhood sexual abuse?

The following areas were considered in relation to this question:

1) Were there any aspects trainees found particularly challenging about their experience?
2) Was there anything that particularly helped trainees when working with this client group?
3) How were they affected by working with adult survivors of CSA?
4) Are there things they would do differently on reflection of working with this client group?

The analysis data was derived from the semi-structured interviews which covered the above areas. The following discussion section will review the findings from the IPA in relation to the existing theoretical evidence base. Accordingly, clinical implications, evaluation of methodological approach, recommendations for further research and reflexive considerations will be provided.

5.2 Power dynamics in the therapeutic relationship

In view of the focus on the therapeutic relationship within the field of counselling psychology, the power dynamic between client and therapist has become an increasingly important discourse (Day, 2010). This appeared to be a highly significant theme demonstrated across all participants within this study. Davies and Frawley (1994) have referred to the struggle of balancing the power dynamic when working specifically with adult survivors of CSA. They describe how abused children often dissociate to split off bad aspects of the object (abuser) and of the self in the abusive relationship in order to survive the experiences. Davies and Frawley state that consequently, adult survivors of CSA continue to repress powerful emotions of anger and contempt at being controlled and disempowered in their childhood. They assert that one of the ways this can manifest is within the transference, which was interpreted as evident from each of the participants' experiences.

5.2.1 Challenges of managing transferential power dynamics for trainees

Neumann and Gamble (1995) propose common countertransference reactions which trainees might experience when working with adult survivors of CSA. Their paper discusses roles with which new therapists identify working with childhood trauma, in particular childhood sexual abuse. They state new therapists can experience

feelings of helplessness, inadequacy, shame and abandonment, which was understood as a projection of the disempowering feelings which survivors may experience (Neumann & Gamble). It was interpreted that the findings from the current study supported this theory through their description of transferential dynamics.

Nicola elaborated on the feeling of vulnerability within the power dynamic of the relationship using the concept of the "triangle of abuse." This was originally defined by Karpman (1968) as the "drama triangle," from which he outlined three roles, the persecutor, the victim, and the rescuer. As the participants described the roles in which they partook, there appeared to be a transient shift in the subtle power dynamics within the therapeutic relationship between client and therapist. For example, Kate's description of her challenging client with whom she ended therapy due to her feeling that the client was not ready to engage was interpreted as a shift of power from the client to Kate. Initially, her client was interpreted as participating in the persecutor role by displaying verbal aggression toward Kate, placing Kate in the victim role. Kate, herself, then subsequently shifted into the persecutor role by ending the therapy abruptly, which was interpreted as reinforcing dynamics of control and abuse. However, prior to this, within the relationship, Kate appeared to be in the rescuer role, describing how she wanted to retain feelings of empathy toward her client rather than engage in persecution reflecting the way others behaved toward her client.

The participant's occupation of the rescuer role was understood as projective identification, a term coined by Klein (1946) which refers to the process whereby a

therapist is drawn into enacting a particular role evoked by the client. Additional such examples were provided in the analysis by both Jill and Sarah who demonstrated enactments of providing maternal care and responsibility toward their clients. These were viewed as illustrations of the client projecting the need for a rescuing mother role onto the therapist. Participants also described feeling an ongoing sense of responsibility toward their client out of sessions; this was interpreted as a form of maternal preoccupation (Winnicott, 1956).

5.2.1.1 Gender in the therapeutic relationship

The influence of gender on the therapeutic relationship was discussed by two of the participants in more depth. John, in particular, noted the importance of the male to female power dynamic working as a man with this client group. The implication of the importance of gender as an issue has been investigated by Simpson and Fothergill (2004). However, they emphasised in their findings that the power dynamic can exist in all dyads and should not, therefore, be stereotyped as applicable to gender. The research investigated 53 mental health practitioners who were presumed to have had experience working with adult survivors of CSA. The lack of homogeneity amongst the professionals who partook in the research could, however, be noted as a limitation. Nevertheless, their research indicated that the therapeutic relationship was of primary importance over gender; although the research did not appear to take into account the dynamic of gender within the therapeutic relationship. Further research, from service users' perspectives of therapists' gender in relation to their own, would be of value to the developing body of literature. John raised questions such as how female clients view working with a male therapist and the impact on power and trust within the therapeutic relationship.

An additional gender implication was reported by Laura regarding the female to male therapist to client dyad. Laura emphasised the need for trainees' awareness as a female therapist pertaining to the physiological reactions which male clients may need to explore within therapy, such as ejaculation during the abuse. Laura asserted the need for therapists to normalise this experience for male survivors in order to help them manage guilt or shame associated with the abuse. Carpenter's (2009) article has discussed the likelihood that males are more likely to experience arousal or ejaculation during the abuse, which may also be a further complex dynamic in the perpetrator's method of control. Carpenter, therefore, highlights the importance of therapists managing the power dynamic with male clients in the therapeutic relationship to prevent replication of shame or control.

5.2.2 Developing a safe therapeutic relationship to empower the client

Another component which emerged from the participants in relation to managing the power dynamic incorporated building a safe therapeutic foundation. Participants in the current study revealed that clients felt empowered through the development of trust.

All the participants referred to the significance of developing trust in the relationship, taking into consideration the early message their clients often received in childhood that a relationship with another is unsafe. The findings in the current research support a study undertaken in this area by Chouliara, Kartzias, Scott-Brien, Macdonald, MacArthur and Frazer (2011). Chouliara et al. investigated 13 adult survivors of CSA and 31 professionals who had experience working with adult

survivors of CSA in Scotland. The study concluded that building a trusting therapeutic relationship to provide a safe space was of paramount importance. Preceding this research, the lack of a safe foundation which adult survivors of CSA experience in their early years was theoretically discussed by Olio and Cornell (1993). Their article addressed key aspects of the therapeutic relationship which attend to building trust. Olio and Cornell highlight the importance of developing a trusting relationship through management of disclosure.

Browne (1991) raised the issue of what might happen when disclosure is improperly managed, a concern which was also shared by several participants in the current research. Both Nicola and Laura stressed the importance of handling disclosure sensitively due to possible, past, negative experiences survivors may have had when disclosing their abuse. Chouliara et al. (2011) also cited management of disclosure to be essential when working with survivors from both the client and the professional perspective. Newgent, Fender-Scarr and Bromley (2002) highlighted the re-traumatisation that may often have occurred to young people within the multiple systems that are intended to assist them, such as the criminal justice system, the care system or others within the helping profession. They assert that professionals working with survivors who have encountered such systems should remain mindful of possible re-traumatisation and of trust in others which may have been further damaged.

An additional central feature of the therapeutic relationship which appeared from participants was in relation to emotional containment; this has also been emphasised by Olio and Cornell (1993). Containment is a longstanding concept originally derived

from the work of Bion (1963). A more recent synthesis of Bion's work states that the projective identifications or split off parts of the client's self require containment by the therapist if they are to be modified in some way (Cartwright, 2010). Within the present analysis a number of important facets appeared to contribute to managing emotional containment, which in turn facilitated trust within the relationship.

Firstly, the engagement of humanistic principles was referenced by several participants as being fundamental to developing a safe place for their client. For example, Sarah felt that such an approach helped her maintain a non-judgemental and empathetic stance. Sanderson (2006) illustrated how the effective use of these principles with this client group can help attend to the power dynamic in the therapeutic relationship. Sanderson outlines the value humanistic principles can contribute to enable a practitioner to maintain unconditional positive regard when power and control issues become difficult within the relationship. She also highlights the importance of the practitioner becoming more aware of their own need for power and control when working with this client group. Sarah provided a good example of this within the analysis, in that she recognised the importance of managing her judgement of the client when she felt frustrated by the client not implementing changes to their external world following sessions. Sarah was able to note her desire for controlling the client in this scenario and through this recognition was able to re-engage with her non-judgemental stance.

Baker (2002) supports the idea that providing congruence, empathy and unconditional positive regard can offer a validating environment for the client. Validation was thought to be a second important element in assisting the process of

emotional containment. Offering a validating environment was interpreted from several participants in the present study. For example, Sarah's reference to providing recognition of the abuse not being the client's fault and that they had no blame was validating for the client. Linehan (1993) described childhood sexual abuse as an extreme example of an invalidating environment when a child's internal experience is dismissed or punished upon disclosure of the abuse. An invalidating environment can result in emotional regulation difficulties (Linehan). Therefore, providing validation for clients who may not have been believed or protected from the abuse experience offers a reparative function in affect regulation (Linehan). She cautions therapists who are anxious to ease client's distress by implementing change strategies without initially focusing on validation and acceptance. Linehan declares that hastily undertaking change interventions can be replicating of an individual's childhood invalidation.

It was interpreted in the analysis that participants felt their clients were empowered through the process of validation. Empowerment of the client emerged through equality within the therapeutic relationship. Kate, for example, referred to a client who was receiving social services involvement which had resulted in the client feeling powerless. Kate believed the therapeutic relationship empowered her client through a sense of equality which in turn enhanced their self-worth. John further supported the concept of equality from an organisational level for the client by providing them a choice of therapist. Normalisation of the client's experience and advancing their understanding of physiological effects of trauma were also felt to be important processes by Laura in order to empower the client. Empowerment through providing a safe relationship, which offers emotional containment and a sense of

equality in the power balance, is considered to be of fundamental importance by Olio and Cornell (1993) when working with adult survivors of CSA. Service user related research has also substantiated that empowerment was enhanced when therapists treated them as equal, listened to and consulted with them on the focus and pace of therapy (McGregor, Thomas & Read, 2006).

5.2.3 Balancing the power dynamic

Balancing the power dynamic within the therapeutic relationship emerged as a nuanced, multifaceted process from each of the participants' experiences. Pacing therapy to gain equilibrium between challenge and support to facilitate growth (Sanford, 1966), was considered to be of principal importance by the participants when working with this client group. Providing a balance within therapy was reinforced by service user related research undertaken by Chouliara et al. (2011). Survivors reported that being directed to undertake trauma focused work before they felt ready was challenging and difficult. Participants within this study raised concerns with placing overt pressure on clients. Nicola specifically highlighted the need to "tread carefully" due to the sensitive and raw emotion attached to the client's experience.

The delicate power dynamic within the therapeutic relationship was interpreted as a challenge for trainees. Jill additionally discussed the importance of letting the atmosphere settle in the room to judge when to "pick up" and explore further. This was also understood within the concept of Sanford's (1966) "challenge versus support" theory. Participants illustrated the difficulty when the pace of therapy was not congruent with their emotional state, consequently causing a rupture in the

therapy. John and Kate both offered examples whereby the power imbalance in the therapeutic relationship damaged trust.

John elaborated on his experience in which he made an assumption regarding his client's meaning without clarifying this, which he felt resulted in a therapeutic breach. McGregor et al. (2006) outlined errors in therapy from service users' perspectives. Their research indicated that clients reported experiencing harm when therapists committed distancing errors or on the contrary were perceived as overly intrusive. Balancing the power dynamic to offer a helpful level of challenge versus support for a client emerged as a complex process for trainees working with this population.

5.3 Vicarious emotional self

Knight (1997) discussed the affective reactions that occur within therapists when working with adult survivors of CSA. Knight emphasised the difference between countertransference reactions, considered to be linked to therapists' own unresolved issues, and affective reactions which therapists may experience due to the emotionally challenging nature of working with survivors. Walker (2004) states the line between vicarious traumatisation and countertransference is not a definitive one. However, within the current research study the participants' emotional state was interpreted as a "vicarious emotional self" due to the psychological equivalence this held with their client.

The theme in relation to participants' experiences of vicarious emotions within the current research study expands upon questions posed within a systematic review undertaken by Chouliara, Hutchinson and Karatzias (2009) regarding vicarious

traumatisation of practitioners working with survivors of CSA. Chouliara et al. concluded that hearing clients' experiences of CSA can be challenging for practitioners. They felt that further investigation should be undertaken into the effect on practitioners' mental health and wellbeing of working with this population. Chouliara et al. proposed that trainees or practitioners who were inexperienced in working with adult survivors of CSA would be at higher risk of developing traumatic symptoms. The current research illustrated that trainees' vicarious emotional states varied in gravity, with some reactions resembling vicarious traumatisation. For example, both Sarah and Laura described feeling dissociated as a result of hearing the client's narrative of the abuse. Chiu (2012) defines the process of dissociation as a stress-related symptom which causes disruption of integral brain functioning, which can be related to being exposed vicariously to negative experiences.

A theme of vicarious emotional state emerged from the participants with regards to disgust. In the analysis, examples from both Kate and Laura were explored, illustrating their feelings of disgust. Ongoing research investigating the "vicarious brain" (Keysers, 2011), has demonstrated that empathising with the disgust of others activates the insula, an area of the brain aroused when we experience disgust ourselves (Jabbi , Bastiaansen , Keysers, 2008). Kate's vicarious emotional state also indicated shame, as did Nicola. Shame and disgust are considered powerful vicarious emotions experienced by trainees when working with trauma generally, which can make them avoidant of wanting to explore the traumatic event further (Adams & Riggs, 2008; Neumann & Gamble, 1995). Based on the accounts of the trainees within the present study, experience of these emotional states appears more likely given the sensitive nature of the material discussed by survivors of CSA.

Participants also reported physical feelings within the body which were regarded as vicarious physical reactions. Jill reported feeling anxiety as a physical experience which is consistent with Figley's findings (1995). He stated that bearing witness to narrative accounts of traumatic events can be expressed physiologically within the therapist. Another vicarious physical reaction in the form of anger was interpreted from John and Laura. John discussed his feelings of anger and his need to be mindful of this to prevent it impacting on his therapeutic work. This endorses earlier research findings by Knight (1997) who reported that in a study of 177 practitioners, 52.6% self-reported vicarious reactions of anger. Nonetheless, limitations of Knight's research were evident, as it is approaching 20 years old and methodological flaws were displayed concerning the validity and reliability of her self-designed questionnaire. However, the anecdotal findings are congruent with the current qualitative report of participants. Laura also described the physiological impact on her own sexual relationship with her partner. This additionally substantiates Knight's findings which indicated 94.3% of therapists felt their work with survivors had an effect on their own sexual intimacy.

5.3.1 Management of vicarious emotional state

The participants' management of the emergent vicarious emotional states was evident through the areas of self-care and use of the supervisory relationship. An article by Neumann and Gamble (1995) emphasised the requirement for personal care when working with clients with a traumatic history. They assert that self-care is an ethical requirement in view of the possible invasiveness of vicarious traumatisation into many areas of a therapist's life and on their ability to undertake

therapeutic work. Sanderson (2013) categorises the aforementioned self-care techniques into the following four categories: physical self-care, emotional and psychological self-care, spiritual self-care and work place self-care. Each of the trainees in the present study made reference to the need for self-care in these various areas.

Jill, for instance, noted a number of practical strategies for physical, emotional and spiritual self-care, such as meditation, yoga and physical exercise such as running. Jill found that caring for herself enabled her to feel more compassionate toward her clients. This form of practical coping was also recommended by Neumann and Gamble (1995) to help make the transition from work to personal life. Laura also discussed implementing physical ways to self-soothe to be an essential component when working with trauma. A more recent study by van der Kolk (2003) demonstrates the positive effect of physical activities on the right brain hemisphere to induce feelings of relaxation. Other practical examples from both Jill and Nicola were provided in the analysis with regards to using the writing process to help make sense the emotional state of self. Creative expression has been encouraged by Figley (1995) as an effective modality to manage vicarious emotional states. Pennebaker (1997) has also undertaken research indicating the positive physiological effects on health, which writing can provide.

All the participants mentioned the use of their own personal therapy as a useful tool to manage vicarious emotional states. This was also recommended as a means of support by Neumann and Gamble (1995) who believe personal therapy to be invaluable when working in the field of childhood trauma. A subsequent quantitative

study by Brady et al. (1999) and a qualitative study by Benatar (2000) both support the need for personal therapy to manage vicarious emotions when working with survivors of CSA.

Sanderson (2006) also recommends that the workplace offer appropriate supervision to therapists when working with survivors of CSA. This appeared to be of fundamental importance to the trainees within this study who all referenced the supervisory relationship as a means to explore their vicarious emotional state. Sarah stated the use of supervision to be imperative when discussing feelings of dissociation. For Kate, supervision provided a place to process the graphic distressing images that were playing on her mind, indicative of supervision being a preventative space for developing vicarious traumatisation, as asserted by Figley (1995). Walker (2004) stated that the supervisory relationship should offer safety and containment for practitioners working with survivors of CSA. Walker argued that hearing the traumatic experiences of survivors can vicariously damage illusions of safety for the therapist, resulting in traumatic emotional reactions. She suggested that the supervisory relationship should prevent this emotional distress remaining unresolved within the therapist.

5.4 Competent versus incompetent self

Working with survivors of CSA appeared to evoke questioning of self-adequacy across the trainees. However, themes emerged in the analysis to demonstrate the participants' containment of self in order to manage feelings of incompetency. Trainees' transition toward gaining self-competency through containment of the self was identified through assertion of choice and by self-directed learning. Facilitative

versus non-facilitative learning environments were considered in regard to their effect on developing a sense of the competent self.

5.4.1 Containment of self to manage feelings of incompetency

In view of the complexity of the client group it is understandable that trainees felt challenged toward their competent self (Grant, 2006). For instance, Kate acknowledged feeling anxiety when meeting a client she considered to be complex, resulting in her questioning her ability to cope or effect change. Kate consequently ended with her client, which was interpreted as a consequence of her feeling overwhelmed by the complexity and her need to contain this emotional process. However, this was considered to raise an ethical dilemma in relation to the client who could interpret this as reinforcement of rejection and abandonment. Davies and Frawley (1994) highlighted this could be representative of the abandonment of the un-protective parent.

An additional ethical dilemma identified by Kate which left her questioning self-competency was in relation to the legal responsibility held by the practitioner to report if the abuser is still deemed to be a risk to others. This is demonstrative of research undertaken by Chouliara et al. (2011) in which professionals disclosed anxiety about damaging the therapeutic relationship when faced with reporting child protection issues.

Further anxieties were mentioned by Jill and Sarah who felt concerned as to what was considered a safe level of exploration. This is understood to be a common dilemma in working with adult survivors of childhood trauma (Briere, 2002). Skovholt

and Ronnestad (2003) report performance anxiety and uncertainty can commonly lead to disillusionment within the self in trainee therapists and counsellors. The participants in the current research reported ways in which they regained a sense of confidence and empowerment of self whilst working with adult survivors of CSA.

Firstly, it was interpreted that having a choice as to whether to work in this field was important for trainees. For example, John felt it was empowering for trainees to have an option about working with a client group when gender may be an issue. John also asserted that choosing the number of clients on one's caseload who had experienced CSA was equally important due to the distressing nature of the work. Kate highlighted the need for self-awareness of one's own competency before taking on complex clients such as survivors of CSA. Both John and Kate's views have been supported as good practice within the concept of monitoring compassion fatigue (Figley, 1995).

All of the participants discussed ways in which to engage in self-directed learning to further one's own self-competency. No one model emerged as being superior to develop self-knowledge. Nicola for example referenced psychodynamic theory as a useful framework for orientation within the work, whereas Laura made reference to neuropsychological theory regarding the impact of trauma. Self-directed learning has long been considered as a means to facilitate the emotional containment of students (Zimmermann, 1989). This method had the further advantage for trainees of enhancing awareness of prevalence of CSA. For example, Nicola indicated that CSA is often linked to many of the difficulties that people present with in therapy. Therefore, she felt developing her awareness of the prevalence was useful in order

to remain mindful of the effect on clients. This was verified by Laura's recognition that "survivors are everywhere."

Development of self-directed learning was interpreted to help trainees move from a sense of unsafe uncertainty to safe uncertainty in their work with a client (Mason, 1993). Mason believes the process of moving toward safe uncertainty can be modelled between client and therapist. The trainees' sense of self-competence through being in a place of safe uncertainty appeared to develop as they evolved in their experience of working with survivors of CSA. This is expected to occur for trainees through natural progression of personal and professional development as they become more comfortable with risk taking in the therapeutic relationship (Flaskas, Mason & Perlesz, 2005).

5.4.2 Facilitative versus non-facilitative environment

Participants' experiences of their learning environment appeared to contribute toward and impede their sense of competent self through sitting with a sense of safe uncertainty (Mason, 1993). John deemed his course learning environment helpful when it enabled reflexivity, a concept which is considered an essential part of working with survivors of CSA (Neumann & Gamble, 1995). However, John appeared to move to a place of unsafe uncertainty again in relation to not feeling the training had provided the knowledge of how to respond to disclosures of CSA.

Nicola made additional reference to a lack of experiential learning provided within the training environment, which she felt would have enabled better understanding as to how the self would respond when working with this client group. Grant (2006)

discusses the validity of experiential training. She emphasises that if trainers focus on skills based practice, trainees become preoccupied with modelling implementation of a superlative intervention. However, Grant asserts that when working with complex clients with traumatic backgrounds, trainees need to be encouraged to focus on the individual needs of the client rather than using a specific skill or intervention. Grant cautions that trainees are at risk of being met with a strong negative reaction from the client should they feel the therapist is not in congruence with their emotional state. By involving trainees in experiential work on the training course, Grant believes they are able to monitor their internal and external responses within a safe environment, whilst experimenting with different interventions.

Counselling psychology training course environments face ongoing challenges in relation to prioritising specialist taught subjects (Woolfe, Strawbridge & Dryden, 2010). However, the consensus from trainees within this study was that additional attention to this area on the course would be beneficial given the prevalence of CSA within the clinical population (Putnam, 2003). Jill, for example, felt training covering vicarious traumatisation would have been useful in relation to this client group and in undertaking trauma work in general. A review of vicarious traumatisation by Chouliara et al. (2009) highlighted the variation in training and supervision. Development of guidelines for trainers and supervisors based on the emergent body of evidence (Chouliara, Karatzias & Gullone, 2014) could be of benefit inensuring equality of training and support through supervision within the discipline of Counselling Psychology.

While the supervisory relationship was important in managing vicarious emotional states, the participants also referenced the supervision and team environment as significant facilitative settings where experiential and theoretical knowledge were gained. Laura for example felt that the practical knowledge she learnt from her supervision and placement environment were fundamental to the work she was undertaking. Chouliara et al. (2014) substantiates the importance of supervision and team to enable effective practice.

5.5. Significance of the study

While there appears to have been much literature written speculating the therapeutic relationship process issues when working with this client group, few studies have investigated trainees' first-hand experience. This is notwithstanding the likelihood trainees have of encountering this group given the wide variation of clinical settings within which they may be placed, and the potential challenges they may face when working with survivors. The experiences from trainees in the current study provide qualitative data validating theoretical literature to underline important considerations to be taken into account when working with survivors.

5.6 Clinical Implications

A number of clinical implications have emerged from the present study for counselling psychology trainees and for counselling psychologists involved with training or supervision of trainees. These have been considered within the following three areas, clinical implications for trainees' therapeutic work, management of emotional self, and trainee development.

5.6.1. Implications for counselling psychology trainees' clinical work

A significant theme interpreted within the current research study was in relation to balancing the power dynamic within the therapeutic relationship. In view of the paramountcy of the therapeutic relationship within the field of Counselling Psychology (Woolfe, Strawbridge & Dryden, 2010), it was anticipated this would feature within the participants' narrative as an important aspect of the work. However, within the therapeutic relationship, it was considered central that trainees remain mindful of the complex transferential role dynamics due to the feelings of control and disempowerment this client group often face in childhood (Davies & Frawley, 1994). This was considered within the framework of re-enactments of the triangle of abuse between trainee and client (Karpman, 1963). Reflection on these roles was deemed to be facilitative for trainees in managing the power dynamics within the therapeutic relationship, particularly given the powerful projective identification with which trainees identified in relation to the rescuer or maternal role (Klein, 1946). A further significant role dynamic was emphasised in relation to gender differences between client and therapist.

In view of the complex transferential dynamics at play, offering a safe therapeutic space for this client group emerged as an imperative element of the work. Trainees working with adult survivors of CSA should be aware of the potential for re-traumatisation by replication of damaging trust, which may have occurred within the systems clients encountered previously (Newgent et al., 2002). No one therapeutic model was deemed more appropriate with which to undertake therapeutic work. However, trainees did advocate use of humanistic principles to build the relationship and psychodynamic frameworks to make sense of the occurring dynamics.

Integration of neuropsychological trauma based theories and cognitive behavioural approaches were also found to be useful by trainees to normalise and manage trauma reactions within the room. Overall, the emphasis towards a pluralistic approach was consistent with the Counselling Psychology ethos of integration based on the individual client (Woolfe et al., 2010). Furthermore, pacing therapy to the appropriate level of challenge versus support to facilitate growth (Sanford, 1963) was flagged as an important consideration for trainees working with survivors of CSA given the sensitive material and complex dynamics within the therapeutic space.

5.6.2. Implications for management of counselling psychology trainees' emotional self

Counselling psychology trainees are encouraged to consider that practitioners who are less experienced in working with adult survivors of CSA would be at higher risk of developing vicarious traumatic symptoms (Chouliara et al., 2011). Vicarious emotional states commonly reported by participants in the current study ranged from dissociation, shame, disgust to physiological reactions of anxiety and anger within the body.

Management of these emotional states was promoted through mindful engagement of self-care and use of the supervisory relationship. Trainees' self-care of their emotional wellbeing has been emphasised as an ethical requirement due to the impact vicarious traumatisation can have on a trainee's personal life and professional practice (Neumann & Gamble, 1995). Based on the participants' experiences, trainees' are recommended to implement self-care. Sanderson has

categorised these within the following four areas, physical, emotional/psychological, spiritual and professional self-care (Sanderson, 2013).

5.6.3. Implications to counselling psychology trainees' development working with survivors of CSA

Working with the complexity with which survivors of CSA can present can generate questioning of the competent self within trainees. Transition toward competent self can be facilitated by containment through self-directed learning, a reflective and experiential learning environment, and an educative supervision space. This coupled with evolving experience of working with adult survivors of CSA promotes a move from unsafe uncertainty to safe uncertainty (Mason, 1993).

Counselling Psychology training courses are required to meet general key competencies; however, in view of the prevalence and risk of vicarious traumatisation, the current participants' expressed a preference for additional experiential and taught modules in working with CSA. A reflective space offered within the training course enables processing of the implicit and explicit emotional dynamics that can be triggered when working with survivors (Chouliara et al. 2011; Knight, 1997). Furthermore, trainees expressed a desire to have experiential learning opportunities from their training course providers. This would enable monitoring internal and external responses within a safe environment, whilst experimenting with different interventions (Grant, 2006). To ensure equality of training across Counselling Psychology courses, a common training and supervision framework would be of benefit in relation to working with survivors of CSA (Chouliara et al. 2014).

Additional relational training, support and supervision were regarded as paramount for professionals working with survivors of CSA to maintain a trusting and safe relationship with clients (Chouliara et al., 2011). Supervision was viewed as an essential learning environment for trainees.

In conclusion, the findings implicate that consideration should be given to future curriculum design and clinical practice in relation to working with adult survivors of CSA. The following recommendations have been outlined in line with the superordinate themes:

- Curriculums should pay particular attention to the complex dynamics within the therapeutic relationship, this includes fostering a safe therapeutic foundation, particularly in view of the importance of management of disclosure, pacing therapy and the influence of therapist gender in the relationship.
- Courses should offer training on vicarious traumatisation and management of emotional state of the self through self-care and supervision.
- Curriculums should include specific training on the impact of CSA trauma to facilitate trainees competent self. This should focus on an integrative framework of practice, including relational models.
- Courses should offer an experiential learning environment to develop therapeutic skills required to work with survivors of CSA.
- Where possible, a choice of clinician should be offered to service users in clinical practice with regard to gender due to the dynamics within the therapeutic relationship.

- Providing additional supportive and reflective supervision to trainees in clinical placement where required.

5.7 Evaluation of methodological approach and limitations

The methodology undertaken for this study corresponded with the aims of the research, providing an in-depth and rigorous exploration of counselling psychology trainees' experiences of working with adult survivors of CSA. In line with IPA principles, the research is idiographic in nature and does not intend to make sweeping statements in relation to all trainees working with survivors of CSA. It aims to make sense of individuals' experiences and contribute these to a developing knowledge base (Smith et al., 2009). While other trainees may have had similar experiences of working with this client group, these results should be considered within the context of the six counselling psychology trainees interviewed for this research. The small sample size may be deemed by some as a weakness; however, this ensured the level of depth required to make sense of each individual's experience.

The homogenous sample of all counselling psychology trainees within their second and third year of training offered an advantage when searching for meaning across the sample. Although the inclusion of one male participant may have impacted the homogeneity of the sample, this also added a divergent dynamic which offered significant meaning to the research in terms of gender differences. This highlighted an interesting area for further study. Another advantage was the sampling pool, which focused on trainees undertaking British Psychological Society Accredited Doctoral training courses in Counselling Psychology. The variance between four

courses could be seen as a hindrance to homogeneity; nevertheless, it was credited as beneficial through offering a form of verification of trainees' experiences across the training courses.

The study attempted to offer transparency throughout to ensure clarity of the process. However, it should be taken into account that the interpretative themes have been derived from the researcher's perspective and others might have found themes which they thought more pertinent. Ensuing from this, member checking was not felt to be necessary due to the double hermeneutic respected within IPA, which focuses on the researcher making sense of the of participants' experiences.

During the interview process the researcher was mindful of avoiding leading question; however, the interview schedule will inevitably have had an effect on the themes interpreted in the analysis. All participants had the opportunity to therefore offer any further comments they felt relevant at the end of the interview to enable material to emerge that was not elicited by the interview schedule.

5.8 Recommendations for future research

The findings within the current research have highlighted some further important areas for study. In particular, further research is required to provide deeper understanding regarding the effect of gender when working with this client group. Investigation into male trainees' experiences working with female survivors, and conversely, female trainees' perspectives of working with male survivors would be beneficial to exploration of these internal processes. Additional service user related research regarding experiences of working with a therapist who shares gender with

that of their former perpetrator could also offer valuable understanding to clinical practice.

Future research should also consider service users' perspectives regarding anxieties or barriers to entering treatment following previous negative experiences when accessing services. This would provide helpful guidance to practitioners and service providers in the area of service development.

There appears to be a dearth of research regarding the impact on trainees working with survivors of CSA who have had personal experience of abuse. One participant in the study briefly mentioned having had personal experience, however, did not expand on this further. Research into trainees with personal experience working with survivors of CSA would be beneficial to explore the impact on issues such as transferential reactions and additional vulnerability to vicarious traumatisation.

5.9 Reflexive considerations

I engaged in the research as I had witnessed that the political climate at the time was resulting in services being closed that had been offering integrative approaches to adult survivors of CSA. The services were often closed in favour of services such as IAPT that provided empirically evidence based approaches. I was concerned this was resulting in further damage to individuals who often find it difficult to establish trust with another. I experienced this happening to a number of clients in my role as a Psychological Wellbeing Practitioner in 2009. Consequently, I felt this triggered a sense of unjust within me toward a client group who may have already experienced unfairness within the systems which they have lived in from childhood. I hold strong

personal values of equality and therefore witnessing disempowerment of this group sparked my interest in further understanding the perceived complexity of working with survivors of CSA. The research topic, therefore, provided me with an opportunity to make sense of and enhance understanding of the processes occurring when working with this client group.

I observed that this client group often provoked anxiety for professionals with whom I worked and I consequently felt apprehensive at the prospect of engaging in therapeutic work with survivors. Since this time, my experience working in the field has enabled me to concretize some of these anticipated challenges of working with this group through evaluation of the process issues which arise. It has, therefore, been important to acknowledge that my beliefs and assumptions as a trainee working with this population group will inevitably have influenced my role as a researcher in interpreting the participants' experiences. I feel the process of being a clinician working in the field naturally meant I had preconceptions about the internal process through my own experience in working with this group. Consequently, moving into the researcher role presented a challenge to bracket off my own experiences whilst immersing myself in the participants' data. My current clinical role involves working within a secondary care specialist adult mental health service with the majority of services users presenting with trauma related to sexual abuse. In undertaking this research, it has also been a challenge for me to manage my own emotional process working with this client group as a trainee while also interpreting the qualitative data from the other trainees. In particular, I was mindful during the interview process of the temptation to collude when they discussed experiences with which I could identify. The main challenge occurred in staying neutral during this

process to provide an open platform as a researcher for the trainees in the interview without collaboration of my own experiences. In order to aid this process, I used my clinical supervision to reflect on the emotional processes occurring between my role as a clinician, researcher and fellow trainee. This reflective space enabled me to further consider the areas where I was identifying with my fellow trainees. Supervision provided me with the opportunity to discuss my own emotional process to facilitate bracketing off my own experiences.

The emergent themes were, however, inevitably informed by my role as a trainee clinician working with survivors of CSA throughout the research process. I was able to recognise and value that there were a number of processes naturally occurring in my fellow trainees which were shared experiences, such as the role dynamics at play within the therapeutic relationship and the questioning of competent versus incompetent self. This also provided an important learning curve for me in relation to my development of becoming an integrated psychologist both in research and practice. My original search for needing a treatment model with which one could offer to survivors of CSA was on reflection my own need for containment as a trainee. The research process enabled me to further recognise this need and acknowledge this within my fellow trainees. I was able to appreciate the importance of working integratively with this client group.

Overall, I have enjoyed the process of undertaking the research as I maintain a strong interest in working with adult survivors of CSA. I believe the research has contributed to the current research body and generated new questions for future research.

6. Conclusion

The aim of the research was to undertake an Interpretative Phenomenological Analysis to explore how counselling psychology trainees' experience working with adult survivors of CSA. There was a lack of research into how trainee counselling psychologists make sense of their internal experiences working with this client group despite the high prevalence, the complexity with which they present, and the uncertainty with regard to the most appropriate treatment (Putnam, 2003; Radford et al., 2011). The aim was to develop understanding of the therapeutic process when working with this client group who are likely to present within counselling psychology training placements.

From the analysis the following three key superordinate themes were developed:

1. Balancing the power dynamic in therapeutic relationship
2. Management of vicarious emotional state of self
3. Questioning competent versus incompetent self as therapist

Balancing the power dynamic was a significant theme across all participants. This supports previous literature which has theoretically discussed this challenge (Davies & Frawley, 1994; Sanderson, 2006). Developing awareness of working with the power dynamic within the therapeutic relationship was deemed to have highly significant clinical implications for counselling psychology trainees embarking on this work.

Management of vicarious self was also interpreted from all of the participants. Affective reactions were conceptualised within the framework of vicarious emotional states experienced by the trainees. Management of these through active self-care and the use of the supervisory relationship were interpreted as having further important implications for practice.

A theme of questioning the competent versus incompetent self arose from the participants. Sub-themes emerged illustrating the participants' containment of self in order to move toward gaining self-competency through assertion of choice and by self-directed learning. Within this theme, participants discussed facilitative learning environments which were considered to further the competent sense of self, versus non-facilitative learning environments. This overarching theme provides important reflections for clinical practice, supervision and training purposes.

An important limitation from the study was identified with regards to the inclusion of one male participant, which impacted the homogeneity of the sample. This contributed meaning to the research in terms of gender differences; however, it highlighted a significant area for additional study. Investigation into trainees' experiences of working with a client from the opposite gender who has experienced sexual abuse would be beneficial to provide further exploration of these internal processes. Moreover, additional service user related research into their experiences of working with a therapist who is of the same gender as that of the abuse perpetrator could also offer valuable understanding to clinical practice.

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Appendix 1: Ethical Approval

LONDON metropolitan university

London Metropolitan University,
School of Psychology,
Research Ethics Review Panel

I can confirm that the following project has received ethical approval by one anonymous Reviewer, the Head of School of Psychology and the Dean of the FLSC to proceed with the following research study (Professional doctorate):

Title: Counselling psychology trainees' experiences of working with adult survivors of childhood sexual abuse: An Interpretative Phenomenological Analysis.
Revised proposal dated 6th January, 2015

Student: ***Ms Amy Gilmour***

Supervisor: *Dr. Joanna Pashdag*

Ethical clearance to proceed has been granted providing that the study follows the most recent Ethical guidelines to dated used by the School of Psychology and British Psychological Society, and follows the above proposal in detail.

The researcher and her supervisor are responsible for conducting the research and should inform the Ethics panel if there are any substantive changes to the project that could affect its ethical dimensions, and re-submit the proposal if it is deemed necessary.

Signed: Date: 28 February 2015

Prof Dr Chris Lange-Küttner
(Chair - School of Psychology Research Ethics Review Panel)

Email c.langekuettner@londonmet.ac.uk

Appendix 2: Participant Information Sheet

Title of Study:

Counselling psychology trainees' experiences of working with adult survivors of childhood sexual abuse: An Interpretative Phenomenological Analysis.

What's Involved?

I am a counselling psychologist in training at London Metropolitan University. You are being invited to take part in a research study. Before you decide whether you wish to participate, it is important that you understand why this research is being done and what it will involve. Please take the time to read the following information, discuss it with others if you wish and decide if you would like to take part. If you have any questions or anything is unclear, please do not hesitate to ask me.

I would like to understand more about counselling psychology trainees' experiences of working with adult survivors of childhood sexual abuse. Research has shown the importance of building the therapeutic relationship with this group. However, this process is considered complex for counselling psychology trainees. This, in conjunction with the vulnerability for experiencing emotional distress when working with survivors of CSA, underlines a need for further research in this area. Finding out more about trainees' experiences of working with adult survivors of childhood sexual abuse may inform course providers and supervisors in relation to training, and fundamentally provide other trainees more understanding of working with this client group.

If you agree to take part in the research, I will invite you to participate in an interview with me in which I will ask you some questions about your experiences of working with adult survivors of childhood sexual abuse. The interview will take place at London Metropolitan University on Holloway Road, Islington, (specific directions will be provided following contact to arrange the interview). I would meet with you just once for about an hour.

All the information you give me will be confidential, unless there is any significant risk of illegal activity or harm to you or others disclosed. However, I will ask to record the

interviews so that I can write down exactly what was said afterwards, but the recordings and the written transcription will be transferred to a password protected memory stick, which will be kept in a locked cabinet in my work office. This will be kept separately from your name and referred to only by number. I would be the only person who had access to the data and a password would be required to access the data. Any information that may identify you will be anonymised in the transcript. You may also withdraw from the study without needing to give a reason up to June 2015 (after this point the data will have been collated). You will be reimbursed for all travel costs within the London area. This research, which is supervised by Dr Joanna Pashdag, is conducted as part of my research component for a Doctorate in Counselling Psychology and may later be published in a journal (all participants' names and any identifying information will be withheld).

You will be allowed to take a break or stop the interview at any time. There will be allocated time at the end of the interview for you to discuss any concerns and you will given an end of interview information sheet, which will also include helpline and crisis line numbers should you feel distressed. You do not have to take part in this study if you do not want to, and you will not be penalized if you decide not to take part or to withdraw after agreeing to take part.

If you wish, I would be happy to send you a summary of the findings at the end of the study in September 2015. However, this would mean keeping a record of your name and address together if you would like to receive this. This research has been given clearance to proceed by London Metropolitan University Ethics Committee.

If you have any questions about this study or are interested in taking part, please contact me on: amy.gilmour1983@gmail.com or Tel: 07839140483

Yours Sincerely,

Amy Gilmour
Counselling Psychologist in Training

Appendix 3: Consent Form

CONSENT FORM

Title of Project: Counselling psychology trainees' experiences of working with adult survivors of childhood sexual abuse: An Interpretative Phenomenological Analysis.

Researcher: **Amy Gilmour**

1. Amy Gilmour has explained what the study involves to me and I have had the opportunity to ask questions. **Yes/ No**
2. I have received satisfactory answers to all my questions. **Yes/ No**
3. I understand that my participation is voluntary and that I am free to leave the study by June 2015 without giving reason and without my healthcare or legal rights being affected. **Yes/ No**
4. I agree to take part in this study. **Yes/ No**
5. I give consent to the audiotaping and transcription of the interview, and the use of direct quotes in the write-up of the study (which I understand will be anonymised). **Yes/No**
6. I understand that the audio-taped recording will be password protected and this will be anonymised for the use of the study. **Yes/No**

NAME IN BLOCK LETTERS: _____

Signature of Participant: _____

Date: _____

Signature of Researcher: _____

Date: _____

Appendix 4: Distress Protocol

Protocol to follow if participants become distressed during participation:

This protocol has been devised to deal with the possibility that some participants may become distressed and/or agitated during their involvement in the research. There follows below a three step protocol detailing signs of distress that the researchers will look out for (devised by Chris Cocking, 2008).

Mild distress

Signs to look out for:

1) Tearfulness
2) Voice becomes choked with emotion/ difficulty speaking
3) Participant becomes distracted/ restless

Action to take:

1) Ask participant if they are happy to continue
2) Offer them time to pause and compose themselves
3) Remind them they can stop at any time they wish if they become too distressed

Severe distress

Signs to look out for:

1) Uncontrolled crying/ wailing, inability to talk coherently
2) Panic attack- e.g. hyperventilation, shaking, fear of impending heart attack
3) Intrusive thoughts of the traumatic event- e.g. flashbacks

Action to take:

1) The researcher will intervene to terminate the interview/experiment.
2) The debrief will begin immediately
3) Relaxation techniques will be suggested to regulate breathing/ reduce agitation

4) The researcher will recognize participants' distress, and reassure that their experiences are normal reactions
5) If any unresolved issues arise during the interview, accept and validate their distress, but suggest that they discuss with mental health professionals and remind participants that this is not designed as a therapeutic interaction
6) Details of counselling/therapeutic services available will be offered to participants

Extreme distress:

Signs to look out for:

1) Severe agitation and possible verbal or physical aggression
2) In very extreme cases- possible psychotic breakdown where the participant relives the traumatic incident and begins to lose touch with reality

Action to take:

1) Maintain safety of participant and researcher
2) If the researcher has concerns for the participant's or others' safety, he will inform them that he has a duty to inform any existing contacts they have with mental health services, such as a Community Psychiatric Nurse (CPN) or their GP.
3) If the researcher believes that either the participant or someone else is in immediate danger, then he will suggest that they present themselves to the local A&E Department and ask for the on-call psychiatric liaison team.

If the participant is unwilling to seek immediate help and becomes violent, then the Police will be called and asked to use their powers under the Mental Health Act to detain someone and take them to a place of safety pending psychiatric assessment. (This last option would only be used in an extreme emergency).

Appendix 5: Debriefing Information Sheet

Title of Study:

Counselling psychology trainees' experiences of working with adult survivors of childhood sexual abuse: An Interpretative Phenomenological Analysis.

Thank you very much for making this study possible. As explained in the original participant information sheet this study aimed to explore trainees' experiences of working with adult survivors of childhood sexual abuse experienced. I was particularly interested in what you found challenging and helpful in your experience working with this client group.

As there is currently very little research into counselling psychology trainees' experiences with adult survivors of childhood sexual abuse experiences your participation has been particularly valuable.

Sources of further support and help

I hope you found your participation in this research interesting and that our discussion following the interview has alleviated any concerns you may have had afterwards. However, if talking about your experiences of working with this client group does leave you feeling low or upset in the next few days and this persists there are local sources of support which you can contact.

1. You can contact your GP.
2. Your university counselling service
3. Samaritans 08457 90 90 90 *or* email: jo@samaritans.org
   Confidential emotional support, 24 hours a day, for people who are experiencing feelings of distress or despair, including those which may lead to suicide.

Thank you again for taking part

Appendix 6: Interview Schedule

1) How would you describe your experience of working with adult survivors of childhood sexual abuse?

2) a) Was there anything you found particularly challenging about experience?
   Prompt – can you tell me a bit more about that e.g. what was challenging about that, did it become easier/harder?

   b) Was there anything you found that particularly helped you when working with adult survivors of CSA?

3) Was the experience of working with adult survivors of CSA similar or different to what you expected?
   Prompt – can you tell me more about that?

4) In what way, if any, were you affected by this client group?
   Prompt – can you tell me more about what you mean about that?

5) Is there anything you would keep doing or would do differently in your experience of working with survivors of CSA?
   Prompt - If you were to give any advice to other trainees working with people who had similar experiences, what would it be?

6) Is there anything else that you would like to tell me that I haven't asked you?

7) How has it been for you talking with me today?
   Prompt - Any questions or concerns?

Appendix 7: Interview Transcript with Initial Notations and Emergent themes

Emergent themes	Original Transcript research interview 3	Exploratory Comments
	R: No that's fine, honestly it's fine no problem, thank you. The interview is obviously is like IPA so it's very open questions and I'll just sort of give you my general questions at the beginning and then we'll take it from there really so the interviews sort of vary between anywhere between half an hour and an hour so just I guess just depends on your experience and what you want to talk about and stuff, so the first questions are just a really open question around how you would describe your experience of working with adults survivors of childhood sexual abuse?	
	P: First of all before I started my training, I was working in a therapeutic community, specialising in personality disorders, it's called (xxx)	
	R: Ok, Yeah.	
	P: ...So my first experience of working with adults survivors of childhood sexual abuse was there.	
	R: Ok.	
	P: And then, um, during my training last year I worked in an IAPT step 4 service	
	R: Ok yeah.	
	P: So I worked for two clients there who fall under that category, a female client and a male client.	*Experience of both male and female survivors*

	R: Ok.	
	P: And then this year, in my psychodynamic placement, in the psychotherapy service, in secondary care, working with a female client as well.	*Psychodynamic orientation at present*
	R: Ok, yeah. And can you tell me a little bit about that sort of experience and anything that you found I guess particularly challenging or things that made it easier, things that made it harder, that kind of thing?	
Enablement of providing safe place	P: I think the challenging part of this work is I'm aware that I'm providing a space that is unique in the sense that maybe many of the clients haven't had the chance to explore and disclose even to disclose for someone…	*'Providing a space that is unique'* *-Saftey?* *Safe to disclose/explore*
Importance of providing space for client's narrative	R: Yeah.	
	P: …let alone explore these experiences, and as such I feel that I'm providing a very unique and special space for them to be able to explore that.	*'Unique special space'*
Providing a safe relationship	R: Mm, yeah.	
	P: Safely in the presence of another person who is there to listen to them and to share the experience with them.	*Safely* *Listen and to share experience*
	R: Yeah, mm.	
Shame as a dynamic process	P: But the challenging aspect of the work I find is the shame.	*Working with shame is a challenge*
Vicarious shame	R: Mm-hmm, mm-hmm.	

Tentative approach	P: I'm aware that I need to tread carefully. You know but it's a very sad sort of territory, very sad sort of landscape to explore.	*Tread carefully* *Sad sort of territory/landscape to explore*
	R: Yeah, mm-hmm.	
Management of disclosure	P: Because it's a story that I sense that needs to be heard, that wants to be heard, wants to be shared, but the same time it feels very fragile, very sensitive, very raw.	*Sense that it needs to be heard* *Very fragile, sensitive raw*
	R: Yeah, mm-hmm.	
Disconcertion of unknown territory	P: So it's a very difficult landscape to walk into with the client and so getting the trust for so long. Earning the trust.	*Difficult landscape to walk into, unknown* *Developing trust in relationship*
	R: Yeah.	
Dynamics of roles in the therapeutic relationship	P: And also I think a major component of the work involves being able to withstand the challenges because many times you can find yourself being placed in dynamics and in certain roles…	*Withstand the challenges* *Projection/trafsferential dynamics* *Placed in…. certain roles*
	R: Yes, yeah.	
	P: …that are being recreated from a psychodynamic point of view, for example.	*Psychodynamic understanding/interpretation*
Dynamic triangle of abuse	R: Yeah.	
Enablement of the self through theoretical understanding	P: Like the triangle of abuse and abuser and observer. So this part of the work as I understand it, is part of the process of working through this trauma, and being able to integrate the processes and incorporate it back into the self. So that involves you having	*Triangle of abuse and abuse and observer* *Using theoretical understanding to make sense of the process* *Integrate the processes and incorporate it back into the self*

Integration of client self through relationship		to persevere through playing the role of the observer or the bystander, who potentially will be abuser so that can be really difficult to cope with.	*Persevere playing the role of the observer or the bystander* *Potential anxiety to replicate role of abuse – struggle to cope*
Emotional containment through supervision	R:	Hmm, hmm… and I guess thinking a bit more around how difficult it was, what I guess has helped you to work in with that challenge set that that type of work brings?	
Reflection through personal therapy	P:	I think the supervision definitely as a place to gain that third perspective, being able to step back and see things from a distance, because sometimes I find that I am very involved and ah emotionally very involved, and that can make it very difficult to think.	*Supervision provides space to gain 'third perspective'*
	R:	Yeah, yeah, mm-hmm.	
Mentalisation processes of self to empathise	P:	I find that supervision gives me that third position to step back. And of course personal therapy and being able to I think I wouldn't be able to do this job if I haven't done my own therapy.	*Personal therapy essential*
	R:	Yeah.	
Balance of emotional self in therapeutic relationship	P:	It's about being able to empathise and you know and finding, um, owning my own traumas in my life and how they have affected me, and being able to connect with the clients through that experience.	*Being able to empathise* *Drawing on own traumas in life… to connect with client's experience*
	R:	Yeah, yeah.	
	P:	But at the same time, maintaining that distance that their position that I mentioned earlier, it's like one foot in, one foot out.	*Maintaining balance 'one foot in, one foot out'*

	R: Yeah, yeah, yeah. So finding a balance I guess.	
	P: Yeah.	
	R: And I guess thinking a bit about the experiences that you've had, what have you found about those that was maybe similar or was different to what you perhaps expected it would be like when working with that client group?	
Disconcertment of competent self Unsafe uncertainty	P: I think, um, before I started my training, the idea of working therapeutically with someone who was endured such trauma would seem like a very scary and risky idea.	*Anticipation anxiety 'scary and risky'*
	R: Yeah, mm hmm.	
Dilemma of competency of managing client's emotional self Training provided enablement of self Humanistic principles	P: I think that I would be filled with thoughts about dilemmas about how I would be able to hold the experience, where to start from, how to be, all these very fundamental questions. Whether what I would offer would be good enough. But I think starting to work with clients in the context of my training gave me some strength and hope that this kind of work is challenging but possible, and that people actually want to engage and to share their story.	*Dilemmas – managing emotional state of self* *How to hold the experience* *Training gave strength and hope* *Client openness - want to engage share story*
	R: Yeah, mm-hmm.	
	P: So the very human aspect that connects us all and being able to understand that we are not that different.	*Human aspect that connects us all* *Normalising to manage anxiety – we are not that different*

	R: Yeah, yeah, yeah. So finding a balance I guess.	
	P: Yeah.	
	R: And I guess thinking a bit about the experiences that you've had, what have you found about those that was maybe similar or was different to what you perhaps expected it would be like when working with that client group?	
Disconcertment of competent self Unsafe uncertainty	P: I think, um, before I started my training, the idea of working therapeutically with someone who was endured such trauma would seem like a very scary and risky idea.	*Anticipation anxiety 'scary and risky'*
	R: Yeah, mm hmm.	
Dilemma of competency of managing client's emotional self Training provided enablement of self Humanistic principles	P: I think that I would be filled with thoughts about dilemmas about how I would be able to hold the experience, where to start from, how to be, all these very fundamental questions. Whether what I would offer would be good enough. But I think starting to work with clients in the context of my training gave me some strength and hope that this kind of work is challenging but possible, and that people actually want to engage and to share their story.	*Dilemmas – managing emotional state of self* *How to hold the experience* *Training gave strength and hope* *Client openness - want to engage share story*
	R: Yeah, mm-hmm.	
	P: So the very human aspect that connects us all and being able to understand that we are not that different.	*Human aspect that connects us all* *Normalising to manage anxiety – we are not that different*

Connection to client through humanistic principles	R: Yeah, yeah, yeah.	
	P: And of course not everyone has endured such adversity or extreme experiences of abuse but I don't believe that we all had our fair share of trauma and difficulties in life and I think that is the point of connection. And the more that is owned by ourselves the more we are able to connect and make that work possible.	*Not everyone… but all had fair share of difficulties* *Search for empathy* *Connection through humanistic principles* *Own that human connection - enables work*
	R: Yeah, yeah, yeah, so it sounds like finding an empathy, understanding or compassion some ways even though the experiences that we might have had are not the same but it's still enables us I guess to have that humanness I think, yeah, yeah, yeah.	
	P: Yeah.	
	R: So there's something I guess in doing that work that's – before you'd started working with that client group you felt I guess more uncertain perhaps about what that would bring, what that would entail, but since working with them it's felt more human, or maybe not the big, scary thing that it was before in a sense?	
Projection of shame Re-integration of client's self through relationship	P: Yeah, I think yeah as I said earlier, the shame is quite a big part of the process of working through this trauma, and being in the presence of someone who is living that experience in the present can be quite overwhelming and quite powerful.	*Shame is a big part of the process* *Presence of someone who is living that experience*
	R: Yeah, mm-hmm	

Self as helpless Projection of helplessness Providing open space Staying with uncomfortable/distress Collaborative sense making Awareness of self-affect regulation	P: And the feeling of helplessness in the presence of that. R: Yeah. P: But also, as I was saying earlier, what I realised personally is things about opening to that experience rather than closing down… And trying to monitor and explore it together rather than avoiding it or running away from it, which is the initial reaction or what we are all prone to doing, it's our immediate response to an experience that's uncomfortable, un-pleasurable, it evokes feelings of shame, just to run away from it and hide, but it's about staying there, and unpacking the experience. R: Mm-hmm, yeah. So working through that shame. P: Yeah. R: And I guess in doing that, or in doing the work with this client group, in what way do you feel – you've talked about it a bit already I guess, but I suppose can you expand a bit more on how you feel it's affected you I guess, working with that group? P: It might sound a little bit technical, the term that I will use now, but I'm thinking more and more recently about affect regulation, my own affect regulation. R: Yep, mm-hmm. P: Like I'm becoming very aware of that, how I'm	*Sense of helplessness* *Opening to that experience* *Monitor and explor it together* *Collaboration* *Rather than.. running away from it* *Easy to do as feel, uncomfortable* *Evokes feelings of shame* - *Projection* *Staying there and unpacking the experience* *Management of self-affect regulation*

Mentalisation Processes between self and client Intense experience	able to cope and regulate my own emotions in the presence of an experience that is so intense and so powerful, and so overwhelming. So I think a major part of the work is that – being able to regulate my own emotions, I mean the theories are secondary, I think.	*Mentalisation* *Recognising own emotional state – intense and powerful* *Overwhelming* *What's therapist's versus client's* *Theories are secondary*
	R: Yeah, yeah, mm-hmm. And I suppose then thinking about your experience of doing that, what do you feel would be helpful or other trainees could consider when they're I guess struggling or having to find ways to regulate their emotion in that way, what kind of advice or experience could you draw upon to help them think about how to manage that?	
Vicarious flight mode Responsibility of therapist to contain experience Professional enhancement through engagement of process	P: I think as I said earlier you're being aware of the fact that quite often a response to something like that might be to run away or hide away, but when we experience this kind of emotions maybe we should remind ourselves of that is where we actually need to stay, and to unpack the experience and to, even though it can be quite painful, to try and go in-depth and really understand what it is that makes us feel this way, and what does it confront us with? Which can be I think very growth-promoting as professionals to engage in that process.	*Instinctual – runa way/hide away* *Stay and to unpack the experience* *Sitting with uncomfortableness* *Painful – try to understand why* *Sense making*
	R: Yeah, so think a bit more – sounds like that sort of reflective way to manage it I guess, to try and think about what those feelings and experiences are that you're having then, when you're working with that group.	*Growth promoting… to engage in process*
	P: Yeah, and I think it's a very relational	

Holding and containment of relational emotional processes	process, the more we are able to engage in it and to stay present in the face of overwhelming emotions like those ones, I think the more we convey that to our clients and convey the message that it's possible to stay and persevere and to cope with it.	*Relational process* *Engage in it stay present* *Modelling to client – coping*
	R: Yeah, yeah, yeah.	
	P: And even to grow from it eventually.	*Grow from it..*
	R: Yeah, yeah.	
Subjective inter-relational processes	P: But I think this is a very relational process, which is subjective.	*Subjective relational process*
	R: Yeah, yeah. I guess is that something that you find is more so with this client group than other client groups that you've worked with, or is there a difference, do you feel, working with this group, to perhaps other clients that you've worked with?	
Vicarious shame Emotional challenge of managing anger for the therapist Exposed emotional process Vicarious emotional block	P: I'm just trying to think – definitely I would say the shame aspect is a very huge thing, and also how this is managed is very individual and very personal. I'm just having in mind that some people might respond with anger. And that can be an extra challenge for the therapist. I mean for me at least, it's something that I need to work towards, being able to work with anger. And also how raw it makes the emotions and obviously, like all trauma it's basically, it often results in damaging the ability to think and to explore and to have a more fluid way of thinking. My experience in these areas, it often concretises emotions, which makes very difficult to work	*Shame – process of managing individual* *Anger – process of managing anger/challenge* *Raw…the emotions* *Trauma damages the ability to think and explore… to have fluid way of thinking*

	with and to use metaphor and to use more abstract terms and even to think about it.	*Concretises emotions*
	R: Yeah, yeah, mm-hmm. I suppose in that way then it sounds like you've, you haven't perhaps worked in the same way with that group that you would have with other clients. Are there things that you've done that are slightly different or that you would do differently if you were working with that group in the future?	*Blocks metaphorical creativity*
Explicit transferential reactions	P: I think what I would like to do is actually part of my learning objectives in my training, is to be able to work with process more and transference and counter-transference and being able to use these processes and make them explicit. And not hold back so much.	*Work with process* *Transferential reactions* *Make these explicit*
	R: It sounds like that's something you feel could be more useful working with this client group from that relational side, yeah.	
Psychodynamic orientation helpful for sense making	P: I definitely think so. I don't know if it's my personal bias, but I think that working in a relational psychodynamic way with this particular client group can be very helpful.	*Relational psychodynamic helpful*
	R: Yeah, mm-hmm.	
	P: And can unpack a lot of meaning.	*Unpack a lot of meaning*
	R: Yes, it feels like that's a model –	
	P: And especially…	
	R: Mm.	

	with and to use metaphor and to use more abstract terms and even to think about it.	*Concretises emotions*
	R: Yeah, yeah, mm-hmm. I suppose in that way then it sounds like you've, you haven't perhaps worked in the same way with that group that you would have with other clients. Are there things that you've done that are slightly different or that you would do differently if you were working with that group in the future?	*Blocks metaphorical creativity*
Explicit transferential reactions	P: I think what I would like to do is actually part of my learning objectives in my training, is to be able to work with process more and transference and counter-transference and being able to use these processes and make them explicit. And not hold back so much.	*Work with process* *Transferential reactions* *Make these explicit*
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Psychodynamic orientation helpful for sense making	P: I definitely think so. I don't know if it's my personal bias, but I think that working in a relational psychodynamic way with this particular client group can be very helpful.	*Relational psychodynamic helpful*
	R: Yeah, mm-hmm.	
	P: And can unpack a lot of meaning.	*Unpack a lot of meaning*
	R: Yes, it feels like that's a model –	
	P: And especially…	
	R: Mm.	

	experience these things.	
	R: Yeah, mm-hmm. And I guess thinking about having that type of experience, what would be useful thinking about having that when you are then in the room with your client, what do you feel that would provide for you, having had more of that type of training?	
Experiential work could enable processing of vicarious emotional state Openness can be counteractive of shame	P: I think it would enable a shared space and an openness, and I think that is really important, especially when you work with shame, because it's something that is – there is a lot of secrecy and there is a lot of separation and dissociation with this experience, and it's kept hidden and far away and a secret between two or more people, that something that is often not to be outside. I think that the more we are able to have open discussions in an open, shared space, I think the more it enables us to work with that. I don't know if it makes sense, what I'm getting at is, because it's something that can often be associated with secrecy and shame, I think it's important to counteract that by being as open as possible, even if that means having experiential workshops on that theme, or more lectures and more seminars.	*Experiential would enable a shared space and an openness* *Particularly in the context of shame* *Separation and dissociation with CSA* *Kept hidden and far away* *A secret between two or more people* *More open spaces enables work* *Secrecy and shame* *Important to counteract through openness*
	R: Yeah, mm-hmm, yeah, yeah. It sounds like there's something that you find quite important about being able to not reinforce the shame, I guess in a way for that person, find a way to remain open and keep that safe space for them, and a way of trying to do more experiential stuff on the course could help to, I suppose, prepare a trainee a bit more for trying to do that in the room rather	

	than being left in the room with the client, not quite knowing perhaps, yeah, what –	
	P: Yeah. I think the way you summarise it makes absolute sense.	
	R: So I suppose, just thinking a bit more about other trainees that might be in similar situations or similar experiences, is there any other advice that you feel that you could give them that might help with that experience and managing that experience?	
Management of emotional self Self-care reflection through writing Self-protection through reflection	P: Personally, what I found really helpful is keeping a journal and just being able to let all my thoughts and feelings out, which also includes my responses to clients and to therapy, just being able to write down what comes to mind, what I'm feeling, and try to make sense from that, try to make connections and I found that very helpful. But again that contradicts what we were saying earlier, it's a very private thing to do, it's very personal, but I guess you need a combination of every possible source of help. That could be another source of help, a journal, in addition to everything else that we talked about earlier.	*Helpful to keep journal* *Self-reflection space* *Responses to clients and therapy* *Combination of every source of help- indication of complexity*
	R: Yeah, yeah, yeah.	
Self-enablement of knowledge through literature	P: And I also feel that the literature can be quite helpful, especially once you, again the psychodynamic literature has offered quite a lot on the subject and I find that when I read case studies and I read about the therapists' dilemmas and countertransference reactions and things like that it makes me feel that I'm	*Self-enablement through literature* *Literature around therapist dilemmas*

Normalisation of process issues through education	less alone and other people before me have experienced very similar emotions and reactions, so maybe it's part of that process, it kind of normalises the reactions.	*Normalises process issues*
	R: I guess can you tell me any more about those reactions for you, and about those counter-transference reactions that you have felt perhaps with that client group or what the effect has been in a way, on you?	
Anticipation/anxiety re role dynamics in relationship	P: I think, going back to what we were saying at the beginning about the dynamics that can often be recreated like the triangle of abuse, I think that really resonates with me, this concept. Because I often find myself feeling like, 'Oh, what am I doing, am I doing the right thing, I'm useless, what can I really offer to that person, oh my God am I harming them?' So these are two reactions that are I think quite relevant to the client's past, feeling helpless and overwhelmed and feeling maybe let down by other people who in their immediate family who were maybe in the position of a parent or someone who should protect them, and help them and support the client rather than leave them vulnerable, so there is also that anger and resentment towards that figure.	*Triangle of abuse* *Oh my god am I harming them* *Anxiety*
Questioning competency		*Relevant to client's past – feeling helpless and overwhelmed… let down* *Anger and resentment towards that figure*
	R: Yeah, yeah.	
Transferential dynamic of abuse	P: So my feelings of not being good enough and not knowing what to do could be related to that. And also my feelings of having to tread carefully or not do any mistake could be also as a result of some kind of transference like the abuser me becoming the abuser in some	*Feelings of not being good enough* *Countertransferential recognition* *Me becoming the abuser*

	way.	
	R: Yeah, yeah, mm-hmm, mm-hmm, yeah. So being there where not wanting to replicate that role, yeah.	
Explicit emotional processes – shame, anger, resentment	P: Yeah. Yeah, it's a very sensitive topic, and loaded with shame and overwhelming feelings of anger and resentment and I think it's so important, and it also affects so many of our clients and just realising how common it is, not only from my own experience of the clients that they've told that I've worked but you know comparing with them other people in my cohort, and it's very often the root of many difficulties that we work with.	*Loaded with shame* *Prevalence recognition*
Prevalence recognition		*Often the root of many difficulties we work with*
	R: Yeah, yeah, yeah, mm-hmm, that underlying a lot of problems, yeah, mm-hmm.	
Understanding context of abuse (significant)	P: Yeah. Although, I said root but at the same time I think it's all a cause and a consequence at the same time. Of course it has a very adverse effect on its own but also we need to explore how it occurred and why and under what circumstances, so it's very complex.	*How it occurred and why and what circumstances*
	R: Yeah, yeah, yeah, so something around depending on the type of abuse and when all of that sort of thing yeah.	
	P: Exactly, yeah, by who it was perpetrated, whether it was a figure that the client relied on for support, parental kind of figure or –	*Who was the abuse makes a difference*
	R: Yeah, I guess that's a helpful thing for people to know in a way, is who the perpetrator was,	

	really, yeah.	
Vicarious dissociation of thought processes Balancing the challenge of exploration	P: And also to – I think it is a huge challenge just to maintain that curiosity as well, because the feelings can be so overwhelming that I don't know but other people at least myself, it can often have an effect of stopping me thinking or I feel a bit disabled in my thinking as if something has frozen, and it's important to be able to maintain that thinking part of ourselves and being able to explore and ask questions but it's again not being intrusive. I can contradict myself.	*Effect of stopping me thinking* *Frozen* *Dissociation from own emotional state* *Not being intrusive*
	R: Tricky balance, yeah it's a tricky balance there, it is, yeah, yeah, yeah. But yeah I think that's really helpful to kind of hear your experience of how that's been for you and the various things that have come up working with that group. I guess is there anything else or anything that you feel I haven't asked you about, anything else that could be useful for me to know?	
	P: Can't think of anything off the top of my head.	
	R: Yeah.	
	P: No, not really.	
	R: That's fine. And how has it been talking about it today, has it felt okay, thinking back through the clients that you've worked with, how has it felt for you?	
Mirroring anxiety of emotional re-triggering	P: I think I felt – before we did the interview was it worth it, it's quite a sensitive topic and it's likely to trigger feelings in me as normal and	*Sensitive topic*

	expected. But I felt quite comfortable talking to you and it felt quite organic. R: Okay, good, it's been okay? P: Yeah. R: Good, okay, well I will stop my recording now. P: Okay.	*Anxiety of re-triggering emotion*

Appendix 8: *Themes Participant 3*

Subordinate Themes within Overarching Superordinate Themes

Superordinate theme: Balancing power in the therapeutic relationship

Creating safe place for client

Enablement of providing safe place

Importance of providing space for client's narrative

Providing a safe relationship

Providing open space

Managing Disclosure

Tentative approach

Management of disclosure

Dynamics of roles in the therapeutic relationship

Dynamic triangle of abuse

Integration of client self through relationship

Re-integration of client's self through therapeutic relationship

Subjective inter-relational processes

Anticipation/anxiety re role dynamics in relationship

Transferential dynamic of abuse

Grounded in humanistic approach

Humanistic principles

Connection to client through humanistic principles

Containment

Containing client's distress

Responsibility of therapist to contain experience

Holding and containment of relational emotional processes

Sense-making process

Collaborative sense making

Managing developmental impairment through trauma
Psychodynamic orientation helpful for sense making
Balancing the challenge of exploration
Significance of understanding the context of abuse

Superordinate theme: Management of vicarious emotional state

Vicarious emotional states

Shame as a dynamic process
Projection of shame
Vicarious shame
Self as helpless – projection of disempowerment
Intense experience
Vicarious anxiety
Explicit transferential reactions
Emotional challenge of managing angry self
Exposed emotional process
Vicarious emotional confusion due to trauma
Vicarious emotional block
Vicarious dissociation of thought processes
Mirroring anxiety of emotional re-triggering
Explicit emotional processes – shame, anger, resentment

Management of emotional self

Emotional containment through supervision (self-care)
Reflection through personal therapy
Mentalisation processes of self to empathise
Awareness of self-affect/regulation
Mentalisation processes between self and client
Balance of emotional self in therapeutic relationship
Management of emotional self
Self-care and reflection through writing
Self-protection through reflection

Superordinate theme: Questioning of self as inadequate therapist

Uncertainty of self as competent therapist

Disconcertion of unknown territory

Disconcertment of competent self

Unsafe uncertainty

Dilemma re competency of managing client's emotional self

Questioning competency

Facilitative versus non facilitative learning environment

Professional enhancement through reflection on process issues

Experiential work could enable processing of vicarious emotional state

Openness can be counteractive of shame

Lack of enablement through training

Lack of experiential learning which would promote self-development

Expectation from course to manage self-emotional state through personal therapy

Self-directed learning

Self-enablement of knowledge through literature

Normalisation of process issues through education

Enablement of self through theoretical understanding

Prevalence recognition

Appendix 9: Emergent themes table across participants

Themes from individual participants						**Emergent Subordinate themes across participants**	**Emerging superordinate themes**
P1 (KATE)	P2 (JOHN)	P3 (NICOLA)	P4 (JILL)	P5 (LAURA)	P6 (SARAH)		
Containment Lack of containment/chaotic presentation Challenge of containment Challenge of 'holding' professional boundaries Pressure of validation Intimidation/Trepidation Pressure to validate client experience Need to promote trust through transparency in therapeutic relationship Re-enactment of client's external relationships Enactment of power dynamic in therapeutic relationship of client's external systems Explicit processes in therapeutic relationship Metaphorical re-enactment through the therapeutic relationship Projection of fear of abandonment Empowering client as self-enabler Empowerment through the therapeutic relationship Promotion of equality Trust/empowerment in therapeutic relationship Humanistic principles Promotion of mentalisation through humanistic principles Maintaining humanistic principles to enable therapeutic relationship	Professional boundaries Interpersonal relationship between client and therapist Consideration of boundaries in the therapeutic relationship Furthering knowledge of boundaries Maintaining professional boundaries Boundaries to minimise vulnerability to self and client Maintaining safe boundaries Awareness of systemic recurrences of abuse Systems reinforcing of shame through avoidance Anger of reinforced disempowerment through organisations/systems Systemic invalidation of impact of abuse on men Anger of underestimation of prevalence in men Anger at psychoanalytic paradigm as traditionally shaming Bewilderment at aspects of psychoanalytic modality concepts Empowered through choice Empowerment of client through choice of therapist Empowerment of therapist through choice of client Client choice Importance of providing a client voice Importance of self-choice Managing Transferential Dynamics Importance of acknowledging countertransference Transferential	Creating safe place for client Enablement of providing safe place Importance of providing space for client's narrative Providing a safe relationship Providing open space Managing Disclosure Tentative approach Management of disclosure Dynamics of roles in the therapeutic relationship Dynamic triangle of abuse Integration of client self through relationship Re-integration of client's self through therapeutic relationship Subjective inter-relational processes Anticipation/anxiety re role dynamics in relationship Transferential dynamic of abuse Grounded in humanistic approach Humanistic principles Connection to client through humanistic principles Containment Containing client's distress Responsibility of therapist to contain experience Holding and containment of relational emotional processes Sense-making process Collaborative sense making Managing developmental	Establishing trust in therapeutic relationship Development of trust in therapeutic relationship Genuine trust in therapeutic relationship as facilitator Establishment relationship before further exploration Balancing power dynamic of the therapeutic relationship to facilitate trust Privilege of trust Respectful of power dynamic in the therapeutic relationship Validation of client Appropriate language to validate client experience Challenge to match emotional state appropriately Challenge to match emotional state appropriately Validation of experience Validation of emotional experience Transferential dynamics Projection of pressure to find cure Client's explicit defences Relationship intensity Emotional intensity in therapy room Power dynamic of the therapeutic relationship emphasised through client vulnerability Projection of client fragility to enact therapist responsibility The relationship as a standalone therapeutic tool Gender dynamic in the therapeutic relationship Pacing therapy – challenge versus support Mindful of appropriateness of level of enquiry Wary of phenomenological enquiry Client readiness versus therapist need for exploration	Managing disclosure Significance of disclosure Disclosure not service specific Significance of managing disclosure Validation of client Validation of client's emotional experience Containment Demonstrating ability to hold/contain distress Managing client dissociation Building trust in the therapeutic relationship Balancing power dynamic in therapeutic relationship to build trust Exploration of trust explicitly through therapeutic relationship Trust in therapeutic relationship promoted openness Importance of providing space for client's narrative Gender significance Gender significance of client group Gender significance therapist to client Humanistic principles Importance of humanistic principles to develop relationship Development of compassion Transferential dynamics Managing recurrent abusive dynamics in client's life Challenge of	Developing safe therapeutic foundation Developing safe therapeutic foundation to lessen client's defence mechanisms Trust in the therapeutic relationship Development of safe foundation in the therapeutic relationship Enablement of trust in the other Development of trust in therapeutic relationship Therapeutic relationship paramount over approach Balancing power dynamic in therapeutic relationship to facilitate client openness Client vulnerability projection of responsibility in self as therapist Development of trust to facilitate openness in the therapeutic relationship Relationship paramount Importance of providing safe foundation Pacing therapy – challenge versus support Pacing therapy Balance of past and present Longer term relational work Client readiness Balance of support versus challenge in therapeutic relationship Transferential dynamics Managing client's explicit defences Lack of space in therapeutic relationship	*Transferential role dynamics* *Role of gender in the therapeutic relationship* *Developing a safe therapeutic foundation* *Empowerment of client through therapeutic relationship* *Pacing therapy - support versus challenge*	***Balancing power dynamics in therapeutic relationship***

	anger Anger Reflection of transferential dynamics Feeling of self-blame Client's need to be de-sexualised Management of sexual transference <u>Transparency in therapeutic relationship</u> Transparency to minimise misinterpretation in relationship Transparency/honesty to strengthen relationship Collaborative approach to clarify/validate client's position Presumption can lead to relationship ruptures Importance of clarification Misinterpretation of theoretical concept leading to rupture Significance of clarification Importance of clarification of client's meaning <u>Role of gender in therapeutic relationship</u> Gender sensitivity Role gender plays in the therapeutic relationship Male/female dyad of sexualised transference Power dynamic of gender Sexualised transference considered shameful Client's perception of gender Significance of referral allocation re gender Consideration of gender in therapeutic relationship Therapist/client gender dynamic <u>Managing difference between self and client</u> Cultural significance Male therapist gender vulnerability to misinterpretation Gender differences in emotional expression	impairment through trauma Psychodynamic orientation helpful for sense making Balancing the challenge of exploration Significance of understanding the context of abuse	Balance of challenge versus support Variation of client's capacity of challenge versus support Emotional temperature in therapy room <u>Containment</u> Holding/containing client emotion Anxiety re containing client's vulnerability Need for longer-term work	working with relational issues Complex dynamics of client group Replication of abusive processes client encounters when entering services Openness can challenge sense of shame Challenge of therapeutic integration External relational transference	Recurrent relational issues for client Power dynamic of trust in the therapeutic relationship Recurrent interpersonal problems for client Therapeutic relationship as reparative Managing external judgement of client Bewilderment of client reaction Projective identification of mother role Maternal preoccupation of client welfare Client vulnerability projects need for responsible self as therapist Ambivalence to challenge client defences Projective identification of mother role Significant meaning through non-verbal actions <u>Containment</u> Managing client dissociation Ruminative holding of client <u>Humanistic principles</u> Demonstrate humanistic qualities to minimise client defences Integration grounded in humanistic principles Core humanistic principles rather than model specific Maintaining humanistic principles to acknowledge the person <u>Managing abusive re-enactments in therapeutic relationship</u> Challenge of ending Recognition of abusive relational patterns in client Challenging ending Trepidation of		

					reinforcing abuser role Client control therapeutic space <u>Validation of client</u> Validation through therapeutic relationship Validation of client's self-worth Liberation of blame for client Liberating the client of self-loathing Empowerment of client Validation of therapist by client		
<u>Therapist emotional state</u> Managing disgust (through supervision) Vicarious traumatisation from graphic description Containment of emotional distress of self Flashbulb memory <u>Cognitive dissonance</u> Overwhelmed by client's overt defence mechanisms (bewilderment) Cognitive dissonance re empathy versus feeling overwhelmed	<u>Management of emotional state of self</u> Management of emotional self through supervision Enablement through self-reflection Enablement of self through reflexivity Development of self through personal therapy Importance of reflection on angry self Managing emotional displacement Awareness of self-biases Provision for emotional management of self Awareness of importance of self-care <u>Supportive team as facilitative for self</u> Positive team communication Promotion of self-reflection by service	<u>Vicarious emotional states</u> Shame as a dynamic process Projection of shame Vicarious shame Self as helpless – projection of disempowerment Intense experience Vicarious anxiety Explicit transferential reactions Emotional challenge of managing angry self Exposed emotional process Vicarious emotional confusion due to trauma Vicarious emotional block Vicarious dissociation of thought processes Mirroring anxiety of emotional re-triggering Explicit emotional processes – shame, anger, resentment <u>Management of emotional self</u> Emotional containment through supervision (self-care) Reflection through personal therapy Mentalisation processes of self to empathise Awareness of	<u>Vicarious emotional states</u> Projection of unsafe place from client Vicarious traumatisation (projection) Risk of vicarious traumatisation increased when strong therapeutic relationship Physical manifestation of emotion Physical manifestation of anxiety Vulnerable silence Vicarious traumatisation through empathy enmeshment <u>Management of emotional state of self</u> Management of emotional self Containing emotional self through writing Importance of self-care to manage self-affect Self-actualisation Realisation of self as human Existential reconciliation of self through self-care Practical coping through meditation Cathartic physical expulsion of distress for self Mentalisation processes adept when engaged in self-care Clarity of transferential processes promoted through self-care/reflection Meditation as a paramount process for self-care	<u>Vicarious emotional states</u> Dissociation Management of disgust Physical manifestation in self of emotional reactions Vicarious physical shock Managing self-affect with difficult content Acknowledgement of vicarious impact on sex life <u>Management of emotional state</u> Self-management to minimise vicarious traumatisation Self-reflection of reaction Existential crisis of therapist Regulation of self-affect to manage vicarious traumatisation Recognition of additional self-care requirements	<u>Vicarious emotional state</u> Vicarious traumatisation through dissociation Anxiety re self as bad Dissociation as vicarious traumatisation Confusion re dissociation Emotional intensity <u>Management of emotional state</u> Sense-making of dissociation Pros and cons to dissociated self Containment of emotional self through structured model	*Therapist vicarious emotional state* *Managing emotional state of self through self-care* *Supervisory relationship to manage emotional state*	***Management of vicarious emotional self***

		self affect/regulation Mentalisation processes between self and client Balance of emotional self in therapeutic relationship Management of emotional self Self-care and reflection through writing Self-protection through reflection					
<u>Questioning of competent self</u> Uncertainty Trainee inadequacy ("anxiety" "complexity") Psychological conflict/cognitive dissonance re challenging client defences Unsafe uncertainty to safe uncertainty Maintaining safe-uncertainty Self-reflection of competency Trainee conflict of inadequacy Trainee self-perception (inadequacy) Unsafe uncertainty to safe uncertainty Projection of disempowerment (self as inadequate) <u>Self-directed learning</u> Enablement of self-knowledge Containment of self through developing knowledge/reading literature Enablement through furthering self-knowledge (traumatisation literature) <u>Sense-making of client experience</u> Sense-making through diagnosis Bewilderment at client's narrative ("matter of fact" "overthrow emotion") Enablement of choice <u>Ethical dilemmas</u> Dilemma re ending (self-reflection of trainee competency versus reinforcement of rejection to client) Managing expectations Anxiety re legal responsibility Survivors can exist in all services	<u>Questioning of competent self</u> Unsafe uncertainty Self as inadequate Recognition of self-competency Self-reflection of competency <u>Facilitative versus non facilitative learning environment</u> Discontentment of training preparation Self-reflection considered positive skill developed in training Diversity of approach to facilitate self <u>Recognition of prevalence</u> Significance of prevalence Reflection of prevalence	<u>Uncertainty of self as competent therapist</u> Disconcertion of unknown territory Disconcertment of competent self Unsafe uncertainty Dilemma re competency of managing client's emotional self Questioning competency <u>Facilitative versus non facilitative learning environment</u> Professional enhancement through reflection on process issues Experiential work could enable processing of vicarious emotional state Openness can be counteractive of shame Lack of enablement through training Lack of experiential learning which would promote self-development Expectation from course to manage self-emotional state through personal therapy <u>Self-directed learning</u> Self-enablement of knowledge through literature Normalisation of process issues through education Enablement of	<u>Managing disclosure</u> Significance of disclosure Shock/overwhelmed re client disclosure Anxiety re managing response to disclosure <u>Uncertainty of self as competent therapist</u> Uncertainty re depth of enquiry Uncertainty re sense-making process Unknown territory Unconsciously competent self Unconsciously incompetent self Existential crisis of therapist Existential questioning – loss of self Anxiety re being 'the good enough' therapist Crisis of self as competent therapist Confidence required for safe-uncertainty Emotional ambivalence through recollection Interview promoted acknowledgment of self-development Developmental/existential crisis during training <u>Facilitative versus non facilitative learning environment</u> Discontentment at preparation from training No acknowledgement of prevalence from training Deskilled sense of self through lack of preparation Disconcertion re lack of acknowledgement in training No acknowledgment of pitfalls on training Importance of developing understanding of vicarious traumatisation <u>Supervisory relationship</u> Self-ability to cope promoted through	<u>Self-directed learning to enable self as competent therapist</u> Awareness of comorbid problems hindering to therapy Awareness of prevalence Enablement through practical techniques Self-enablement through theoretical trauma knowledge Self-knowledge as emotional container for client Enablement of safer practice through practical techniques Significance of normalisation process to clients Experience provides self-enablement through safer practice Acknowledgement of prevalence Advancement of self-knowledge provides containment for self and client Empowering client and self through enhancement of knowledge Self-enablement through advancing practical knowledge Acknowledgement of prevalence across all services Self-enablement	<u>Uncertainty re competent self as therapist</u> Inadequate self Ambivalent self re competency Unsafe uncertainty re where to explore with client Anxiety re competency of self Questioning of competent self <u>Enablement of self as therapist</u> Moving to safe uncertainty Acknowledgement of self re positive outcome Assurance to self <u>Facilitative versus non facilitative learning environment</u> Discontentment re preparation by training Desire for further experiential training <u>Supervisory relationship</u> Importance of supervision as reflective space	*Questioning of the self as inadequate* *Self-empowerment through choice* *Enablement through self-directed learning* *Facilitative versus non facilitative learning environment*	***Questioning of competent versus incompetent self as therapist***

		self through theoretical understanding Prevalence recognition	positive reinforcement in supervision	through developing knowledge Experience develops safe uncertainty Reflection of self-development through experience <u>Supervisory relationship</u> Facilitative supervision – practically and emotionally Supervision as educative space Supervision as reflective space <u>Facilitative versus non facilitative learning environment</u> Supportive team Containment through transparency in team Discontentment with lack of acknowledgment from training <u>Self-development for working complexity</u> Transferable skills to enable working with complexity Enabling for other challenging therapeutic encounters			