Traumatology

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Online First Publication, March 23, 2015. http://dx.doi.org/10.1037/trm0000024

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1085-9373/15/$12.00

Therapists, Complex Trauma, and the Medical Model: Making Meaning of Vicarious Distress From Complex Trauma in the Inpatient Setting

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Limited research explores therapists' vicarious exposure to complex trauma narratives within an inpatient medical model promoting emotion regulation and symptom alleviation. This phenomenological study explored subjective interpretations of 4 senior trauma therapists working in inpatient settings. Data from semistructured interviews were analyzed using interpretative phenomenological analysis (IPA). One superordinate theme, *Therapeutic integrity and vicarious growth*, overarched 4 subordinate themes: (a) *Severity, complexity, and repetition*; (b) *Personal distress and the medical model*; (c) *Intrapersonal confrontation*; and (d) *Growth*. Two themes interpret coexisting distress, guilt, self-doubt, and sense-of-failure as internalized responses to the misfit between medical model interventions and complex psychosocial traumatic experiences of clients. The third interprets a personal search for therapeutic and personal integrity when vicarious distress and felt therapeutic futility collide. Fourth, redefining 'self' through intrapersonal honesty, altruism, and relational connectedness with patients distilled psychological wellbeing and growth. Overtime, these participants experienced vicarious psychological distress and loss of therapeutic integrity working within a medical model framework. Further, they perceived limited recovery and growth in clients. By redefining and prioritizing their therapeutic integrity and relational alliance, these therapists found renewed commitment to trauma work and grateful appreciation of limitations and strengths for autonomy and wellbeing. Clinical implications are discussed.

Keywords: interpretative phenomenological analysis (IPA), medical model, posttraumatic growth, trauma therapy, vicarious traumatization

Complex narratives of childhood maltreatment such as sexual and physical abuse, or witnessing maternal battering are common in adult mental health inpatients (Edwards, Holden, Felitti, & Anda, 2003). Those with a history of sexual abuse have an increased risk of lifetime diagnoses of multiple psychiatric disorders (Chen et al., 2010), particularly posttraumatic stress disorder (PTSD), depression, eating disorders, and suicide attempts (Chen et al., 2010).

Invariably, the sharing of distressing narratives of trauma with a trauma therapist risks vicarious contamination of the therapist. Many studies recognize that the empathic support given by therapists increases their own likelihood of developing vicarious distress and related psychopathology (Adams & Riggs, 2008; Arnold, Calhoun, Tedeschi, & Cann, 2005; Kadambi & Truscott, 2004). Conversely and encouragingly, recent findings also suggest that in integrating client trauma narratives, some therapists have experienced positive internal transformation (Linley & Joseph, 2007). What is unknown is how therapists working within an inpatient medical setting which promotes emotional regulation and symptom alleviation interpret first, the impact of complex trauma narratives on their sense of self, and second, their effectiveness as therapists. With this in mind, this qualitative study explores both the positive and negative interpretations of trauma therapists working with severely unwell mental health inpatients, and how they make sense of the impact of such work and the constructs they work within, on their lives and their therapeutic effectiveness.

The risks of psychopathology after vicarious trauma exposure have been reported across a broad range of professional cohorts including police workers (Follette, Polusney, & Milbeck, 1994), nurses (Spinelli, 2011), lawyers (Levin & Greisberg, 2003), disaster workers (Zimering, Gulliver, Knight, Munroe, & Keane, 2006), humanitarian aid workers (McCormack & Joseph, 2013), researchers (Wasco & Campbell, 2002), funeral directors (Linley & Joseph, 2006), social workers, and therapists (Adams, Figley, & Boscarino, 2008; Arnold et al., 2005; Brady, Guy, Poelstra, & Brokaw, 1999; Dlugos & Friedlander, 2001; Linley & Joseph, 2007; Linley, Joseph, & Loumidis, 2005; Pearlman & Saakvitne, 1995; Schauben & Frazier, 1995). The uniqueness and scope of carer responses has been captured by terms such as emotional contagion, compassion fatigue (Figley, 1995), secondary victimization (Figley, 1982), burnout (Maslach & Jackson, 1982), negative countertransference (Gold & Nemiah, 1993), secondary traumatic stress (Stamm, 1995), and vicarious traumatization (McCann & Pearlman, 1990). For the purpose of this study compassion fatigue and secondary traumatic stress will be encompassed within our discussion of vicarious traumatization as each relates to traumatic distress experienced from vicarious exposure.

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The authors are grateful to the senior trauma therapists who made this study possible.

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Several theories underpin vicarious traumatization, including systemic trauma theory (Figley, 1998) and constructivist self-development theory (McCann & Pearlman, 1990; Saakvitne & Pearlman, 1996; Spinelli, 2011). Systemic trauma theory describes how prolonged exposure and empathic support to trauma survivors can lead to a contamination of those vicariously exposed. It posits that transmission is linked to the therapist/carers' susceptibility to emotional contagion. Those impacted experience negative transformation of inner experience, inclusive of memory systems and schemas about oneself, others, and the outside world (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). In response, they are at risk of emotionally distancing themselves, overwhelmed by the enormity of the task of caring (Figley, 1995).

Constructivist self-development theory provides the scaffolding for the relationship between cognitive schemas and the process of psychological adaptation. It describes how each individual develops cognitive schemas about themselves, others, and the world which serve as their own unique and personal template of reality (Trippany, White Kress, & Wilcoxon, 2004). Prolonged exposure to trauma narratives can challenge these perceptions of reality. In consequence, the development of distorted and often irrational perceptions can be seen as an adaptive form of self-protection (Trippany et al., 2004).

However, there is also significant risk of pervasive maladaptive transformations given schematic changes are cumulative (i.e., reinforced by ongoing exposure) and pervasive (i.e., potential to generalize to all aspects of ones frame of reality; McCann & Pearlman, 1990). The extent to which schemas are challenged or altered is dependent on the salience of the schema and the therapists' current and early interpersonal, cultural, social, familial, and intrapsychic experiences (Saakvitne & Pearlman, 1996).

As such, vicarious traumatization occurs through cumulative empathic engagement with the emotional experience of one or more traumatized individuals leading to negative schematic distortions (Adams & Riggs, 2008; Kadambi & Truscott, 2004; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995; Schauben & Frazier, 1995). Vicarious traumatization also captures the manifestation of subclinical posttraumatic stress (PTS) symptomology that often mirror those reported by the trauma survivor (Arnold et al., 2005; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995; Spinelli, 2011; McCormack & Joseph, 2013). For example prolonged exposure to sexual abuse narratives may challenge the therapists preexisting schema that the word is a safe place. Under the adapted premise that the world is in fact dangerous, the therapist engages in heightened protective behaviors.

The impact of vicarious traumatization varies and will be influenced by organizational factors (e.g., trauma survivors in caseload; support) and personal factors (e.g., history of trauma and training or experience level; Pearlman & Saakvitne, 1995). For example, therapists with a history of traumatization are thought to be more at risk for adverse effects from their clinical work than those with no such history (Pearlman & Saakvitne, 1995). However, empirical findings are mixed. In a study exploring impact of exposure to traumatic material and wellbeing, 60% of the 188 self-identified trauma therapists reported a trauma history (Pearlman & Mac Ian, 1995). Similar rates of traumatization were reported among 148 female therapists, with 83% experiencing at least one form of victimization and 37% reporting two or more (Schauben & Frazier, 1995). However, a history of victimization was unrelated to symptoms of distress in these sexual violence counselors even when the client's trauma narrative matched the therapists (Schauben & Frazier, 1995). This latter finding suggests therapists who themselves are survivors were at no greater disadvantage in providing clinical work. Further research is needed to clarify the potential impact of a personal history of trauma as a moderator for vicarious traumatization.

Researchers have suggested that level of experience may influence the development of vicarious traumatization rather than number of survivors in a caseload (Pearlman & Mac Ian, 1995). Newly practicing therapists are more likely to report higher levels of cognitive disruptions in comparison with experienced therapists (Gamble, Pearlman, Lucca, & Allen, 1994; Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995). This finding may be explained by a reluctance to seek supervision or support because of feelings of shame, incompetency, and anxiety as a result of experiencing vicarious trauma symptomology (Neumann & Gamble, 1995; Pearlman & Mac Ian, 1995).

Such findings are consistent with burnout literature (emotional exhaustion, depersonalization, reduced sense of personal accomplishment) which suggests being younger or less clinically experienced is positively correlated to higher burnout rates (Ackerley, Burnell, Holder, & Kurdek, 1988). Greater experience has been correlated with fewer disruptions in self-trust, self-intimacy and self-esteem then newer therapists (Pearlman & Mac Ian, 1995). This finding may be explained by disrupted schemas becoming less so over time or conversely, experienced therapists with disrupted schemas having left the field and thus being unaccounted for in current studies. However, treatment of acutely unwell individuals in the space of a short hospital admission may present significant difficulties for therapists whether experienced or new to the field. The constant flux of patients means inpatient therapists rarely provide long-term treatment, and as such are less likely to witness significant progress in their patients before discharge.

The notion of vicarious posttraumatic responses clearly resonates with trauma focused therapists and has repeatedly been captured by qualitative research (Kadambi & Truscott, 2004). For example, all female sexual assault therapists interviewed in Steed and Downing's (1998) study reported negative work related affective responses (e.g., anger, pain, frustration, sadness, horror and shock), somatic complaints (e.g., low energy, poor sleep), and posttraumatic stress related symptomology. Thematic content analysis revealed schematic disruption across themes of increased vulnerability, suspiciousness, loss of faith and trust in fellow man, and alterations in sense of self identity. Changes in cognitive schemas regarding safety and lack of security, world view, awareness of power/control, and lowered trust have also been reported through semistructured interviews with domestic violence counselors (Iliffe & Steed, 2000). Mirroring these findings, Benatar (2000) reported negative changes to relationship with self, and isolation from others in highly qualified trauma therapists. Lay counselors have also reported lasting changes around tolerance, interpersonal relationships, and changes in beliefs which they felt were triggered by the provision of therapy (Ortlepp & Friedman, 2002).

Discrepancies regarding the pervasiveness, scope, and severity of vicarious trauma have been reported when a mixed qualitative and quantitative approach has been used. For example, when interviewed, mental health workers reported viewing therapeutic

work as traumatizing. However such perceptions were not conveyed by quantitative measure of distress (Sabin-Farrell & Turpin, 2003). This discrepancy may be explained via a lack of sensitivity, or poor reliability and accuracy of self-report questionnaires (Steed & Downing, 1998).

In contrast to reports of negative posttrauma outcomes, numerous researchers have suggested the majority of health professionals are not adversely affected, emotionally or psychologically, by their clinical work (Coster & Schwebel, 1997; Elliott & Guy, 1993; Raquepaw & Miller, 1989; Thoreson, Miller, & Krauskopf, 1989). For example, only 5% of mental health professionals working with sexual violence, cancer, and general clients reported elevated levels of traumatic stress (Kadambi & Truscott, 2004). Moreover, there was no difference in traumatic stress symptomology across the clinical populations. Further research is required to clarify these discrepancies and explore the full range of post trauma responses in therapists.

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

Further inadequacies are evident through the attempted application of causal disease models of mental distress and classification through narrowly defined treatment parameters. These parameters frame psychiatric care as a succession of distinct interventions that can be analyzed and objectively measured independent of context (Bracken et al., 2012; McCready, 1986). Unfortunately, this approach fails to recognize the psychosocial complexities of trauma therapy and the therapeutic relationship as an interpersonal process characterized by unconditional regard, empathy, compassion and therapist congruence (Elkins, 2009). Similarly, it ignores the potential for compassion satisfaction (satisfaction and pleasure derived from working effectively: Stamm, 2010). To date, little research has been dedicated to exploring the impact of exposure to complex trauma work when therapists are constrained by the limitations of a first world medical model approach to trauma intervention.

Although the risk of psychopathology exists, research exploring adverse responses to traumatic experiences often reveals a paradox in which many who report negative outcomes also report areas of posttraumatic growth (Seligman & Csikszentmihalyi, 2000). Posttraumatic growth has been conceptualized as a transformative engagement with the existential challenges of life through areas of autonomy, relationships, personal growth, life purpose, mastery, and self-acceptance (Durkin & Joseph, 2009; Joseph & Linley, 2005; Ryff, 1989; Ryff & Singer, 1996; Keyes, Shmotkin, & Ryff, 2002; Tedeschi, Park, & Calhoun, 1998). This transformation reflects increased psychological well-being (PWB), over and above subjective well-being (SWB) and the medical model's focus on emotion regulation and symptom alleviation (Durkin & Joseph, 2009).

Earlier research exploring the construct of posttraumatic growth recognized three domains: (a) improved interpersonal relationships, (b) enhanced view of self and self-worth, and (c) positive changes in life philosophy, values, and beliefs (see Joseph, 2012). With the burgeoning literature into vicarious posttrauma growth, similar positive gains such as redefined values, beliefs, sense of self-identity, and worldview, are described following vicarious exposure to trauma (McCormack, Hagger, & Joseph, 2011). Inclusive in this literature is the potential for positive outcomes following vicarious trauma in wives of prisoners of war (Dekel & Solomon, 2007), wives of Vietnam veterans (McCormack et al., 2011), adult children of veterans (McCormack & Sly, 2013), interpreters (Splevins, Cohen, Joseph, Murray, & Bowley, 2010), disaster survivors (Linley, Joseph, Cooper, Harris, & Meyer, 2003), humanitarian aid workers (McCormack & Joseph, 2013), and therapists (see Brockhouse, Msetfi, Cohen, & Joseph, 2011).

A systematic review of 39 studies by Linley and Joseph (2004) suggested that positive change is commonly reported in around 30% to 70% of survivors of various traumatic events, including transportation accidents (shipping disasters, plane crashes, car accidents), natural disasters (hurricanes, earthquakes), interpersonal experiences (combat, rape, sexual assault, child abuse), medical problems (cancer, heart attack, brain injury, spinal cord injury, HIV/AIDS, leukemia, rheumatoid arthritis, multiple sclerosis, illness), and other life experiences (relationship breakdown, parental divorce, bereavement, immigration). They also reported that growth is associated with personality traits such as optimism, extraversion, positive emotions, social support, and problem focused, acceptance, and positive reinterpretation coping.

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

With this in mind, the current phenomenological study explored the 'lived' experience of four trauma-focused therapists working with mental health inpatients with complex trauma histories. As the authors were seeking the participants' interpretation of this unique phenomenon, the reiterative, funneling, and double hermeneutic approach of interpretative phenomenological analysis (IPA; Smith, 1996) was used. Unlike grounded theory, which aims to generate theory from data in the process of conducting research, or a discourse analysis approach, which focuses on deconstructing expressions and conversations as a way of understanding social interactions, IPA, underpinned by critical realism, stresses the importance of alternative subjective positions and different ways

of making sense of the world (Blaikie, 2000) and thus draws on a process of iterative interpretative activity. The interview data provided a detailed insight into the participants' meaning making from their vicarious exposure to trauma within a medical model, both positive and negative.

Using semistructured interviews each participant/therapist detailed how their work with trauma survivors within the confines of a medical model had affected their personal and professional lives. IPA aimed to identify pervasive schematic changes reflective of both positive and negative interpretations particularly the impact of pathologizing conceptualization of trauma experiences in clients on therapists' psychological well-being.

Method

Participants

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

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

Procedure

A purposive strategy was used to recruit participants for whom vicarious exposure to acutely unwell mental health inpatients with trauma histories was both relevant and held personal significance. Participants were sourced through professional word of mouth within two inpatient psychiatric hospitals. Following ethical approval, willing participants were contacted to explain the study. A semi structured interview schedule was developed using the "funneling" technique of IPA (Smith & Osborn, 2003). The second author carried out each audio-recorded interview in the location and time of the participants choosing. Each interview lasted between 1 hour and 1 hour 20 minutes. The interviews were conversational in nature allowing time for subjective reflexivity, exploratory prompting, clarification, and empathic support. Each interview followed the direction of the participant with questions adapted in respect to the participants' responses. This process allowed the interviewer to explore any interesting and significant narratives that arose. Participants were invited to offer a rich and detailed account of both positive and negative changes arising from their vicarious exposure to inpatient trauma narratives. All interviews were transcribed verbatim by the second author, providing the data set for analysis.

Analytic Strategy

The phenomenological and hermeneutic qualitative approach of IPA (Smith, 1996; Smith, Flowers, & Osborn, 1997; Smith & Osborn, 2003) was used in this study. This approach provides a flexible set of guidelines adaptable to the specific aims of the researcher. Table 1 provides the step-by-step stages of this analytic process. Following the analytic stages described by Smith and Osborn (2003), each interview was transcribed and analyzed individually. First, each transcript was read with first impressions recorded in the left-hand column of the transcript. Second, fresh readings focused on gaining a detailed understanding of psychological concepts while mapping specific emergent themes/phrases. Third, themes and labels were clustered through a thorough and deductive analysis. Care was taken not to lose the participants' own words in the researchers interpretation of the narrative. Fourth refinement of understanding and interpretation of the data led to the development of a table outlining super and subordinate themes. A descriptive analysis, which treated the transcripts as one data set, then followed. In accordance with IPA guidelines, independent

Table 1
Stages of Interpretative Phenomenological Analysis Process

Stage	Process
1	Repetitive listening to recorded interview, transcribing verbatim, and preparing the first transcript.
2	Interpretation of transcript by paraphrasing and summarising the participant's phenomenological and hermeneutic experience followed by annotation of emerging themes. Each author independently audits each transcript before joint discussion.
3	Robust discussion between authors to agree on themes of first transcript leading to any superordinate and subordinate themes.
4	Stages 1, 2, and, 3 repeated for each transcript searching for convergence and divergence and clustering of themes that supported evidence of a superordinate theme.
5	Exploration of overarching higher theme "Therapeutic Integrity and Vicarious Growth". Listing of emergent themes for connectedness.
6	Further examination of higher theme, assessing its relationship and links to the agreed super and subordinate themes.
7	Clustering of themes around concepts and theories.
8	Analysis continues throughout write-up with attention to biases and presuppositions of either author likely to impinge on interpretation.
9	Narrative account embedded with rich data extracts to validate thematic analysis and interpretation.

analyses were conducted by the first and second authors before robust discussion occurred to concur on emerging themes and argue biases and preconceptions. Audit trails from both authors gave credibility to the analysis, which ensured that interpretations were grounded in the text (Glaser & Strauss, 1967).

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

Results

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

Severity, Complexity, and Repetition

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

Table 2
Overarching Superordinate Theme: Therapeutic Integrity and Vicarious Growth

Subordinate themes
• Severity, complexity, and repetition
• Personal distress and the medical model
• Intrapersonal confrontation
• Growth

> And the more traumatic the story the more tiring that is because you're trying to empathize and also understand and not look horrified. I think that's the other thing you're sort of trying to not sort of judge the patient.

Sensitive to their own vicarious responses, participants described flashbacks, nightmares, fatigue, intrusive thoughts, and avoidance coping similar to those reported by their patients. Intense feelings of anger, anxiety, and sadness were reported during patient engagement, and for days to years following. At times, horrific trauma narratives kept them struggling to maintain genuine empathy and support for their patients:

> So then I get angry when I hear about what they've gone through in that moment or I get sad . . . it's been hard . . . I would have trouble staying present, I would have trouble staying connected, I would get tired.[1]

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

> Well I don't know whether I'm desensitized to it or like I'm just chronically traumatized . . . So it's hard for me to say whether it's like locked and shelved like in a pathological sense or whether it's just a um . . . a desensitization in some sort of healthy sense that I'm more able, more able to rapidly assimilate that sort of stuff because of just chronic exposure.

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

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

Personal Distress and the Medical Model

Although the first theme captured distress through vicarious exposure to complex and severe inpatient presentations, what also emerged was frustration, distress, and a sense of threat to the participants' moral integrity. Working within a medical model embedded in first world psychopathological practices and subject to the dictates of categorization and prescriptive practices, bred self-doubt, guilt, and a sense of failure. Horrific stories, acute treatment timeframe, the artificial therapeutic relationship, and a diagnose-treat-discharge approach to patient care left the participants feeling de-skilled and complicit in their patients' distress. Limited by what they came to believe were artificial objectives they recognized that success as a return to an ideal state of being

[1] '. . .' indicates pause in speech.

was not realistic in respect to inpatient complex psychosocial trauma:

> You know this trauma work takes years and years to work through.

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

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

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

> Sometimes you will stop asking questions because you're not going to be there . . . how much do you ask because you're not going to be there to pick up the pieces.

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

> As a consultant you sort of feel that the buck stops with you.

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

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

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

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

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

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

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

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

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

> You're just one person trying to make an indent on that and you're probably not going to make a difference as an inpatient psychiatrist.

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

> All you're doing really is bandaging the situation rather than having any long term sort of impact.

Intrapersonal Confrontation

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

> Sometimes the biggest impact is when you really connect in a particular moment um . . . and there's been a shift then in the therapy.

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

> Drugs won't fix it for her . . . it's the therapy. It's the containment of therapy that's going to be helpful.

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

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

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

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

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

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

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

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

Growth

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

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

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

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

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

> It makes you appreciate your life and appreciate where you're at.

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

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

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

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

Discussion

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

The participants of this study experienced significant psychological distress as they struggled to maintain genuine empathy, support, and compassion in the face of chronic exposure to uniquely complex and severe inpatient presentations. Reports of vicarious distress are hardly surprising given the growing body of research describing negative outcomes in therapists following vi-

carious exposure to client trauma narratives (see Arnold et al., 2005). However, what is noteworthy and unique to this study are the participants 'lived' experiences of frustration and distress arising through exposure to complex trauma within the constraints of a first world medical model of therapeutic intervention.

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

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

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

Although seemingly valuable, this dichotomy further serves to focus research and practice on the alleviation of negative symptomology to the exclusion of promoting positive well-being. Pressure and therapeutic constraint to adhere to this dichotomy, while simultaneously recognizing the limitations to "fixing" patients within this model, cultivated a sense of futility, failure, and disappointment. Participants came to reflect on the medical model's failure to consider their therapeutic practice, and the therapeutic relationship as an interpersonal process characterized by unconditional regard, empathy, compassion, and therapist congruence.

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

Limitations

This qualitative study is not without limitations. Phenomenological investigations provide an alternate approach to positivist methods by providing an understanding of individual subjective distress. However, unlike nomothetic studies we are unable to generalize findings, nor infer cause and effect. Although generalizing the experiences of these participants would be inappropriate, our results suggest the negative impact, and the positive benefits to self-integrity when working with complex trauma in an inpatient settings governed by the medical model are important findings of this study.

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

As the data for this study came from females only, future studies might consider the responses of males to such work. This is particularly of interest and may lend insight into a minority group within many areas of mental health services.

Conclusions

Overall, this study offers a unique insight into how an individual therapist might redefine their own vicarious exposure to trauma as personal and psychological growth. It opens the 'black-box' of interpersonal relationships within a therapist/client context highlighting the potential for both vicarious trauma and psychological growth. As such it adds to earlier findings where personal benefits and positive changes can arise through vicarious exposure in therapists (Arnold et al., 2005; Brady et al., 1999; Linley, Joseph, & Loumidis, 2005; Pearlman & Saakvitne, 1995; Schauben & Frazier, 1995). Similar to recent studies with wives of veterans (Dekel & Solomon, 2007; McCormack et al., 2011) and Humanitarian Aid Personnel (McCormack & Joseph, 2013), it recognizes that therapists in their role of caring are equally susceptible to their own mental health concerns. Importantly, this study raises awareness of the individual therapist's struggle with self-identity and integrity, when constrained by their position within a hierarchical medical model. Social psychologists have provided insight into the defining and redefining of individual identity when roles in society, group membership, and personal characteristics collide (Heise & MacKinnon, 2010; Burke, & Stets, 2009). Without professional organizational support, therapists within inpatient settings may be at risk of poor self-actualization and chronic psychopathology as they struggle to make sense of their distress from vicarious traumatic exposure, and marry their personal and professional identities.

Nevertheless, this study also provides hope, that with time, therapeutic integrity can challenge personal vicarious distress and organizational/professional constraints, through renewed altruism, the relational connection, and honesty. Compassion, gratitude, and humility also appeared to facilitate wellbeing and psychological growth, domains of growth only recently recognized in the literature (see Joseph, 2012). Therefore, with reflective insight and organizational support, exposure to trauma in the course of the working life has the potential to positively, as well as negatively,

transform the therapist's inner world, inclusive of schemas, beliefs, and values, leading to lasting psychological and emotional change (Figley & Stamm, 1996; Pearlman & Saakvitne, 1995).

These findings highlight the potential benefits of a reciprocal relational approach to psychological intervention for therapist well-being within the inpatient system. Additional research may seek to further capture the impact that working within the medical model has on therapists and care professionals while detailing how a medicalized framework may impede or facilitate opportunities for personal growth following adversity. Notably, limitations to therapeutic success within the medical model significantly contributed to therapist distress and well-being. Importantly, it would seem that vulnerable individuals, often seen as experts within the medical model, may not readily seek support, and employing organizations may not provide the necessary supportive framework for nurturing growth in their staff. With greater awareness, distressed therapists working within the medical model of care, exposed to others' traumatic history, may find greater professional autonomy for building relational strengths within therapy, contributing to wellbeing in both therapist and client.

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Received October 16, 2014
Revision received January 9, 2015
Accepted February 3, 2015 ■