

ABSTRACT: This is a phenomenological study into the lived experience of vicarious traumatisation in a helpline supervisor. A semi-structured interview was conducted and three themes have emerged: 1. Being professional at all costs, 2. Being alone and feeling disconnected, 3. Reconnecting. Practice implications have been concluded such as to ensure more effective systems are in place for staff exposed to trauma and more supportive supervision to be in place. The study highlighted the need for further research into the roles of helpline supervisors as these roles differ from traditional counselling supervisors.

Introduction

The cost of caring

At the heart of the therapeutic relationship is empathy – which is understanding and relating to the distress of another person. However, empathic engagement can lead to the counsellor becoming traumatized in the face of frequent exposure to the distressing traumatic experiences of others (Figley, 1995). Trauma counsellors are susceptible to vicarious traumatization, harmful effects similar to those their clients experience (McCann & Pearlman, 1990). Studies have shown that levels of stress can be similarly high in counsellors as in clients (Arvey & Uhlemann, 1996, Steed & Downing, 1998). Affected therapists are more likely to function less effectively and professionally (Arvey & Uhlemann, 1996).

The potential impact on psychological well-being of working in the caring professions has been subject to considerable attention over the last 20 years, with recognition that people in these roles suffer more stress than other occupational groups (Firth-Cozens & Payne, 1999). Whilst those in the caring professions are more at risk of developing these conditions, not everyone is affected. Therefore it can be safely concluded that “the work itself is not sufficient to explain the development of these conditions” (Phelps et al, 2009, p 314).

Phelps et al (2009) take the OED definition of well-being to “encompass the notions of being happy and healthy, working efficiently, and being physically and psychologically able to cope with occupational and social demands” (Phelps et al, 2009, p 315). In addition, Alexander (2002, cited in Phelps et al, 2009) added in his definition of well-being, a component of resilience or the ability to “bounce back” and recover from difficult situations.

The term vicarious traumatization has been used almost interchangeably with compassion fatigue, burnout and secondary stress disorder. These terms are characterized by a range of nonspecific symptoms from the physical (e.g. aches and pains, fatigue, sleep disturbance) and the cognitive (e.g. poor concentration, impaired memory, impaired decision making), to the behavioural domain (e.g. social withdrawal, loss of interest in activities).

PTSD: Post-traumatic Stress Disorder

According to the *DSM-IV* (American Psychiatric Association, 1994), being exposed to a traumatic event which can trigger a response of intense fear, helplessness, or horror can lead to PTSD. During a traumatic event, one typically experiences, witnesses or is confronted with threatened or actual death or serious injury. Traumatic events can include war, natural disasters, accidents, sexual assault, abuse, or the death of a loved one (Hesse, 2002). PTSD consists of a range of behavioural, emotional and cognitive symptoms. Three clusters of behaviour are defined (DSM-IV):

1. The traumatic event is persistently re-experienced (including recurrent and intrusive recollections and dreams of the event).
2. Avoidance or trauma related stimuli or numbing responses (including avoidance of thoughts and feelings, activities, places and people associated with the trauma, inability to recall an important aspect of the trauma, feeling of detachment or estrangement from others).
3. Symptoms of increased arousal (including sleep disturbances, irritability or outbursts of anger, difficulty concentrating, hyper-vigilance and exaggerated startle response).

The most frequently experienced symptoms of PTSD “include *intrusive thoughts*, often in the form of flashbacks or nightmares, in which the traumatic event is re-experienced; *avoidance*, when the person tries to deny or reduce exposure to people or things that might elicit painful feelings; and *hyperarousal*, which includes physiological signs of hypervigilance or increased startle response” (Baldwin, 1995 cited in Hesse, 2002, p. 296, italics in original). In addition, the DSM-IV stipulates that for a diagnosis of PTSD, the symptoms need to be present for more than one month and have to cause serious impairment to daily functioning (American Psychiatric Association, 1994).

Burnout

The characteristics of burnout include symptoms such as “physical and emotional exhaustion, decreased self-esteem, feelings of helplessness and hopelessness, depression, reduced insight, and reduced capacity for decision making”(Phelps, et al, 2009, p 316) have been described.

Freudenberger (1974) was the first to characterize the phenomenon of burnout as “the extinction of motivation or incentive, especially where one's devotion to a cause or relationship fails to produce the desired results.” He identified four symptoms: (a) appearing depressed and suspicious, (b) being easily angered, (c) being cynical and resistant to change, and (d) spending too much time at work while not actually being productive.

According to Pines and Aronson (1988), burnout is caused by long-term exposure to emotionally demanding situations. They define it as a state of physical, mental and emotional exhaustion, marked by physical depletion and chronic fatigue, feelings of hopelessness and negative self-concept and negative attitudes towards work and others.

Although burnout is a comprehensively researched topic, there is “no consistent definition of the term *burnout* in the literature” (Phelps et al, 2009, p 315). Maslach, Jackson, and Leiter's (1996) theoretical conceptualization of burnout to encompass the three dimensions of (a) emotional exhaustion, (b) depersonalisation, and (c) feelings of incompetence or reduced personal accomplishment remains the basis of most current definitions. Burnout is conceptualized as resulting from the cumulative effect of emotionally demanding situations that raise personal stress levels beyond the capacity of the individual's coping resources (Figley, 1995; Maslach et al.,1996). It is generally understood as a process in which helpers feel progressively more worn down, overwhelmed by their work, and incapable of facilitating positive change (Collins & Long, 2003; Figley, 1995).

Sanderson (2010) suggests that a counsellor “may over-extend herself and over-identify with the survivor” (Sanderson, 2010, p. 282) leading to the counsellor questioning the value and effectiveness of the work. If burnout goes unnoticed, she argues, it can lead to Secondary Traumatic Stress.

Compassion Fatigue

Compassion fatigue has been used to describe reduced capacity for, or interest in, bearing the suffering of others (Figley, 2002), as the therapist is emotionally “too tired to care” (Collins & Long, 2003, p.417). Compassion fatigue is understood to develop as a result of exposure to distressed others, which can elicit feelings of obligation or desire to help, and overwhelming emotional involvement through empathy. Figley (1995) defines secondary

traumatic stress as “the natural consequent behaviours and emotions resulting from knowing about a traumatising event experienced by a significant other—the stress resulting from helping or wanting to help the traumatised or suffering person.” (Figley, 1995, p.7).

Secondary Traumatic Stress

Secondary Traumatic Stress has been linked specifically with the empathic engagement in traumatic material (Figley, 1995) and empathic working with survivors of traumatic events. It is similar to PTSD. The counsellor may experience PTSD-like symptoms such as avoidance, numbing and depersonalisation leading to “an avoidance of trauma material, withdrawal, diminished interest in activities, and a sense of detachment and estrangement from others” (Sanderson, 2010, p. 283) or intrusive thoughts and images, as well as hyper-arousal as a result of indirect exposure to trauma (Figley, 1995). Unlike burnout, which is understood to be a product of cumulative stress, the onset of secondary traumatic stress may in some cases be sudden and acute (Figley, 1995).

Vicarious traumatisation

McCann and Pearlman (1990) described the potential adverse psychological effects of working with trauma survivors as *vicarious traumatisation*. According to Hargrave, Scott & McDowell (2006) vicarious traumatisation relates to “covert disruptions to cognitive schemas” (Hargrave, Scott & McDowell, 2006, p. 39) about self and the world. McCann and Pearlman (1990) suggested that the counsellor’s cognitive beliefs can be disrupted by trauma in 5 areas: (1) Safety, (2) Trust/dependency, (3) Esteem, (4) Control, and (5) Intimacy. Furthermore, changes to interpersonal relationships, and changes to the counsellor’s imagery system (vivid accounts of traumatic experience may be internalized as own memory and re-experienced by the therapist as intrusive imagery) are prominent in counsellors with vicarious trauma (Pearlman & Saakvitne, 1995).

Counsellors can incorporate clients’ traumatic experiences into their own memory resulting in flashbacks, dreams or intrusive thoughts comparable to PTSD. Defensive reactions can include psychological numbing, denial and distancing (McCann & Pearlman, 1990). Empathic engagement and identification with the client’s traumatic experience have been noted to be key factors in the development of vicarious traumatisation (Pearlman & Saakvitne, 1995). Researchers have asserted that vicarious trauma can result from exposure to a *single* traumatic experience (Conrad & Perry, 2000, cited by Hesse (2002), whilst others view vicarious traumatisation as the *cumulative* effects of engaging in therapeutic relationships with trauma victims (Pearlman & Mac Ian, 1995). Researchers agree that this condition is severe enough that counsellors may need extra support to cope with the effects of listening to others’ traumatic experiences (Figley, 1995; Pearlman & Saakvitne, 1995).

Whilst there is agreement among researchers that the “particular stressors associated with helping people in the aftermath of trauma and disaster may contribute to certain several types of stress conditions” (Phelps, et al, 2009, p 317), these conditions are not always clearly distinguished in the literature. Although differing terminology suggests differences, there are some overlaps in the experience of trauma in the counsellor. For the purpose of this research, I use the term vicarious traumatisation where signs of PTSD are apparent.

Factors influencing the development of Vicarious Trauma

Not all counsellors experience vicarious traumatisation. Various internal and external factors have been identified in negotiating the impact of a traumatic experience. A personal trauma history in the counsellor has been shown to be a deficit and risk factor by several studies (Collins & Long, 2003). Dunkley and Whelan (2006b) point out counsellors with personal trauma history can be more traumatised as they can relate to the detrimental effects of their clients' experience. This suggests that identification has some role in the development of vicarious trauma. However, some writers have proposed to see a personal trauma history as a potential strength in understanding the clients' experiences empathically (Hargrave, Scott & McDowell, 2006).

It has been pointed out that trauma work "especially in the voluntary sector, is a self-selecting process that may attract individuals with a personal history of trauma" (Hargrave, Scott & McDowell, 2006, p.38). However, discrepancies between quantitative and qualitative research regarding the prevalence, scope, and severity of vicarious trauma among professionals have been noted (Sabin-Farrell and Turpin, 2003). Greater stress in terms of higher numbers of caseloads have been linked to higher disruptions in counsellors (Schrauben & Frazier, 1995).

Coping mechanisms

Adaptive coping mechanisms, including emotional support, active coping, social support, humour and planning and dealing with the problem, have been linked with low levels of disruption in cognitive beliefs (Dunkley & Whelan, 2006b). Talking to peers and friends (sharing) is a frequently employed coping strategy (Arvey & Uhleman, 1996, and Dunkley & Whelan, 2006b).

Non-productive or maladaptive coping styles, such as use of alcohol or drugs, denial and behavioural disengagement, have been associated with greater disruptions in cognitive beliefs and greater distress (Dunkley & Whelan, 2006b; Johnson & Hunter, 1997). Maladaptive coping has also been linked with feeling helpless and not confident (Steed & Downing, 1998).

Telephone Counselling

A lot of research on vicarious traumatisation has focused on counsellors working with survivors of sexual violence (Dunkley & Whelan, 2006b) and has been restricted to face-to-face counselling (Dunkley & Whelan, 2006a). However, even though telephone counselling has become more important and more prevalent, research on this topic has been largely ignored (Dunkley & Whelan, 2006b). Benefits of telephone counselling such as its ease of access, anonymity, and perceptions of control and empowerment have purported telephone counselling to such an important position in the provision of mental health services. Furthermore the "immediacy with which callers can receive assistance" (Dunkley & Whelan, 2006b, p 454) when they are at their most vulnerable, is one of the reasons why telephone counselling is so widely accessed. However, witnessing traumatised clients and service users at immediate high risk exposes the telephone counsellors to high levels of trauma with deleterious effects.

Telephone counselling is widely available and has long been ignored in terms of researching effects of vicarious traumatisation (Dunkley & Whelan, 2006a). Some telephone helplines specifically work with high trauma clients (e.g. suicide), and research has shown telephone counsellors are susceptible to vicarious traumatisation (Dunkley & Whelan, 2006a). Mauldin (2001) investigated telephone counsellors working with rape survivors and found that consistent exposure to trauma victims by telephone resulted in significant PTSD symptoms, albeit less severe symptoms than their face-to-face colleagues experienced. Neuman and Gamble (1995) stated that all counsellors are at risk for developing vicarious traumatisation.

Helpline counsellors are often exposed to a very high degree of trauma – ranging from experiencing actively suicidal callers to those living with trauma and in abusive environments. Without the certainty to be able to refer the person on the other end of the line as the helpline wants to guarantee an anonymous service within certain remits the Helpline counsellor may experience more stress than her face-to-face colleagues.

Dunkley & Whelan (2006a) noted that the majority of telephone counsellors had not had any training specifically for vicarious traumatisation. Those without training had slightly higher scores of vicarious traumatisation. Researchers have argued for the need for specialist training, supervision, and debriefing for trauma counsellors (Sexton, 1999; Mauldin, 2001). However, a lot of telephone counselling is provided by charities and volunteer organisations and may attract volunteers with a personal trauma history (Hargrave, Scott & McDowell, 2006). In addition, these organisations may not have the funds to offer training in and support for vicarious traumatisation.

Supervision

According Pearlman & Mac Ian (1995) a third of trauma counsellors did not receive supervision despite recommendations. Those who received supervision reported great variation in the type of supervision they received and differences in frequency of contact with supervisors and length or sessions. Pearlman & Mac Ian's (1995) found that approximately half of their sample of self-identified trauma therapists received any form of trauma-related supervision.

However, receiving supervision is not enough, a positive relationship with one's supervisor is necessary to successfully manage to effects of vicarious traumatisation (Dunkley & Whelan, 2006a). Research has shown that the "stronger the perceived supervisory working alliance, the lower the disruption in cognitive beliefs" (Dunkley & Whelan, 2006b, p. 460).

Sexton (1999) argues that it is necessary for organisations to provide adequate resources and opportunities for self-analysis and supervision to work through trauma reactions.

However, Sexton (1999) warns that supportive structures for the processing of traumatic material do not guarantee that they are used appropriately as "staff may also feel ashamed or professionally exposed and hence avoid sharing their pain and vulnerabilities with their colleagues" (Sexton, 1999, p.399). McCann & Pearlman (1990) noted the ambivalence that staff feel in discussing their trauma-related reactions: on one hand, wanting to give voice to the trauma; on the other, wanting to protect their colleagues from the trauma they carry.

It has been suggested that establishing and maintaining emotional boundaries may be an important protective mechanism against vicarious traumatisation (Phelps et al, 2009). One of the important functions of supervision is to support the therapist in establishing and maintaining boundaries.

Unsurprisingly, research has found that a supportive work environment benefits the happiness and health of employees and increases resilience to stress (Boscarino, et al, 2004; Sexton, 1999). Furthermore, social support outside of work has been identified as important, with those married less likely to suffer burnout (Boscarino et al, 2004).

Potential for post-traumatic growth

There is some evidence for posttraumatic growth – which is “the individual's experience of significant positive change arising from the struggle with a major life crisis” (Calhoun, Cann, Tedeschi, & McMillan, 2000, p 521). Traumatic events can produce a major disturbance in a person's understanding of the world. Furthermore, the previous worldview can become invalidated by the occurrence of traumatic experiences (Calhoun & Tedeschi, 1999).

Greenberg (1995) proposes that cognitive processing helps the affected individual to rebuild their worldview and adapt to the trauma. Cognitive processing has also been suggested as an important component in terms of developing posttraumatic growth (Tedeschi & Calhoun, 1995). Furthermore, religious participation has been shown to be related to posttraumatic growth (Tedeschi & Calhoun, 1995). Also, increased religiousness has been reported as an outcome of stressful experiences (Park, Cohen, & Murch, 1996).

Qualitative research on the growth experience of counsellors suggests that counsellors exhibit signs of vicarious traumatisation and grow with their clients (O'Sullivan & Whelan, 2011). Three major criteria for posttraumatic growth have been identified: positive changes in self-perception, interpersonal relationships, and life philosophy.

Goal of this study

There are a lot of helplines that are staffed by frontline counsellors who are supported and guided through the phone calls by their supervisors. Their experience of vicarious traumatisation has been neglected by research. This piece of research aims to address this lack in literature and provide a rich description of vicarious traumatisation of a helpline supervisor.

Methodology

Research design

This project used the qualitative research approach of phenomenology to explore the lived experience of vicarious traumatisation of a helpline supervisor. In order to achieve this, a semi structured interview was conducted with a counselling helpline supervisor.

Participant

Chris is a friend and colleague who I have known for over 6 years. Chris had related an incident of vicarious traumatisation. Chris was 55 years old at the time of the study, living in the South of England with her husband Bob. My personal relationship with her was beneficial for the research as we had already established mutual trust and acceptance which brings a sense of relaxation in each other's company. I believe, Chris was able to be more open and honest about her feelings and thoughts because of our pre-existing friendship. However, as she also knows me as a colleague, certain aspects about her work might have been more important for her to stress, for example she may have been more concerned with ensuring I still see her in a professional role.

From my standpoint, interviewing Chris gave me an extra incentive to represent what it was like to be her, to do right by her.

Place of work

Chris works at a national charity which offers a 24 hour counselling and crisis helpline that can be accessed by telephone, chats and emails. These are answered by either volunteer or staff counsellors. The charity has several bases throughout the United Kingdom. Many service users contact the helpline particularly when in crisis. Chris's job is to supervise the counsellors. That means supporting them during and after calls, debriefing them at the end of their shift as well as making referrals to other services.

Data Collection

Chris is a close friend of mine and colleague on the helpline. She identified herself as being the ideal candidate and offered to be interviewed after I told her about my research project on the topic of vicarious traumatisation. After obtaining approval for my research proposal, I obtained informed consent from Chris before starting the interview (Appendix B). The interview was conducted at her home for her comfort and convenience. The interview lasted about 50 minutes.

Data Analysis

It was recorded and subsequently transcribed verbatim. The interview transcript can be viewed under Appendix A. The transcribed interview was analysed using thematic analysis by re-reading the transcript repeatedly. I used IPA – interpretative phenomenological analysis (Smith, 1996) to carry out the thematic analysis. In order to immerse myself in the data, I chose to read the transcript line-by-line, as well as listen to the recordings repeatedly. I highlighted passages, and key phrases of the transcript and wrote in the left margin possible meaning making as “the process involves a focused act of discovering sedimented meanings, nuance and texture” (Finlay, 2011, p 229). This procedure allows for transparency

in the analysis of qualitative data (Smith 1996). However, as Finlay points out “the analysis process is often a messy one, involving both imaginary leaps of intuition as well as systematic working through of many iterative versions.” (Finlay, 2011, p 228).

As Aronson (1994) suggests, I aimed to identify all data that related to an already categorized pattern. I then combined related patterns into sub-themes in order to piece them “together to form a comprehensive picture of their collective experience” (Aronson, 1994, p 17). The connections between the themes were drawn in a diagram, so that I could cluster together as well as separate out themes more succinctly. The outcome of this yielded several themes.

I also drew on the help of a colleague (Rosie) who read the transcript. We met up and discussed our interpretations of the data. There was a great amount of overlap in our interpretation. When we differed, I chose to look more closely into why we differed in our interpretation. This was extraordinarily helpful as my colleague was able to offer a view point that was in part more objective (as my participant and I share important features - such as we both work in the same organisation in the same job - my analysis of her interview was influenced by my own experiences).

Ethical Considerations

The participant was informed of the research aim (which was to research the lived experience of vicarious traumatisation of a supervisor of helpline staff) before the research was undertaken. Chris offered to be interviewed as he had a fairly recent experience of vicarious traumatisation. She was informed that he could withdraw from the research at any time, including within a month after the interview. Anonymity was guaranteed in that identifiable characteristics would be changed. Chris was asked to choose a pseudonym. He was made aware that I was going to share and publish this research, and that therefore confidentiality could not be offered. The participant agreed to the interview being recorded so that it could be transcribed afterwards. The recording was stored in a password encrypted file on my computer.

I also advised my participant that the interview might trigger distressing memory. To mitigate this, a therapy session with a colleague was offered free of charge. I originally offered Chris a copy of the interview transcript and my analysis. I had originally agreed with her that she would offer her feedback on my making sense of her experiences, that she would be a co-researcher. However, Chris became ill, forcing her to take time off work for several months. My TA colleague Rosie was drawn into the research at that point, as I felt it would be unethical to continue to expose her of the research material while unwell.

Findings

In trying to capture Chris's world as she experiences it, the following themes emerged:

1. **Being professional at all costs.**
2. **Being alone and feeling disconnected.**
3. **Reconnecting**

1. **Being professional at all costs.**

Chris starts off by painting the backdrop to her experience as "a busy night" with her and her colleagues responding to "lots of risk flags – as we do" suggesting that this highly stressful work is very normal for her. In this high pressure environment, she is used to dealing with callers with suicidal tendencies and behaviours. However, this one call was different. In her professional capacity, she looks after the young person's needs through the counsellor, and she looks after the counsellor by going back and forth (in between contacting emergency services to attend at the scene) as her body language signals that she required Chris's assistance. They both hear a person at the other end going through with her suicide attempt as help arrived. Both Chris and Marie, the counsellor, are traumatised greatly by what they heard during this particular call. Her attempt to gain control of herself despite the effects of the trauma is by relying very heavily on her professional role. She is preoccupied with supporting her colleague who needed support. Yet at the same time she is repressing her own needs. She remembers:

"... my insides churning – so I had physical responses to it, but I couldn't let any of them go. Because I had to ... in my mind, I was being professional supervisor, offering the right amount of support to a colleague who needed it. And I would sort myself out later. How, I don't know. But I just thought, 'you can do this later. You can deal with your stuff later. It's about supporting her at the moment, and moving her away from the trauma, looking at plans forward.'"

It seems as though being professional means having to put herself and her trauma response on hold. She experiences physical stress reactions in her body, yet tries to contain them with her mental focus on being professional. At this moment, Chris seems to keep telling herself that "it's about supporting her" almost like a mantra to keep going - a mantra to keep her focus on the other in order to avoid her own sensations. It seems that the experience has triggered a far-reaching altruistic response in her. A message of *I can only get through this if I care for the other* seems deeply imbedded in her reactions to the trauma. However, she cannot escape her physiological responses. They keep reminding her that she has the need for emotional support, too. She seems to view herself as an afterthought and tells herself to "deal with your stuff later."

Chris continues to talk in depth about being in that professional role, and how it impacted on her experiencing and also letting go of the trauma. After the traumatic incident she focuses her attention as much as possible on the counsellor in order to help her feel able to cope. She says:

“I knew that was my aim to get her to a state where she wasn’t in chaos, coz she was. And also I got her into a state where she was able to get up from the table and go and make a cup of tea – coz maybe half an hour previous she wasn’t able to. She couldn’t move. She was just numbed. So I think to get her to that state where she could say ‘yeah, I’m gonna go wash my face. I’m gonna get a brew. Then I’ll write up.’ ... And then I slumped and went into that chaos for a few minutes. I really felt as though I had expended every bit of energy I had. So emotionally we were both connected on that call. Then I had to maintain that high emotional contact with her to get her through it. And to get through the debrief and to get to some sense that she was ok. And I did feel very drained – emotionally and physically - after that shift.”

The cost caring for the counsellor comes at such a great personal expense. Chris is feeling “very drained – emotionally and physically”. She is so invested in getting the counsellor “to a state where she was able to get up” that she can put a temporary stop to her own emotional reaction to the event. In fact, it seems as though maintaining “that high emotional contact with her to get her through it” is her sole focus. Yet she acknowledged that she “had to” do this - indicating that there was no choice involved. There again is this inescapable sense of *I can only get through this [exist] if I care for the other*. The minute the counsellor leaves, and there is no other to care for any longer the need to be professional subsides, and Chris experiences chaos. Being professional seems instrumental to Chris in terms of being able to carry on but also in letting the trauma go unprocessed. She is aware of this when she states that her “focus was for her - and that was really difficult.”

The counsellor’s wellbeing is paramount in Chris’s acting and thinking throughout the interview. She takes her out of the room, and then makes a plan to ensure that Marie can come back. Months later, she says she has “never spoken to the counsellor about it since” as seems to project on to her that it might be “too painful for her to bring it up again.” Perhaps to some degree, Chris’s avoidance of talking with Marie about the incident is protective and supportive of Marie. Perhaps her projecting how painful it was for the counsellor hinted at how painful it was for Chris too, and so by masking it with “being professional supervisor” she can remain *professional* at work.

She seeks out supervision for support, and her supervisor looks at how to do things differently next time, how to use the organisational systems in place for support. Yet these seem meaningless as “the things she was talking about were impossible or I didn’t want to do as I didn’t feel comfortable with”. The organisation’s needs are identified as being more important than her needs of self-preservation. She indicates that her colleagues’ needs carry more significance than hers. She ensures the counsellor is debriefed immediately, but she does not seem to feel entitled to having a debrief herself. Her colleagues both checked in with her to see how she was doing “but it was very much in the surface coz they don’t, in my view, they don’t want to take this on board either.” She is unable to convey to them how deeply she had been traumatised, and seems to project on to them that they would not want to have the same experience. Perhaps holding on to the trauma was a way of preventing it from being passed on to her colleagues, a way of containing it by keeping a lid on it.

Perhaps the environment, the organisation supports and encourages martyr behaviour. There is a strong sense of Be Strong that seems to be expected from the job. She seems to

have incorporated messages that she needs to be “professional” first, and not emotionally effected by her work. She shows some awareness of this process by stating:

“I think that’s a facet of me. I think it’s a facet of work as well. As in the role of the supervisor you do have to deal with the immediacy of other people, and your own stuff does get left. ... But in that instant it wasn’t helpful to do it. I had to do it that’s my role but as a person that wasn’t good for me.”

2. Being alone and feeling disconnected.

Throughout Chris’s story, the inescapable sense of being alone prevailed. Although the traumatic event is shared with the counsellor, Chris seemed to be fundamentally alone in dealing with her traumatic experience. Only after the counsellor was debriefed and able to look after herself, Chris is left on her own. Only in this brief moment, where she does not have to look after anyone else’s needs, she allows herself to cry. She states that she “burst into tears – for a very short time. I think I just needed that momentary release coz I couldn’t go back into the room feeling the way I did.” She almost appeared apologetic when explaining she needed that “momentary release” so she can get on with supporting her colleagues in the counselling room. At the end of the shift, she does not ask for support from her colleagues. She rationalises this as “they had their own stuff from shift as well” and appears to think of asking for support as a burden to her colleagues. Again, she seemed cut-off from those around her. Perhaps she does not want to admit she was affected by the experience, perhaps she wants to protect the others from being traumatised as well. So she seems to carry the trauma herself and is fundamentally alone in it.

This tension becomes really apparent to me – she feels disconnected from the people with whom she normally shares connections, leaving her feeling alone. She cannot reach out, and when others reach out to her, for example when the counsellor asks how she is, she deflects. She seems enmeshed in Marie’s trauma and instrumental to her road to recovery, yet so alone in her own. She supports the counsellor by sitting right next to her, ensuring Marie is not alone during this call. She stays with her after the incident to ensure Marie is ok. She makes plans with the counsellor to ensure she continues to receive support. All the while she is so alone; she describes her physical and behavioural experiences as very private, mostly physical experiences. She recalls:

“Inside my stomach was churning. I could hear it. It was like I was hungry, but I wasn’t. It was just that my stomach was churning over. I was aware that my leg was shaking. I was sort of... I was resting on the ball of my foot and my knee was up and down which I know is a traditional stress trait of mine that I will shake my leg. And it will show that I am tense. I felt sick because I think I was just pushing all my feelings down and it let to me feeling nauseous. I didn’t cry until the counsellor had left. But I could feel it intensely being there. I felt hot. I know I was red in the face. Just general anxiety tension and symptoms. And when I came home I was crying and I think at one point screaming. And pacing up and down. Restless until I was just worn out. And then I just sort of crashed out.”

She describes her “traditional stress trait” as part of her trauma reaction. Her physical sensations are not shared with anyone, only she is painfully aware of them, as she “could

feel it intensely being there". At home she cries and screams – perhaps to let out some of the reactions she had been pushing down in the company of others. When she is alone, she can let go. But being alone also means there is no-one to support her.

At home, she realises that she doesn't "actually remember any element of the journey" home. So the time she spent in the car, on her own, she cannot recall – as if being alone was so unbearable it had been blocked out. A state of disassociation through memory loss is not uncommon for traumatic events. However, it is unusual for it to occur hours after a traumatic incident. Chris experiencing memory loss on her way home could mean that she replayed the incident and became re-traumatised. She said that she did suffer with intrusive thoughts of the event that played on and on. However, it could also mean that the exhaustion from the demanding job led to her being on autopilot. In any case, arriving at home, the realisation that she cannot remember her journey frightens her immensely. There is a moment when she reflects on her own safety, and whether she should have driven home.

At home, she does not feel able to share her trauma with her husband, she tells him that "something traumatic had happened and that I had to support a counsellor." Reflecting on the impact of the traumatic incident, she describes her impaired ability of sharing her inner world, sharing her pain, her fears. She seems disconnected from her husband, as she cannot put into words her disintegrated experience:

"I think with this particular occasion because I felt so out of control mentally I felt like my head was spinning. I wasn't able to say it. I wasn't able to say 'I think I am losing the plot! I think I can't do this anymore.' I just cried and cried and cried. And then I was saying 'I can't go back, I can't do it anymore, I can't do my job'. But I couldn't say I felt helpless, I felt desperate ... I wasn't able, at the time, to say it. And I just kept remembering the sounds that I heard down the phone and it would spark off crisis again for me and anxiety. So he saw the physical side of things that I was crying and ranting a bit and doubting myself. But I wasn't able to say those feeling words and descriptive words to actually bottom out what I was feeling. That was hard."

She describes how she is unable to give voice to her experience, unable to make a connection with her husband and feel understood. She can say she "can't go back" and "can't do it anymore", but not how she feels. It seems like she is seeking a connection by communicating with her husband, yet feels disconnected, perhaps even disconnected from herself. Perhaps she wants to protect him like she did with her colleagues, too. She feels unable to share these intrusive thoughts and recollections with anyone. Her memories are private and continue to keep her in this trauma alone.

3. Reconnecting.

After almost 2 weeks, she seeks to connect with someone outside of the organisation and home – a counsellor. She talks about feeling heard when talking to a professional who is not connected to her, and also starts to reconnect with herself.

"So I had six sessions with a counsellor. It really helped me to let go of some stuff. And it just helped that there was somebody there to listen which I do have to an extent. But I think

it was being external to that where I didn't have to talk about the actual incident, but I could talk about my reactions in times of stress and feeling under pressure. Which is what happened on this occasion. So I was pleased that I accessed it."

In this quote, Chris is saying how valuable her counselling was. The "extent" to which she had someone to listen to her at home and with her colleagues, was not enough. The supervision was not enough. She manages to "let go of some stuff" through working with someone who was unconnected. With this counsellor she is able to talk about the things she could not voice before. She stresses that the vital distinction about this counselling "being external" and therefore she was able to focus on herself and her feelings and "reactions". In this quote, she eludes to her supervision not being about her, but about the incident – about how she should have done better. Perhaps she felt more able to process the trauma with an outsider because she felt she would not be judged by her work performance. Perhaps that is why she does not need to or want to talk about the "actual incident". Instead this support outside of work is just for her. It seems like she can form a connection with her counsellor, and by managing to integrate the experience with other experiences "in times of stress and feeling under pressure", she seems to re-establish a connection with herself.

The counselling she receives and the distance gained from the incident also helps her to understand "that I have needs myself and those have to be met to be continually effective in role. But also for my own personal good mental health." With this quote Chris understands that her personal needs "have to be met" suggesting that she does not have to continue to put her professional role first at her own expense. She also points out that although the experience was traumatic there were some positive outcomes for her. She says the experience "has led me to reflect on my practice, my behaviour, highlight my needs more." This suggests that she learned to integrate her professional role with her personal needs. It also suggests that the behaviour that seemed to previously focus on supporting the other whilst not seeking support immediately for herself – which was intrinsically linked with her role and needs – has been examined with the help of an outside counsellor.

Discussion

Literature review

Telephone counselling is widely available today. Helplines are staffed by counsellors that are supported by supervisors during and after calls. The dynamics between counsellor and supervisor and has long been ignored in terms of researching effects of vicarious traumatisation (Dunkley & Whelan, 2006a). Whilst research has shown telephone counsellors are susceptible to vicarious traumatisation (Dunkley & Whelan, 2006a), helpline supervisors' experience of vicarious trauma has not received research attention. The helpline supervisory relationship is often different from the established counsellor-supervisor relationship. The helpline supervisor supports the counsellors during calls, and is therefore much more exposed to the traumatic circumstances callers experience and relate during contacts with helplines.

In line with *DSM-IV* definition of PTSD, Chris experienced all three clusters of symptoms. She reported intrusive, repetitive thoughts about the incident (1). She described her sense of disconnection and estrangement from others as well as loss of memory about her journey home or the following day's shift (2). She also described feeling anxious, not being able to sleep properly, panicking, and pacing around the house (3).

Hargrave, Scott & McDowell (2006) noted the disruptions to cognitive schemas about self and the world present in vicariously traumatised individuals. Chris's interpretation of being professional at her own personal cost could have been one of those cognitive disruptions. She thinks she cannot do the job or that her colleagues wouldn't want to debrief her.

In line with research findings, changes to interpersonal relationships (Pearlman & Saakvitne, 1995) in the counsellor experiencing vicarious traumatisation were evident. Chris seemed unable to engage with her colleagues or her partner in a way that signalled to them what she was experiencing. She seemed to be distant to them as a result of the trauma. Sanderson (2010) lists "withdrawal ...and a sense of detachment and estrangement from others" (Sanderson, 2010, p. 283) as the consequences of exposure to trauma. The current research project recognised Chris as being alone in her trauma until she managed to seek a connection through counselling outside of work. MacCann and Pearlman (1990) also noted that staff may feel the need to protect their colleagues from the trauma they experienced.

As important features in the development of vicarious traumatisation, empathic engagement and identification with the client's traumatic experience have been identified (Pearlman & Saakvitne, 1995). In this interview, Chris very often talks about her own experience as through the eyes of her colleague and how she needed to support her. It seems as though Chris continued to be traumatised by the counsellor's trauma as she seemed to identify with her.

Consistent with research finding on posttraumatic growth (Calhoun & Tedeshi, 2006), Chris's cognitive processing through counselling helped to develop some positive changes in Chris's life. The cognitive processing seemed to support her in acknowledging and valuing her own needs, and that these have to be met in order for her to be consistently functional in her professional role.

Implications for research

This research project has implications for further phenomenological research into vicarious trauma for helpline personnel including supervisors, as the present study is only a small scale research project.

Helplines are growing in numbers; the helpline counsellor-supervisor relationship needs more attention. The professional role of helpline supervisor might have some commonalities with the face-to-face counsellor-supervisor relationship; however, it has some distinct differences, such as being in the room when the counselling takes place. These differences may impact on factors such as vicarious traumatisation.

Implications for practice

The research has highlighted the need for helplines to offer more effective systems to be in place when staff are vicariously traumatised. Chris was relaying her supervision experience as a meeting to look at how to do things better next time. Pearlman & Saakvitne (1995) argue against authoritarian and expert-based models of supervision, and argue for a relational and interactive model to offer a safe relationship where the therapist can be open and honest.

The system in place was not one that Chris seemed comfortable with and would not make use of the Night Manager in future. It seems that systems that are in place are not accessible when suffering with a traumatic reaction. However, as the nature of job predisposes helpline workers to being traumatised, there needs to be adequate support in place. Therefore, I would advise that the systems in place need reviewing bearing in mind that the professional will be under enormous stress at the time of trauma, the system they operate in must be rigorous enough to support the professionals.

Overall usefulness of this study

This was a phenomenological study into the embodied experience of vicarious trauma in a helpline supervisor. The goal of the study was realised and has added rich description to already existing qualitative research into the phenomenon of vicarious trauma. In addition, the study highlights practice issues for organisations and helpline staff when faced with vicarious trauma. The study aids in painting the picture of vicarious trauma in helpline staff.

Reflective analysis

Relational issues

At the time of the interview, I had been on maternity leave for 6 months. I thought that this time away would be beneficial for my engagement in the research, as I would be able to cast fresh eyes onto the research material. I thought that the distance from work would provide me with more objectivity to conduct this project. I thought I would be able to be more objective in analysing, too. However, at the time of analysis, I had returned to work. However, I had started back at work again when I was writing up my project. New as well as old feelings of anger and sadness surfaced as I saw my colleagues more burnt-out and stressed than they had been when I left.

As Chris and I have been working in the same job together for several years, some of the anger I felt about the lack of organizational support may well be mine, hers or both of ours. I realised after the interview how compounded the feelings were. I could not separate out whose feelings were whose: Chris spoke of feeling anxiety and helplessness. She described how the counsellor's body language was spelling out helplessness and nervousness. Furthermore, I certainly felt helpless sitting opposite my colleague and friend, hearing how she was suffering at home and at work following the traumatic experience. I felt that I should have done more at the time, had I known how she was feeling. Those feelings I transferred on to the organisation as a whole and her manager.

I asked myself about her motives in volunteering to be part in this project. Was it to be heard, to voice what she previously could not say out loud? Telling her story might have been really beneficial to her in putting the trauma behind her. There seemed to be some part of her that was eager to tell me, and some part that wanted to forget. So this interview could have been beneficial to her or it could have led to her re-experiencing the trauma.

Perhaps she was seeking the connection she had lost as a result of the trauma? This might have been a chance to reconnect with one of her colleagues. Perhaps she was accommodating my need to find a research participant – at the possible cost of re-visiting the trauma. I wondered after the interview whether I took advantage of her when I should have been protecting her.

Transference and Countertransference

I felt very protective towards her during the interview and analysis process, I was aware of wanting to look after her, nurture her and support her when she was struggling so hard. Some of that protectiveness was a barrier for me dwell on aspects of the interview. I did not want to cause her upset, so decided not to dig deeper.

I also felt a lot of sadness and anger during the analysis. Seeing my friend and colleague all alone in this frightening experience was painful to observe. At times I did not know whether it was my sadness or her sadness I picked up.

At the same time I picked up a lot of anger towards the organisation, and the procedures in place that allowed this to happen to my colleague. At the same time I felt guilty for not supporting her enough when she was going through a traumatic time. Perhaps I picked up on how she wanted her colleagues to know how she was feeling. Chris talks about being in a

highly stressful, emotionally demanding job as normal. She trivialises “normal” suicidal calls because it is such a common phenomenon. I also felt angry with the organisation for not having more protective systems in place.

Chris used a lot of gallows humour. Sometimes, it felt as though she was trying to protect me from the trauma and desperation by adding a laugh to lighten the mood. At other times, it may have been protecting her to not re-experience the feelings from the incident. And at other times, it felt as though it acted as a barrier – a “let’s not delve deeper” sign.

Strengths and Limitations

Being friends with my co-researcher was a strength and limitation. During the interview and also the analysis process, transference and countertransference processes interfered with a more objective stance. Being her colleague meant that I could understand the processes and procedures in place that made access to organisational support very difficult. I felt a sense of anger, as well as futile resignation, when Chris talked about how her supervision was turned into what she should have done better rather than being supportive. Being her colleague meant that my work lens which informed my understanding of working at the helpline coloured my vision of what it’s like to be Chris.

As the meaning-making is co-created, my professional involvement with the organisation, and personal involvement with Chris has informed my making sense of Chris’s experience. On the one hand, it will have helped me to really understand her and her experiences, on the other, it will have been adulterated by my experience too.

Research method

Researching a colleague meant that at times, it was difficult to really ascertain whose feelings were whose. Did I pick up on her feelings of anger toward the organisation or were they mine? When engaging in qualitative enquiry, the effects of the researcher onto the research material are well known. However, this phenomenological study handled differently, richer results might have been obtained, for example from interviewing someone without a personal connection. If I were to repeat the study, I would want to choose interviewees without a personal connection. I would also obtain a slightly larger sample across different helplines. This way I could obtain a rich descriptive picture of helpline supervisors’ experience of vicarious trauma, and organisational factors that might impact on the experience. I would also look into systems and procedures in place within different organisations to see how frontline staff are cared for.

Goals for the study

The goal of the study was to obtain a rich picture of the lived experience of being a helpline supervisor who has been vicariously traumatised. At the start of this research project, the interviewee was going to be a co-researcher to offer feedback on the interpretation and analysis of her words, so that the findings would be more firmly grounded in her experience (and not solely confused or informed by mine). However, at the time of analysis, Chris had been diagnosed with depression. Out of ethical consideration, I decided not to include Chris any further. I thanked her for the involvement and informed her that when she was well enough to be back at work, I would share my findings.

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