A portfolio of academic, therapeutic practice
and research work

Including
'Exploring growth outcomes in the aftermath of
rape: An interpretative phenomenological analysis'.

by
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Practitioner Doctorate (PsychD) in Psychotherapeutic and Counselling Psychology.

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Introduction to the research dossier

**Literature review:** Posttraumatic growth after the experience of being raped: A review of the literature.

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*N.B. copy of one transcript appears in accompanying confidential appendix*

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Appendix 1: Further information provided to respondents at first contact and screening questions
Appendix 2: Interview schedule; consent form; socio-demographic form
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Appendix 4: Ethical approval letter and details of target journal
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*N.B. copy of one transcript appears in accompanying confidential appendix*
Introduction to the portfolio

This portfolio shows my ongoing personal and professional development as a counselling psychologist over four years of training. It is divided into three dossiers covering aspects of training; theory, practice and research. The work included reflects areas of personal interest, which have evolved over the course of my training and influenced my development.

Before introducing the material in each dossier, I would like to place my portfolio in context by describing my pathway to becoming a counselling psychologist. I grew up in a troubled family, where the house often felt like a stage for my parents’ drama and we (the children) were the audience. These were difficult experiences, but looking back seem the beginnings of an interest in relationships as well as a need to feel connected and intimate with people. I think that this experience of “looking on” from outside also evolved, with training, into a capacity to try and understand clients by observing as well as participating in our relationship. I wonder if I also wanted to become the therapist I didn’t have during this part of my life.

I enjoyed studying psychology as an undergraduate although much of the course content seemed detached and objective, as if people could be broken down into “parts” and studied or measured. However, in my final year I did a counselling psychology module, which introduced me to integration and the importance of relationship. I felt excited by these ideas and after graduating, began a counselling diploma (person-centred) to “test out” whether becoming a therapist seemed right for me. I also knew that a counselling psychology training would involve leaving Scotland, and didn’t feel ready yet to leave my home and friends. I loved the humanity of the person-centred way of being and relating and also its contribution in a culture where rationality seems over-valued. My client work, the encounter and experiential groups and personal counselling all underlined the power of the core conditions and importance of developing an openness to myself. However, I felt uneasy staying with just one model and at the PsychD open day, liked how we were invited to consider holding multiple, often contradictory, “truths” about clients, although this also seemed a real challenge.
I'm glad that I have studied counselling psychology, which gave me the freedom to try out different approaches and see what they can teach me and how they fit with my personal style. It also showed me that there are many ways of working and that the client and our relationship are the most important parts of the work. I am also glad to have had experienced a quite long personal therapy and to have used it to explore my fears and anxieties so that now I feel more equipped to take my own path. The course also encouraged me to develop my knowledge of theory, produce research and develop personally through my practice, supervision, therapy and experiential learning, explored in my clinical paper.

Indeed, turning to my portfolio, this is divided into an academic, a therapeutic and a research dossier. Each will be introduced separately to provide an overview for the reader.

**Academic dossier**

The first essay, entitled 'To what extent can traumatic events be viewed as developmental opportunities? What are the implications of such a position for counselling psychologists working with clients who have experienced trauma?' marked the beginning of my exploration of the concept of posttraumatic growth. I liked this idea, which seemed culturally ancient and yet quite new to psychology, and used this essay to discover and critically evaluate some of the key papers in the literature, paving the way for my subsequent literature review and research. In this essay, I tried to reflect my interest in this topic but also my concern to avoid taking an overly hopeful, "Pollyanna"-ish stance to people's experiences of trauma.

The second essay, entitled 'Using clinical illustrations, explore contemporary definitions of countertransference and discuss its importance in understanding what the client brings to therapy' considers Freud's original view of countertransference as an impediment to effective therapy and alternative perspectives suggesting that countertransference can be a rich source of information. This essay points to how there are two frames of reference in the counselling room, one person being committed to
attend to themselves as a means to help the other. I chose this because reflecting and
drawing on my countertransference (including bodily sensations and how I hold my
body when I am with clients, as well as my thoughts and emotions) is for me one of the
richest parts of therapy, and I place trust in these processes.

The last essay, ‘In cognitive therapy, how would the therapist understand and work with
the difficulties that arise in the relationship? Illustrate with examples from your own
practice’ considers the therapeutic relationship in cognitive therapy. A safe relationship
where clients feel able to bring all of themselves if they need to is important, and writing
this essay began to challenge my assumptions of cognitive therapy as a mechanistic
approach inconsistent with the philosophy of counselling psychology. It was helpful for
me to start reframing cognitive therapy as having much to say about the therapeutic
relationship, encouraging me to find my own style in CBT.

Therapeutic practice dossier

This dossier contains an overview of my four therapeutic placements and my final
clinical paper. I experienced difficulties in my third placement and felt that it never
really got off the ground, although towards the end did some work that I felt able to
stand by. These difficulties however turned out to be fundamental to my processes of
growth and development in my forth year, for example increasing my learning about
myself and showing that I could survive the very real possibility of failure, although
these were also painful lessons. Indeed, in my final clinical paper I attend to the self-
development I needed to do in order to be more available to my clients. When I began
the course, I felt fearful of making mistakes, doing harm, and of failing. It was important
for me to come accept my limits, model that for my clients, and accept their human limits
too. I realised as I was preparing this portfolio that I was feeling anxious and slipping
into my “old ways”, tiring myself by over-polishing and overcorrecting the work
included. Rather than try and portray “perfection” therefore, I have decided to conserve
my energies, use my time more wisely and risk showing a less-than-perfect (but more
honest) picture of my development. My clinical paper also considers my therapeutic
practice and research, as well as an account of my own approach to integrating theory
and research into my practice. I have drawn on some of the personal and professional experiences that shaped my identity and were integrated into my practice to illustrate.

Research dossier

The portfolio concludes with my literature review and two qualitative studies. The review considers whether the concept of posttraumatic growth can be applied to the experience of recovery from rape. I felt drawn to the idea that difficulties can sometimes be survived and drawn from, but uncertain if this could be taken as far as trauma, especially a trauma like rape. I found the literature review a quite daunting task, and although I found it a quite dry academic exercise (in re-reading it, I think this is perhaps reflected in my use of language), I still felt proud that I had got it done. I felt reassured that other female researchers had attended sensitively and persuasively to this topic, because I often questioned whether I was making a serious mistake in exploring recovery from this trauma from a perspective that included “growth”.

The qualitative research was more engaging. Although it felt isolating to travel the country to talk to women, I felt humbled that they trusted me to talk about such a painful and personal experience. I was touched by their stories and by their strength, as well as by how much they still suffered. It was very powerful to do these interviews and I felt totally unprepared for their intensity and the haunting countertransference I took away with me, and the feeling that each interview added to this load. I also felt frustrated and sad that I had therapeutic skills that might help some participants, but had to leave them untouched because I was there as a researcher. I felt naïve for not having foreseen these difficulties, although when I did my final project I found it reassuring to hear that other researchers had felt similarly unprepared for researching this trauma. Both these projects deepened my understanding of how important it is to take care of myself, no matter the pressure I am under to get things completed on time.

In conclusion, I hope that this portfolio gives the reader an impression of my continuing development as a person and a counselling psychologist, as well as giving a sense of my academic development and interests.
ACADEMIC DOSSIER

Introduction

This dossier has three essays, written over three years of my training. These cover the concept of posttraumatic growth from a developmental perspective, an exploration of countertransference as a source of information about what the client brings to therapy, and finally a consideration of the relationship from a cognitive perspective.
To what extent can traumatic events be viewed as developmental opportunities? What are the implications of such a position for counselling psychologists working with clients who have experienced trauma?

Traumas are events involving actual or threatened death or serious injury, or which threaten one’s own or others’ physical integrity, evoking intense fear, helplessness or horror (American Psychiatric Association, 1994). A large literature demonstrates the relationship between experiencing trauma and psychological / physical distress and social problems. Yet, Tedeschi and Calhoun (2000) suggest that this literature may paint an overly negative - even misleading – picture, and that many survivors of trauma seem more robust than psychologists have acknowledged. Traumas may be viewed as transformational, developmental experiences for some, with opportunities for growth as well as damage, suffering and harm (Aldwin, 1994, 2000; Cordova et al., 2001). The term ‘posttraumatic growth’ (PTG) (Tedeschi and Calhoun, 1995) describes this perception of development following traumatic events.

Aldwin (1994, 1998) points out that the view of traumas as developmental opportunities is not new: within existential philosophy, Nietzsche famously suggested that ‘what does not kill me makes me stronger’ and Kirkegaard echoes this, believing that despair is an essential prerequisite for adult development. Major world religions also highlight the transformational potential of experiencing trauma. Suffering therefore appears to have long been represented as an unavoidable, yet also developmental, experience. Aldwin also points to an analogous area within the developmental literature, where a minority of children raised in social deprivation or by parents with severe psychological problems are said to be resilient (Masten, Best and Garmezy, 1990; Garmezy and Rutter, 1988; Velleman and Orford, 1999).

Several studies suggest that trauma can precipitate development in adulthood, with some people describing at least something valuable having arisen from their attempts to deal with (for example) cancer (Cordova et al., 2001; Taylor, 1983); HIV infection (Schwartzberg, 1994); rape (Burt and Katz, 1987; Veronen and Kilpatrick, 1983); incest (Silver, Boon and Stones, 1983); bereavement (Schwartzberg and Janoff-Bulman, 1991; Calhoun and Tedeschi, 1989-90; Lehman, Davis, DeLongis et al., 1993); heart attacks
(Affleck, Tennen and Croog, 1987) and disasters (McMillen, Smith and Fisher, 1997). About two-thirds of samples seem to report at least something valuable arising from their coping efforts, although rates vary as a function of methodology, definitions and the trauma under consideration (Tedeschi and Calhoun, 2000). However, much research relies on self-reports although some people may wish to deny or minimise how extensively they were damaged by trauma, or may respond in socially desirable ways (although some researchers attempt to control for this, e.g. Park et al., 1996; Tedeschi and Calhoun, 1996). Supporting self-reports with data from close others might increase reliability. Likewise, participants may contrast current degrees of functioning with the point when they felt at their lowest, rather than against normal previous functioning, which might exaggerate the amount of "growth" (Cohen et al., 1998). Assessing functioning before a trauma (e.g. in men reporting to their GP with a testicular lump) would minimise this, although huge numbers of participants would need to be involved.

Parkes (1971) characterises traumas as ‘psychosocial transitions' (p. 101), meaning that individuals must ‘restructure [their] ways of looking at the world and [their] plans for living in it’ (p. 102). Some such changes may be valued. For example, Cordova et al. (2001) suggest that ‘having cancer may entail [ ] a shift in life priorities and an increased appreciation of the time and relationships one currently has’ (p. 181). Indeed, Calhoun and Tedeschi (1998b) propose a cognitive model of PTG occurring over two stages. Immediately following a trauma, the "cognitive assumptive world" (e.g. that bad things happen only to bad people) shatters and the person is highly distressed (Janoff-Bulman, 1992). There may be intrusive imagery, thoughts or other traumatic symptoms (described by the posttraumatic stress disorder literature). Over time, many people reduce their distress by coping, and a period of rumination is said to begin, individuals processing and assimilating the trauma and assembling new beliefs about themselves, others and the world, a point at which some may experience PTG. This model may be criticised however (distress may reoccur, rather than be ‘worked through’, and PTG may represent attempts to maintain connections to old beliefs), although seems consistent with existential theory. For example, Frankl (1984) portrays traumas as confrontations with mortality, which may stimulate ‘a search for potential meaning [in life] in spite of
its tragic aspects' (p. 161) – which ‘may arouse inner tension rather than inner equilibrium’ (p. 126).

Self-reports of growth tend to fall into three broad spheres (Aldwin, 2000; Tedeschi and Calhoun, 2000; Tedeschi, Park and Calhoun, 1998). Self-perceptions may fundamentally change: whilst individuals may feel distressingly aware of their mortality and vulnerability, some may also feel more resilient (Tedeschi and Calhoun, 1996). Relationships with others may change, individuals reporting greater closeness, expressiveness or empathy (Calhoun and Tedeschi, 1989-1990). Finally, changes may occur in philosophy of life, with unimportant problems placed in perspective or values reappraised (Aldwin, 1998, 2000; Taylor 1983). Existential changes may transpire, with life appreciated as precious and finite and greater possibilities recognised (Tedeschi and Calhoun, 1995). Changes here may also include an awakening or deepening of religious/spiritual beliefs (Park et al., 1996). These areas seem interlinked; for example, receiving social support may increase self-esteem and existential changes may eventually lead to experiences of deepened relationships.

Whether self-reports of PTG have any association with measures of psychological/physical health seems unclear, since few studies explore this and the findings conflict. Several studies suggest a small association (Affleck, Tennen and Rowe, 1991; Affleck et al., 1987). For example, McMillen, Zuravin and Rideout (1995) related perceptions of ‘benefit’ (p. 1037) following child abuse to current adjustment in 154 women. Those perceiving high levels of benefit (feeling better able to protect children and themselves, being more knowledgeable about sexual abuse, becoming a stronger person) were better adjusted (in terms of self-esteem, relationship anxiety and comfort depending on others) than abused women who perceived no benefit. Ninety percent of those women reporting benefit also acknowledged having been damaged.

However, some ‘benefits’ - controlling access to children, feeling ‘cautious (and) ... suspicious’ (p. 1040) around others and refusing to trust men – may suggest damage, not development. The authors propose that these changes signify growth in this population: participants were from a deprived urban area, many with Child Protection Services
involvement. Protecting themselves and their children by mistrusting others may be adaptive, if not developmental. However, studies asking participants open-ended questions about ‘ways in which they benefited’ (p. 1038) from trauma may incur problems; participants may interpret ‘benefit’ very differently, some for example experiencing changes which they do not report as “beneficial’ because they seem so frightening, such as becoming more aware of one’s vulnerability.

Post hoc classifications of participants’ self-reports may also introduce bias: for example, not all researchers may view strengthening of religious beliefs as growth (Cohen et al., 1998). These studies may also lead participants, although Russell (1986), also addressing abuse, simply asked women how their lives had been affected: damage and growth (reprioritising their life, feeling stronger, establishing equality in relationships) were reported. Studies that also include data from other sources naturally have higher validity: Taylor et al. (1984) found a significant relationship between women’s experiences of growth following cancer and improved psychological adjustment compared to women who perceived no benefits. Women’s interview and questionnaire data were supplemented with doctors’ and interviewers’ evaluations of growth, and related to an overall measure of adjustment. However, it is possible that individuals’ personalities determine whether or not they see themselves as having “grown”, rather than experiences of growth paving the way for better adjustment (Cohen et al., 1998).

Not all studies associate PTG with adjustment (e.g. Cordova et al., 2001; Joseph et al., 1993). Lehman et al. (1993) studied 94 people bereaved of a partner / child in car accidents 4-7 years previously: those describing positive changes were ‘not less likely to report a range of psychological symptoms [or] more likely to report happiness’ (p. 106, emphasis in original) as those who did not, although the bereaved group might still have been coping with their losses, suggested by their poorer adjustment compared to non-bereaved controls. Perhaps the positive changes they reported were attempts to reappraise the situation differently rather than reflecting “real” growth (Cohen et al., 1998). Coping and PTG are related but distinct: distress must be managed before any PTG can be acknowledged (Park, 1998), although as coping reduces distress, the richest period for growth may conclude (Calhoun and Tedeschi, 1998b).
The data here are not in agreement and how long growth experiences may persist is also unclear. Calhoun and Tedeschi (1998a) suggest that PTG may be related to adjustment in certain areas only, or that there is no predictive relationship, but point out that perceiving PTG has at least never been associated with negative adjustment. Many studies are also cross-sectional or retrospective yet patterns of growth, and any predictive relationships, might be better discerned by longitudinal designs, especially as PTG is a developmental *process* occurring over time. Longitudinal designs might also allow the influence of factors such as "personality traits" to be considered (Cohen et al., 1998) although others debate the usefulness of this (Saakvitne et al., 1998). However, longitudinal designs come with their own problems, as outlined above.

Viewing trauma developmentally suggests that psychologists can be open to (but not invested in) the possibility of growth, and therapy may facilitate this process (Danish and D'Augelli, 1980). Psychologists who are familiar with PTG may recognise that clients' reports of growth do not *necessarily* indicate denial or minimisation and may be prepared if and when a client begins to discover growth (Calhoun and Tedeschi, 1999). They may also be aware that, whilst experiencing distress and growth seems paradoxical, this is common and that positive and negative outcomes seem independent dimensions (Lehman et al., 1993). Yet, psychologists should not try and introduce growth or rush clients towards this (Calhoun and Tedeschi, 1998a). Many clients will not experience growth, and psychologists should avoid implying that this is expected: cancer patients often feel angered by the "tyranny of positive thinking" (Cordova et al., 2001). Yet therapists who are aware of the possibility of PTG may follow clients' lead in identifying areas of valuable change, using sensitively-timed, considered interventions.

An eclectic / integrative approach may lend itself to working with PTG (Herman, 1992). Traumas are naturally experienced as unwanted and distressing and therapists can first offer a "holding" environment (McCann and Pearlman, 1990). Cognitive-behaviour therapy may be useful to address high levels of anxiety and posttraumatic stress disorder although some clients will find being listened to and supported more important. Clients are likely to experience extreme distress, which may recur, and psychologists may need to contain this as well as hear disturbing details, meaning that
supervisory and therapeutic supports seem particularly important (Calhoun and Tedeschi, 1999).

Once distress becomes more manageable, clients may begin to consider their assumptions about themselves, others and the world, which were shattered by the trauma (Janoff-Bulman, 1992). In reviewing these, some may describe early perceptions of growth. There may initially be few observable changes to corroborate these reports yet respecting clients' experiences - even if they seem illusions - may foster hope and self-esteem (Calhoun and Tedeschi, 1998a, 1999). Asking clients how they have experienced and dealt with traumatic experiences before may help psychologists identify clients who can use trauma developmentally, although this may also depend on the nature of the previous (and current) traumas. Allowing clients to lead the process (e.g. avoiding mentioning growth unless clients do), using reflections at first and then well-timed, sensitive interventions may also minimise the possibility that interventions will be rejected or misunderstood (Calhoun and Tedeschi, 1998a). It may also be important to explore any social pressures to abandon 'victimhood'. Psychologists may also help identify and clarify any areas of growth reported and frame these as having arisen from their efforts to cope with the trauma, not from the trauma itself (Calhoun and Tedeschi, 1999).

Clients may eventually be helped to develop a narrative incorporating the traumatic experience into their life (Saakvitne et al., 1998). Meaning may emerge as clients retell their narrative and connections are made between old and new identities (Saakvitne et al., 1998). In the process of developing a narrative, opportunities for change may be identified. For example, survivors of rape may wish to explore other occasions when they had felt victimised, which could be explored (Veronen and Kilpatrick, 1983). However, searching for meaning in a trauma such as rape may be impossible for some people, and others may make sense of this experience by blaming themselves ('this wouldn't have happened if I'd been more careful') (Janoff-Bulman and Frantz, 1997). Whilst therapists can challenge such conclusions, this highlights how searching for meaning may not always be a developmental or helpful experience (Frankl, 1984).
Some clients may use religious/spiritual beliefs to find meaning. Pargament (1990) suggests that religious beliefs are usually robust and although faith may weaken immediately after a trauma, often it deepens in the long-term. Faith may also provide a framework within which suffering can be integrated and meaning located. Psychologists can help clients explore how their faith - or existential beliefs - have changed, provided that psychologists are comfortable engaging with these areas.

Such a therapy might be quite long and justifying it might depend on finding a robust relationship between PTG and good adjustment, although helping clients consolidate growth seems a helpful process (Linley and Joseph, 2002). However, Cruess et al. (2000) describe a time-limited (20 hours) cognitive-behavioural therapy (psycho-education, skills training, group discussions) for women being treated for breast cancer. Ways in which the cancer had ‘made positive contributions to their lives’ (p. 304) were assessed by questionnaire. The authors found that ‘intervention-induced positive growth changes [were] related to cortisol reductions’ (p. 306). How the intervention contributed to greater benefit-finding is unclear, however, and attempting to stimulate growth in clients this way may be risky (see above). Overall, more information is needed concerning whether, and is so how far, therapy can facilitate growth (rather than coping), what form interventions might take and their timing and whether working with traumatised people this way involves any risk of causing harm.

In conclusion, it seems possible to argue (if only modestly) for a view of traumas as developmental experiences, involving - for some people - growth and change, as well as suffering, harm and loss. Indeed, this perspective is not recent, having lengthy cultural and historical roots. However, many people do not experience growth following traumatic events and perhaps engaging with, for example, existential issues remains (understandably) frightening and threatening (Golsworthy and Coyle, 1999). It is clear that there are also oversights in the literature on PTG; for example, the extent to which any development may occur following trauma is uncertain, and “typical” patterns of gains and losses remain unidentified. Aldwin (1998) suggests that all these need to be addressed if PTG is to be established as a reliable phenomenon. But despite these
potential difficulties, this remains a rapidly growing area and may be a potentially rewarding and engaging one for counselling psychology research and practice.
References


(Discuss an aspect of the therapeutic relationship in relation to psychoanalytic ideas):

Using clinical illustrations, explore contemporary definitions of countertransference and discuss its importance in understanding what the client brings to therapy.

Introduction

What is meant by ‘countertransference’ has been revised several times although broadly this concept refers to ‘those thoughts and feelings experienced by the analyst which are relevant to the patient’s internal world and which may be used [ ] to understand the meaning of his patient’s communications’ (Bateman and Holmes, 1995, p. 109). This essay explores the challenges to Freud’s view of countertransference from the British object relations school, how countertransference can help understand clients, and projective identification, a specific form of countertransference.

Freud’s view of countertransference

Freud (1910) considered countertransference a hindrance to therapy, recommending that analysts be as “pure” as possible, blank screens onto which clients could project unconscious feelings or attitudes and transfer their experiences of significant past relationships. It was assumed that, in doing so, ‘no corrupting and prejudiced feelings and ideas at work in the therapist either interfere with the process of therapy or hinder the objective perception of the patient’ (Rowan and Jacobs, 2002, p. 17). Therefore, countertransference feelings were seen to cloud the therapist’s ability to neutrally and accurately receive the client’s unconscious communications, as if tainting the therapeutic relationship with her¹ own unresolved issues.

Freud did not really define countertransference although recognised two forms: the therapist’s own transference onto the client (e.g. treating him as an important historical figure) and her responses to the client’s transference (e.g. having sexual dreams about a client in response to the client’s own unconscious attraction to her). He saw both as

¹ For the sake of convenience, the therapist is always assumed to be female and the client male.
potentially dangerous, needing to be recognised and overcome (or at least managed) in personal analysis (Gorkin, 1987). Freud therefore seemed not to recognise the potential for using countertransference to gain insight into the client’s unconscious process. Indeed, he treats the therapist’s and client’s responses as separate rather than mutually interacting parts of the therapeutic encounter, assumes that countertransference responses are unhelpful and that additional personal analysis can restore the therapist’s neutrality (Freud, 1910). Little describes this cautious stance towards having emotional reactions (although not cognitive associations) towards clients as ‘phobic’ (1951, p. 33). Indeed Little, Winnicott (1947) and Heimann (1950) (representing the British object relations school) argued extensively for a paradigm shift, separating the psychoanalytic movement into those accepting their broadened definitions of countertransference and those preferring Freud’s position.

The debate over countertransference: challenges to Freud’s view

Winnicott (1947) distinguishes ‘objective countertransference’ (p. 195) from more subjective experiences (which, like Freud, he thought indicated a need for more personal analysis). Objective countertransference comprises ‘the analyst’s love and hate in reaction to the actual personality and behaviour of the patient, based on objective observation’ (p. 195). This refers to the tendency of very damaged clients to induce hatred, resentment and fear, ‘crude feelings’ (p. 196) that most therapists would experience in response to the client’s conscious and unconscious provocations. These feelings reflect natural, expectable responses to the client’s transference, personality or style of relating and do not stem from the therapist’s ‘unconscious hate [associated with her unresolved] inner conflicts’ (p. 196), an argument relieving much of therapists’ shame and fear regarding their countertransference. Winnicott also suggests that therapists become aware of and quietly ‘bear’ (p. 198) their own and their client’s hatred until this can be safely disclosed, informing the client about his impact on others and allowing the alliance to survive.

Winnicott also refers to ‘identifications [ ] belonging to an analyst’s personal experiences and [ ] development’ (p. 195), which allow every therapist to offer something distinct
and precious as they identify with a particular part of the client which another therapist may be unable to resonate with. This recognises therapists' individual personality and growth, whereas Freud, interested in minimising the influence of countertransference, might be described as attempting to eliminate the therapist's self as much as possible within the therapeutic relationship (Rowan and Jacobs, 2002). It also explains why a particular therapist may be the right helper for a client.

Heimann's work (1950) 'remains a cornerstone of contemporary thinking about countertransference' (Bateman and Holmes, 1995, p. 110), since she suggested that, rather than obstructing therapy, emotional responses could become 'an instrument of research into the patient's unconscious' (1950, p. 81). Heimann recognised that 'many candidates are afraid and feel guilty when they are aware of feelings towards their patients and consequently aim at [ ] becoming completely unfeeling and detached' (p. 81) (echoed by Little, 1951). Instead, she suggests that the therapist's unconscious understands that of the client and that this deep attunement generates feelings which the therapist holds and reflects on, gaining insight into the client's otherwise seemingly-incomprehensible conflicts and defences.

Stressing the value of emotional responses, Heimann suggests that countertransference includes all the feelings, attitudes and associations experienced in response to the client's communications and behaviour (a "totalistic" view, as opposed to Freud's "classical" stance) (Kernberg, 1965). However, this sweeping definition may be problematic, unless one also categorises all the client's responses to the therapist as transference, ignoring interactions within the "real" relationship (Gorkin, 1987). Heimann recognised but did not resolve such issues. She later suggested that different sorts of clients induce different sorts of countertransference. Part of the therapist's emotional response to the client can be explained, therefore, as the client projecting elements of his experience into the therapist (elaborated in subsequent work on projective identification).

Little (1951) worked with severely disturbed clients, whom she recognised as highly sensitive to countertransference (and, presumably, also induce powerful countertransference). Like Winnicott, she was interested in therapists' use of their
emotional reactions and recommended a bold way of using them. Little argued that therapists sometimes 'behave unconsciously exactly like the parents who put up a smoke screen, and tantalise their children, tempting them to see the very things they forbid them from seeing; and not to refer to counter-transference is tantamount to denying its existence, or forbidding the patient to know or speak about it' (1951, p. 38).

Therefore, to communicate genuineness, affirm the client’s sense of reality and help him to accept his own transferences, Little suggests that it is sometimes necessary to disclose countertransference. If a client detects a countertransference reaction and comments accurately on it, after exploring his fantasies about this, Little might acknowledge the correctness of his observation (particularly if, as a child, his parents had apparently muddied or denied their emotional reactions to him). However, Little seems unclear about when exactly she would disclose countertransference and nor did she state how disclosing one should be, other than suggesting that she would be more likely to do this later in therapy (presumably when the alliance is most robust and the transference has begun to be “dissolved”). As described, Winnicott (1947) also mentions positive experiences of disclosure, likewise later in therapy.

**Disclosing the countertransference**

There is debate about whether therapists should discuss their countertransference with clients, and if so, how. Most use countertransference “silently”, cautioning against communicating these responses (whether objective or subjective). For example, Heimann (1950) does not recommend disclosing intense reactions, suggesting that countertransference should be kept under the therapist’s control. Samuels (1993) likewise suggests that contemporary use of countertransference might lead to greater self-disclosure than has traditionally occurred, questioning the wisdom of revealing all of one’s responses to clients. Arguments against disclosure include the possibility of burdening clients, providing inappropriate gratification, or distorting the transference. Others suggest that advantages are achievable in other ways (e.g. by exploring the client’s fantasies about the countertransference) and that disclosure reflects the therapist’s needs.
Whilst freely revealing all reactions seems unwise – even humanistic therapists would not reveal all their congruent reactions to a client (Mearns and Thorne, 1999) - selective disclosure may be useful, perhaps clarifying for the client his impact on others (Winnicott, 1947). For example, I disclosed to a client who seemed to project her persecutory, aggressive feelings onto black people that it was sometimes difficult to listen to her views, which made me feel distanced from her. Disclosure can also help to break through therapeutic impasses and “resistance” (Winnicott, 1947; Little, 1951). These reasons seem most applicable to work with very disturbed clients, where boundaries between self and other may be fuzzy and trust low, although Little, 1951, discusses occasional disclosure with “healthier” clients. Advocates of disclosure tend to stress deficits and traumas in the early environment as the causes of disturbance and believe that real, new experiences in therapy help clients to get better: cautiously communicating the countertransference can offer such experiences (Gorkin, 1987).

Countertransference may also be disclosed when gross enactments (e.g. forgetting sessions) occur, or when the therapist becomes aware of a vague reaction which she does not fully understand, wondering aloud if the client has any thoughts on this. Whilst not offering a thoughtful interpretation, this invites the client to “fill in the gap” (Gorkin, 1987). For example, following supervision, I shared a persistent feeling of disconnectedness and emptiness with a client, who acknowledged its familiarity, revealing how, despite appearances, she felt “numb” and “cut off” from people. Whilst such interventions risk frightening clients, they may deepen understanding. However, perhaps more important than disclosure is an openness to emotional responses to clients, which are not denied to oneself or others (Wilkins, 1997).

Redefining countertransference

Returning to the challenges to Freud’s definition of countertransference, Racker (1953, 1957) attempts to redefine countertransference, describing the various reactions that might be expected in work with different clients. He has been criticised for his “mechanistic” approach, although may simply point to the probability of experiencing certain reactions with particular clients (Gorkin, 1987). Like Heimann, Racker takes a
totalistic view of countertransference, defining two types. “Concordant countertransference” occurs when the therapist ‘identifies [] his id with the patient’s id, his ego with the ego, his superego with the superego’ (1957, p. 311). This helpful response derives from empathic resonance with the client, allowing the therapist to attune, rather like Stern’s (1985) concept of “affective attunement” between mother and child which enables the mother to “read” her baby’s emotional state and respond, which in turn is understood by the baby.

However, another type occurs if the therapist unconsciously identifies with one of the figures in the client’s history or internal world, who the client feels negatively about. She may then behave how the client expects, drawn in by his unconscious provocation. These ‘complementary identifications’ (p. 312) share much with projective identification (below), reflecting what the client feels about, or is doing to, the therapist. Although potentially interfering with therapy, if the therapist can recognise, detach from and reflect on this experience (rather than enact it), complementary countertransference may lead to helpful emotional insights. Avoiding complementary identifications is hard, since (despite what Freud implies) even after extensive personal therapy unresolved conflicts may remain and sometimes be transferred onto clients (just as some clients constantly induce therapists to respond in complementary ways to their difficulties) (Racker, 1953).

Racker does not explore whether countertransference should be disclosed. His ideas are developed by Clarkson (1991), combining her distinction between “proactive” and “reactive” countertransference (whether the therapist proactively introduces her own transference, or responds to the client’s unconscious) with complementary and concordant countertransferences, defining four types of countertransference. Clarkson suggests that it is essential that therapists learn to distinguish between proactive and reactive countertransferences, although acknowledges that this is difficult.

**Projective identification: a specific instance of countertransference**

The revisionist view of countertransference is strongly associated with projective identification, which addresses the “objective” component of countertransference (why
some clients evoke strong, disturbing reactions, e.g. boredom, hate or hopelessness) (Gorkin, 1987). Once considered problematic, projective identification is now seen as another way to understand what may be happening for the client. Originally a Kleinian concept (1946), it enjoys wider usage and is thought to occur particularly with clients who are regressed to / fixated at the paranoid-schizoid position and who are relatively unaware of self-object boundaries. Several authors (Heimann, 1950; Racker, 1953, 1957; Money-Kyrle, 1956) also point to its occurrence with healthier clients as, occasionally, the intensity of the therapeutic relationship induces a temporary blurring of boundaries (Gorkin, 1987).

During projective identification, the client unconsciously projects unwanted aspects of himself into (not just onto) the therapist in order to get rid of or disown them or to communicate what unmanageable feelings are happening for him. In turn, the therapist experiences strong feelings and responses which do not seem quite her own, and may feel “out-of-character”. Over several interactions, she is pressured to become strongly identified with these rejected feelings and representations, and may begin to feel or act in accordance with them. The client really believes that she possesses these characteristics, and responds accordingly (perhaps, for example, feeling persecuted) (Grant and Crawley, 2002).

When projective identification is used as a form of emotional communication, the client needs unconsciously to make the therapist aware of what is happening and seeks a particular emotionally involved knowing and understanding (Bion 1965, 1970). At some level, he knows he is “getting to” her, otherwise may feel that he has not made contact, and will seek clues that the therapist is doing something about his unwanted experience (Gorkin, 1987). The therapist’s work is to contain and process these projections before returning them in a more acceptable form (Ogden, 1982). The client, having re-internalised his projections, now has available new ways of handling disturbing feelings. One of the most important functions of projective identification is therefore to transform intolerable distress into something manageable, which the client can take back in. This “containment” resembles the mother’s sensing of her baby’s unbearable feelings and
doing what is necessary to correct this without retaliating, which the baby re-internalises and experiences as containing (Grant and Crawley, 2002).

Projective identification allows the therapist to experience what the client may be unable to describe, although may need to wait uncomfortably before recognising what is happening (and should reflect on whether personal issues could be evoking this experience). For example, a male client complained that his therapy with me wasn’t working, that he felt worse and wanted ‘a proper psychologist’. Over several sessions, I became increasingly annoyed, withdrawn and defensive, feeling confused and manipulated. In supervision, we recognised how he was perhaps making me feel as his apparently domineering father had made him feel, and I was able to help him to recognise other instances of how he drew others into this sort of relationship. By monitoring countertransference reactions, therefore, therapists can use projective identification as a basis for interpretations, also modelling putting words to feelings and dealing thoughtfully with experiences (Grant and Crawley, 2002).

How this is done matters: a rapid-fire or very deep interpretation might feel to the client as if his unwanted feeling is being flung back at him, implying that it is harmful and cannot be contained and making him more anxious. A stony silence may likewise feel more withholding than containing. The extent to which the therapist can “digest” unpleasant feelings without acting out is also important: if she cannot understand what is happening or communicate effectively, the client may escalate his attempt to make her feel how he was made to feel by important others (Bateman and Holmes, 1995). To avoid internalising or personalising the projections and becoming overwhelmed, hurt or acting out, it is important that therapists understand projective identification, particularly since increasing numbers of damaged clients who use such ways of communicating present for therapy (Grant and Crawley, 2002).

Projective identification is often viewed warily by humanistic therapists, as if it interferes with the therapist’s authenticity and awareness of her “own” inner responses. However, Hart (1999) wonders whether projective identification, whereby the therapist feels “seized” by aspects of the client, resembles the quality of being carried along or
responding in unusual ways which Rogers describes: 'when I can relax and be close to the transcendental core of me, then I may behave in strange and impulsive ways in the relationship, ways which I cannot justify rationally ... But these strange behaviors turn out to be right, in some odd way' (Rogers, 1980, p. 129). Similarly, Mearns describes from a person-centred perspective the experience of being used as a container for a client’s unbearable distress, which he ‘earths’ (Mearns and Thorne, 1999, p. 100).2

Unlike empathy or attunement, where transient identifications allow the therapist to experience the client’s emotions (concordant countertransference), projective identification involves accepting a particular role thrust upon her by the client (complementary countertransference, or Sandler’s “role responsiveness”, 1976). This goes beyond transference: not only does the client interact with the therapist in distorted ways, he induces her to experience herself and to behave in ways that complement these distortions (Klein, 1946). It is also more powerful than projection, which lacks an interactional element (Bateman and Holmes, 1995). Projective identification is therefore ‘at once a type of defence, a mode of communication, a primitive form of object relations, and a pathway for psychological change’ (Ogden, 1982, p. 21).

However, there are problems with the notion of “placing” parts of oneself into others, which implies that the other is like an empty vessel. For instance, the countertransference experienced may not “really” reflect how the client feels, but might be unconsciously transformed as the therapist processes it through her self. Kernberg (1965) suggests that therapists probably feel appreciations of the client’s experience which can be considered, based on what she knows about him and the possible ways she has distorted his projections, and that therapists must be tentative when using projective identification to understand what is happening for the client.

Conclusion

There now seems general agreement (although with different emphasises) that countertransference is not necessarily an unwanted obstacle but can provide useful

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2 This example is included in an appendix at the end of the text (p. 29).
information about the client's unconscious process. Countertransference is a flexible concept (Little, 1951), explaining its multiple meanings e.g. empathic identification, the result of projective identification, responses to the transference, transferences onto the client, or all of one's reactions to a client. It is now also recognised that transference and countertransference are 'linked in an ongoing and reverberating manner' (Gorkin, 1987, p. 56), although there seems disagreement about what, if anything, should be disclosed to clients. Countertransference seems relatively neglected by humanistic and cognitive behavioural therapies, including how the therapist's difficulties adversely affect therapy (these often assumed to have been overcome during training) (Rowan and Jacobs, 2002). Nonetheless, psychodynamic and person-centred approaches agree that therapists' responses to clients are helpful tools, perhaps encouraging explorations about the similarities / differences between these approaches (Wilkins, 1997).
Appendix: example of projective identification from a humanistic perspective

'This case note was written by one of the authors (Mearns) after a session with Bob, a war veteran whose psychological damage had rendered him mute.

... Tonight Bob and I had our most powerful session to date ... it must have been about half an hour later when I found myself crying inside. I could feel it so strongly – I was really choked and yet not a sound came out of my mouth. Everything flashed before me – I knew that my history had some similarities to his. But I also knew that I wasn’t crying for me – my experiences had been similar, but it wasn’t with me then. It wasn’t me crying – it was more like he was crying inside me. And that crying was so very, very strong – and mute. And I looked at him and he looked at me and it felt like love passed between us, from one to the other. (...) I reached out to Bob with both my hands, and he put one of his between them. It was as though the touch had “earthed” all the sensing that was so strong within us. I cried. Not that gentle tear that is often a response to the sadness in a client, but a deep, deep sobbing. I remember being amazed at the strength of this feeling within me, yet, at another level, I knew that it was OK. Slowly, Bob cried too, and eventually his sobbing became screaming... He let his desperation and his fears meet the light of our day.’ (Mearns and Thorne, 1999, p. 100, emphasis in original)
References


In cognitive therapy, how would the therapist understand and work with difficulties that arise in the therapeutic relationship? Illustrate with examples from your own practice.

Traditionally, cognitive therapy considers the therapeutic relationship the means by which clients receive a coherent body of empirically-validated techniques: the relationship breathes life into these, preventing their application from being experienced as mechanistic or dehumanising (Beck et al., 1979). "Collaborative empiricism" enables the client to *discover* that his^3^ perceptions are at odds with “reality”, rather than the therapist pushing this view. Client and therapist work together, testing out the client’s cognitions about self, others and the world in order to bring about helpful changes (Beck et al., 1979). The client is considered to hold important information – observations concerning his thoughts and behaviours - is helped to identify and share these. These are evaluated and, if needed, changed. The therapist possesses specific skills and knowledge enabling the client to uncover his cognitions although does not adopt an expert role, suggested by the importance placed on guided discovery (Corrie, 2002). Highlighting and correcting cognitive distortions is believed to be responsible for change and it is assumed that the client then tests his beliefs outside and reviews his thinking to accommodate disconfirmatory evidence.

A strong alliance enables the client to trust the therapist and engage with his difficulties, so emphasis is placed on establishing this quickly (Beck et al., 1979). The "core conditions" (Rogers, 1957) encourage a climate of openness, trust and honesty, demonstrated by the therapist’s curiosity, commitment and hopefulness. These qualities are assumed to create an optimum environment within which techniques can be most effectively applied, although are considered insufficient to produce change in and of themselves (Beck et al., 1979). They are used to encourage compliance with therapeutic tasks rather than to facilitate self-acceptance (Safran and Segal, 1990). Collaboration also means that the therapist regularly invites feedback, encouraging the client to raise concerns rather than allow these to develop and disturb the alliance.

^3^ Except where specific examples are provided from my practice, the therapist is assumed to be female and the client male.
Beck et al. (1979) describe issues such as client mistrust, hostility, dependency and avoidance as “technical problems”; unwelcome intrusions that impede progress and which can be addressed using problem-solving. Difficulties in the relationship are therefore tackled using cognitive tools rather than the relationship itself. For example, client “resistance” may be due to therapist “failings” (e.g. the rigid application of techniques, inflexible adherence to treatment protocols or poor understanding of the client’s most pressing problems), client “failings” (e.g. forgetting to do “homework” or accept responsibility for their own contribution) or mutual problems such as poor collaboration or colluding to avoid the real issues (Beck et al., 1979). Such problems are viewed as issues that require attending to and ironing out before returning to the original goals of therapy. The therapist may be better able to cope with and to solve such technical problems if she maintains a high frustration tolerance and views difficulties as opportunities to apply her problem-solving creativity, modelling this for the client and encouraging collaboration (Beck et al., 1979).

For example, depressed clients may appear almost willfully stuck and helpless (leading the therapist to feel irritated and the client criticised). The therapist is recommended to confront, identify and ‘correct’ the client’s ‘cognitive distortions which contribute to his passivity, lack of initiative and “oppositionalism”’ (Beck et al., 1979, p. 58). Client and therapist collaborate in identifying and solving such difficulties in the relationship by challenging the client’s distorted views of cognitive therapy, which are considered responsible for his difficulties in accepting help. In this way, it is assumed that most of the work considers problems outside of the therapeutic relationship (Beck et al., 1979; Corrie, 2002).

Some client reactions correspond to concepts of transference and countertransference (Beck et al., 1979). For example, a client may believe that the therapist is too young to understand him, or sees her as a rescuer / ideal partner, which may produce difficulties in the therapeutic relationship. In earlier writings, Beck suggested that, by stressing that the relationship is based on collaboration and a “reality” focus, the therapist can ‘undermine [such] a counterproductive therapist-patient interaction’ (Beck et al., 1979, p. 313). Rather than providing disconfirming evidence (e.g. behaving with exaggerated
concern to a client who apparently feels rejected), the therapist can diffuse transference by raising and exploring the client’s feelings and beliefs and encouraging him to examine their rational basis. Such difficulties are viewed as originating from the client’s distorted cognitions and are managed using cognitive techniques. A client who idealises the therapist can therefore be encouraged to identify his ‘high evaluation and expectations’ (Beck et al., 1979, p. 58) and consider these in light of evidence, helping him see that his image is inaccurate. This reality-testing is assumed to not only enhance the relationship, but provides a “live” example of identifying and examining cognitions (Padesky and Greenberger, 1995).

Some difficulties within the therapeutic relationship may occur as a result of the therapist’s unhelpful cognitions (Beck et al., 1979). The therapist may have blind spots or vulnerabilities, perhaps finding it difficult to remain empathic when a client’s difficulty closely parallels a current personal problem (Padesky and Greenberger, 1995). By using thought records when encountering difficulties in the therapeutic relationship, therapists can become aware of how their cognitions and feelings may impede work, for example, ‘it’s my fault this client isn’t improving’ or ‘working with this client is pointless’ (J.S. Beck, 1995; Beck et al., 1979; Beck and Freeman et al., 1990; Padesky and Greenberger, 1995). These can then be taken to supervision or personal therapy and solutions applied in the next session.

In their more traditional formulation, therefore, cognitive therapists consider the therapeutic relationship a vehicle for the delivery of technical interventions. The relationship is seen as a necessary foundation for change rather than inherently part of it. It is also assumed to develop relatively straightforwardly, but if problems occur - such as if clients do not complete assignments - the therapist is advised to problem-solve, perhaps by discussing goals, the rationale behind assignments, exploring the client’s motivation or identifying and evaluating any distorted views of cognitive therapy (Overholser and Silverman, 1998). However, Castonguay et al. (1996) suggest that therapists who treat alliance strains as expressions of the client’s distorted thinking - perhaps by challenging the client’s perceived dysfunctional beliefs about the therapist - may increase avoidance or oppositionalism. Therefore, the interventions suggested by
Beck et al. (1979) may not always be sufficient, or appropriate. Likewise, by treating the relationship relatively mechanistically, therapists may neglect a potent area for effecting client change (Safran and Segal, 1990).

Jacobson (1989) suggested that the therapeutic relationship itself can be used to help depressed clients, saying that the client’s salient dysfunctional beliefs are apparent within the therapeutic relationship and can be evaluated as they emerge. This relationship can then be used as a medium to practice new ways of relating. For example, one of my clients revealed a core belief of herself as fundamentally worthless, thinking that only way to keep others from discovering this was to remain socially distant (be vague in conversations, apologetic, not reveal any personal opinions or feelings). I encouraged her to risk revealing herself more in relationship with me, meeting this with acceptance and thereby attempting to provide an experience that disconfirmed her expectations before she felt able to try similar experiments outside. In this way, the therapeutic relationship can become a “testing ground” for challenging beliefs. Indeed, Jacobson suggests that clients should not be encouraged to take interpersonal risks without first experimenting within the therapeutic relationship, and that incorporating interpersonal elements enables therapists to actively use the relationship to work more deeply, reducing the likelihood of relapse.

This suggests that integrating interpersonal and experiential interventions into cognitive therapy may help to deal with difficulties in the therapeutic relationship (Castonguay et al., 1996). This may be particularly true of clients who meet criteria for a diagnosis of personality disorder (Beck and Freeman et al., 1990; Safran and Segal, 1990; Young, 1990). These clients may find forming and maintaining a therapeutic alliance difficult and may demonstrate ‘overt non-compliance (e.g. missing appointments) as well as more complex interpersonal reactions (distrusting the therapist, demanding special entitlements or using suicide threats to communicate)’ (Corrie, 2002, p. 24). To understand these forms patterns of relating, and to develop cognitive therapies that better meet these clients’ needs, there has been increased interest in actively using the therapeutic relationship. This has lead to the development of schema-focused and
interpersonally-based cognitive therapies, which can also inform work with clients who do not meet criteria for diagnoses of personality disorder (Corrie, 2002).

Schema-focused therapy (Beck and Freeman et al., 1990; Young, 1990) attempts to understand the interpersonal difficulties that “drive” personality disorders, expressed as problems in the therapeutic relationship. For example, the client may rigidly interpret the therapist’s behaviour according to their maladaptive schema, giving clues to what these schema are (Beck and Freeman et al., 1990; Padesky and Greenberger, 1995). For example, a client I experienced as narcissistic constantly sought reassurance that I found him special and seemed vulnerable to feeling criticised. After listening to him running down his wife, I suggested that he ‘seemed angry with her’. His tone and posture immediately changed and he appeared defensive, suggesting a transference cognition (Beck and Freeman et al., 1990). It seemed that he felt criticised by me (as by his mother and wife): however, rather than evaluate a general underlying belief that others are critical (looking at evidence for and against this and generating solutions for future interactions), I might have asked if he felt criticised by me, or the meaning of feeling criticised, to arrive at core schema. Whilst using many traditional cognitive techniques (e.g. guided discovery, problem-solving), this approach differs in its use of interpersonal methods, using the therapeutic relationship as the main means by which unhelpful schema are identified and worked with (Young, 1990).

Safran and Segal (1990) place cognitive therapy within the broader context of interpersonal theory and therapy. In contrast to Beck et al. (1979), who primarily view schema as rules by which individuals evaluate self-worth (as implied by the rule, “unless I do everything perfectly, I am a failure”), they suggest that the concept of schema can be particularly applied to relationships. Similar to Bowlby’s concept of internal working models, they propose that infants’ cognitive representations of self-other interactions are abstracted from early experiences with attachment figures. These resemble templates for preserving relatedness and reflect perceptions of self and other (for example, someone seeing himself as unlovable may see others as hostile / rejecting). These schemas were presumably once developmentally appropriate but may sediment if they do not continue to evolve. Such interpersonal cycles tend to “pull” particular schema-consistent
responses from others, reinforcing the individual's usual behaviours.

For example, a female client described believing that men are dangerous and aggressive, based on distressing earlier experiences. From her descriptions, it seemed that she perhaps interpreted fairly neutral glances from men in the street as hostile, or even unwittingly evoked antagonism by looking suspiciously at men as she tried to 'gauge their intentions'. She then described responding with hostility and defensiveness; the antipathy that this often provoked confirmed her expectations of men and maintained her cognitive interpersonal cycle. In this way, individuals with relatively extreme or inflexible schema may "pull" similar responses from different people (Safran, 1990a).

Of course, therapists are also vulnerable to responding to this pull. However, therapists can monitor their feelings and urges to respond, using these to generate hypotheses about the client's interpersonal schema based on the assumption that the client's in-session behaviour reflects his other relational difficulties (Safran, 1990b). It is possible that the therapist's emotional responses say more about her own difficulties than the client's, although Muran and Safran (1993) suggest that the likelihood that her reactions mirror those of others increases with the intensity of the client's interpersonal style. Liotti (1987) shares these ideas, suggesting that dysfunctional early attachment patterns are repeated in the therapeutic relationship. Collaborative exploration can then be used to explore how relevant the observed interpersonal pattern is to the client's difficulties.

For example, a client who complained of health anxiety described constantly seeking reassurance about his health, particularly from his GP. Regrettably, it was not until after our work ended that I recognised that I had been subtly manipulated into giving him reassurance, consistent with his cognitive "pull" and confirming his beliefs of himself as helpless and vulnerable. I might have used this observation to hypothesise about underlying mechanisms and pointed out his invitation to provide reassurance. Becoming aware of this continuing pull might also have allowed me to lessen this response, disconfirming his schema by exploring what was happening and supporting him to learn to reassure himself (e.g. using Guided Discovery or Thought Records). We might also have thought about what he would like to be different in our relationship, helping him change his usual patterns of relating and gain support in more adaptive ways.
Awareness of the cognitive interpersonal cycle may therefore enable therapists to develop insight into their client’s difficulties as expressed within the therapeutic relationship. The client is also likely to have better access to their cognitions when these are activated in the here-and-now (Safran, 1990b).

Traditionally, cognitive therapy pays little attention to therapists’ thoughts, feelings and behaviours in relationship to clients (countertransference), assuming that they simply apply technical interventions without allowing personal feelings to interfere. However, ‘there is no reason to assume that cognitive therapists are any more immune to countertherapeutic reactions and feelings than are their psychoanalytic counterparts’ (Safran and Segal, 1990, p. 41) although may be relatively unused to personal reflection (Scaturo, 2002). Therapists with flexible, accepting self-concepts can “own” their feelings about clients, rather than ignoring these or projecting them onto clients. In this way, the moment-by-moment therapeutic relationship can hint at the client’s cognitions and interpersonal schema, informing interventions (Beck and Freeman et al., 1990; Safran and Segal, 1990; Young, 1990). This is in marked contrast to Beck et al. (1979), who see the collaborative relationship as either present or absent.

Mending alliance ruptures can be powerful experiences, likened to working through empathic failures (Kohut, 1984) and may strengthen the relationship in ways that an anxiety to avoid ruptures may not. Ruptures occur when the relationship becomes stressed, perhaps when an intervention activates important interpersonal schema. Whether occurring in “traditional” or interpersonal cognitive work, ruptures offer opportunities to illuminate the client’s unhelpful interpersonal beliefs and support him to recognize his own contributions to difficulties (Safran and Segal, 1990). Therefore, rather than “technical problems” necessitating problem-solving, ruptures can provide a ‘window into the patient’s subjective world’ (Safran and Segal, 1990, p. 89).

During ruptures, it is easy for client and therapist to lock horns and defend themselves but the therapist can try to “unhook” from the negative interpersonal cycle and explore and empathise with the client’s experience. For example, the female client above (who found men threatening) described an interaction with her boss leading to her being fired for ‘aggressive behaviour’. I felt that the outcome might have been different if she had
handled this assertively and gently suggested ‘perhaps you feel that you need to be aggressive to be strong?’ I immediately experienced her as angry and withdrawn although she denied any negative feelings. I wondered if she felt unable to express her anger at what she experienced as an attack, but that if this rupture were ignored she might not return.

I suggested that, ‘it seems that it was hard for you to hear that, when you felt criticised by me?’ By responding empathically rather than defensively (and avoiding challenging the rational basis for their anger), clients may learn that difficulties are potentially solvable and that they do not have to deny inner experiences to maintain relatedness (Rogers, 1957; Safran and Segal, 1990; Stern, 1985). This approach not only explores cognitions but also encourages clients to understand and accept their emotional responses. Therefore, ‘empathy does more than to provide a necessary precondition for effective cognitive interventions; in and of itself, it can be one of the most powerful means of changing the patient’s dysfunctional interpersonal schema’ (Safran and Segal, 1990, p. 189).

By empathically helping the client explore his cognitions about the therapeutic relationship, clients can consider how their own processes shape painful interactions and may begin to see their perceptions as testable hypotheses. The therapist can also use cognitive interventions to identify dysfunctional beliefs and help the client explore whether these have been confirmed or disconfirmed within the therapeutic relationship. The therapeutic relationship can become a safe place to build up more flexible and adaptive ways of relating before testing these outside. However, Corrie (2002) suggests that the idea of the relationship as providing corrective emotional experiences may be inconsistent with notions that client and therapist collaborate to explore the client’s belief system and its rational basis.

Likewise, whilst integrating concepts of countertransference and transference may be useful, Corrie (2002) also wonders whether such issues should be explored only at moments of alliance rupture or become a more central focus of exploration. Whilst this issue remains unclear, it is important to point out that the interpersonal therapeutic relationship is not psychodynamic; cognitive interventions and principles still apply.
However, less emphasis is placed on evaluating old beliefs and constructing new ones, but on looking at current interpersonal schema. This approach also encourages therapists to consider how cognitive interventions impact on the relationship and relational events impact upon the client’s cognitions, in helpful or unhelpful ways (Castonguay et al., 1996; Safran and Segal, 1990).

In conclusion, difficulties in the therapeutic relationship have traditionally been seen as necessitating a shift from working towards therapeutic goals to strengthening the alliance using techniques; once difficulties are smoothed out, the original work can continue. More recently, cognitive therapy has altered its view of the therapeutic relationship. This has lead to a deeper consideration of issues including how to think about and deal with difficulties within the therapeutic relationship. Accordingly, alliance ruptures are considered powerful ways of identifying and exploring clients' beliefs and assumptions. These difficulties can be worked on within the therapeutic relationship before being experimented with outside. Rather than being seen as a necessary (but insufficient) platform for effective work, the relationship between client and therapist can therefore be used as a mechanism for change in its own right.
References


THERAPEUTIC PRACTICE DOSSIER

Introduction

This offers a brief account of my clinical experiences throughout my training. It includes brief descriptions of my placements as well as my final clinical paper, which describes my development as a counselling psychologist.
I worked in a student counselling service in a large university for one day a week, when I saw five-six clients. The service offered free, time-limited work, usually six-eight sessions (due to pressure on the service, and because short-term work seemed developmentally appropriate for many clients in late adolescence). Appointments were usually available within a week of self-referral although in a crisis, students could usually be seen that day. The population was diverse in terms of nationality, culture, ethnicity and age and presenting problems, including interpersonal difficulties, transitions, identity issues, eating disorders, anxiety and depression.

I received weekly individual supervision from a psychotherapist (integrative/psychodynamic). I felt able to bring my whole self into this relationship as well as my “mistakes”, and liked that he constantly challenged me without ever shaming me. My responsibilities were to assess clients, provide psychological therapy and attend fortnightly team meetings (where client work was presented for group supervision, presentations made on practice issues and theoretical papers discussed). I discussed my client work several times and made a presentation on self-injury amongst students. I found this placement a containing beginning, feeling welcomed into the team of five trainees and four qualified therapists and enjoying the energy and support that comes from being in a team.
This placement was in a GP surgery in SW London. The clients were from a deprived urban area, many experiencing social problems (long-term unemployment, poverty, poor housing conditions, etc.) and at first I found it hard to tolerate these areas I could not help with. The presenting problems varied, including depression, anxiety, interpersonal difficulties and trauma. Most were seen within three months of referral although every effort was made to respond within six weeks. I was observed doing assessments and my supervisor encouraged me to adopt a reflective, thoughtful style that would support clients to make the transition from assessment to short-term psychodynamic work. Clients were usually offered twelve sessions although I saw one client longer-term.

My supervisor, a Senior Counsellor (psychodynamic) gave me weekly supervision of at least ninety minutes and I really appreciated him providing this unhurried space to reflect. He worked at another site, which was developmentally helpful; he was only a phone call away if I needed him, but I felt encouraged to develop my own judgment and reflection. It took me a while however to find ways to deal with the isolation of primary care work. I also visited other NHS services in the Trust.
Third year placement (3a): Psychology Service in a Community Mental Health Team

September 2003 - July 2004

This provided a service for clients from a suburban, moderately affluent part of south­east England. The multi-disciplinary team consisted of Community Psychiatric Nurses, Occupational Therapists, Consultant Psychiatrists and Social Workers. A 'Psychology Service' was run within the CMHT, staffed by a Consultant Clinical Psychologist (who supervised me), two Trainee Psychologists and an Assistant Psychologist. GPs or other team members made the referrals.

The client population was mainly white British and clients presented with a range of severe or enduring difficulties including health anxiety, agoraphobia, depression, trauma, abuse and interpersonal difficulties. The Psychology Service offered individual cognitive therapy (usually up to ten sessions) and group psycho-education / cognitive therapy.

My responsibilities included assessing clients (including using self-report measures), offering individual cognitive therapy and co-facilitating a group for posttraumatic stress disorder. I also liaised with other team members involved in clients' care, as appropriate. I had the opportunity to attend Psychology Department meetings and weekly team meetings, a ward round and also shadowed two other Team members.
Final year placement (3b): Psychological Therapies Service in primary care

September 2004 - July 2005

This cognitive placement took place in a GP surgery. The clients were mainly young professionals from an affluent part of SW London and were on the whole really motivated. I found my client load heavy at first, although once I got "into my stride" I appreciated the developmental experience this offered.

My role included assessing large numbers of clients, many of whom were referred on to other NHS services, our primary care mental health worker or to counselling in the voluntary sector. I also provided cognitive therapy to clients whose presenting problems and personal style seemed suited to this approach. Up to ten sessions were available although very occasionally this was extended as a training experience for me. A final aspect of my role involved containing clients who presented in crisis until they could be seen by other services. There was an enormous amount of paperwork and I had to learn ways to produce good-enough reports fairly quickly, a useful challenge to my perfectionism.

My supervisor was a Consultant Clinical Psychologist (cognitive-behavioural) who offered weekly individual supervision. At first I found his high standards anxiety-provoking, although he helped me develop my CBT and I reminded myself that he was also praising me. He also allowed me leave to attend three cognitive workshops, which really added to my awareness of cognitive therapy. The Trust also offered a multi-disciplinary training workshop which meant that I could meet people training in other disciplines.
Final clinical paper: Reflections on integrating theory, research and practice

Introduction

This paper offers an overview of my personal and professional development to date as a counselling psychologist; in other words, who I am and what I do. This process has been influenced by training and practice experiences, the discipline and values of counselling psychology and my engagement with theory and research. I will discuss how each is becoming integrated into my emerging identity as a counselling psychologist.

Counselling psychology

Counselling psychology is ‘the application of psychological knowledge to the practice of counselling’ (Woolfe, 1996, p.4). This has personal significance; before the PsychD, I did a diploma in person-centred counselling, valuing this model’s respect for individuality and importance placed on the therapeutic relationship (Rogers, 1951, 1957). I also liked the encouragement to be present as a real person rather than be hidden behind an ‘expert’ mask, but disliked the ‘anti-scientific’ culture and counselling psychology was a way to combine the importance I place on both the relationship and research. I feel both comfortable with and stimulated by the tensions involved in this synthesis.

Counselling psychology is an alternative to positivistic views of people and their difficulties, challenging ‘a psychology too devoted to the narrow scientific principles to pay proper attention to what it means to be human’ (van Deurzen-Smith, 1990, p. 9). It rejects medicine’s deficiency model, stressing growth and development rather than pathologising difficulties. Woolfe (1996) suggests that counselling psychology is therefore ‘concerned with enhancing the psychological functioning [ ] of individuals [whose difficulties] may well be temporary’ (p. 8). This has been challenged (Golsworthy and Wilkinson, 1997) and seems unreflective of much of my practice, where clients presented with issues including interpersonal difficulties, eating disorders, agoraphobia or experiences of sexual abuse or rape; none of which seem ‘life-span developmental issues’ (Woolfe, 1996, p. 8).
What distinguishes counselling psychology is its recognition that the relationship is the most significant component of therapy (Woolfe, 1996). I understand people as having an inherent need to relate, developing within relationships (Bowlby, 1997; Stern, 1985) and assume that people suffer not just from thoughts or feelings but also from relationships. Yet people can also be understood and restored in relationship. I see my first task therefore as establishing a relationship where clients feel safe, which I can use to inform myself about their difficulties; whatever approach I use, this remains the most important factor. This is supported by research suggesting that the relationship is the most significant influence on change (Bergin and Lambert, 1978; Elton-Wilson, 1994; Roth and Fonagy, 1996). This also implies that the therapist’s self is influential (Woolfe, 1996) meaning that I continually try to develop awareness of my own contribution through reflection.

Research integration: the scientist-practitioner model

The scientist-practitioner model acknowledges the integrated relationship between individual expertise, theory and research. It stresses the importance of research to provide an evidence base for practice and to enable critical evaluation of work. This may fit well with the values of counselling psychology since it opens up practice, seeming an appealing example of egalitarian working. However, in other ways the model sits less comfortably with counselling psychology’s ethos since it seems to favour the methods and values of positivism such as objectivity, explanation, measurement, experimentation and statistics, a preference reflected in the nature of the evidence base where studies involving randomised control trials predominate (Corrie, 2003; McLeod, 1996).

Whilst quantitative methods are appropriate for many enquiries, counselling psychology encourages a broader approach to knowledge-generation (Barkham, 1990). Qualitative research allows counselling psychologists to develop the scientist-practitioner model creatively, enriching the knowledge base that practitioners draw on (Corrie, 2003; Strawbridge, 1996). Qualitative research often analyses accounts given at interview, meaning that researchers must form relationships with participants. It is less concerned with explanation than with description and clarification of meaning, researchers often
reflecting on their role in creating this (McLeod, 1996). These practices could be seen as close to the values of counselling psychology and may be ‘a style of enquiry that many counselling psychologists [ ] do well’ (McLeod, 1996, p. 82).

Producing knowledge is an important part of the scientist-practitioner role. I used Interpretative Phenomenological Analysis (IPA) (Smith, 1996; Smith and Osborn, 2003; Smith, Osborn and Jarman, 1999) to research women’s experiences of growth following their efforts to recover from being raped. IPA attempts to inhabit participants’ phenomenological worlds by engaging with their perspectives. It is assumed that in doing so, meaningful interpretations can be made about their experience. A qualitative approach seemed appropriate since I sought detailed description of experience and did not want to risk excluding important data by restricting responses to pre-defined categories using questionnaires. It was also important for me to capture the values of counselling psychology in my interview schedule when inviting women to discuss this sensitive issue.

My experiences processing and integrating the personal impacts of this research gave birth to my final project. This considers the impact on researchers of investigating trauma, highlighting how psychologists are researchers as well as practitioners. It suggests how close these roles can become, being potentially either complementary or producing dilemmas. Engaging with this topic also lead me to reflect on how, whilst researchers consider how participants may be affected by sensitive research, they often overlook how such discussions could disturb them. I chose Grounded Theory (Glaser and Strauss, 1967; Pidgeon and Henwood, 1996) because of the absence of theory in this area and because I wanted to foreground participants’ experiences in producing theory. It was also normalising for me to interview other researchers and hear how they had felt affected by investigating sexual violence.

I recently assessed a male client who disclosed that, years before, he had broken into a woman’s home and had raped her⁴. I found this disclosure powerful and overwhelming; my conversations with survivors immediately came to mind and I realised that I sat with

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⁴ Ethical note: this client had served a prison sentence for these crimes.
him not only as a woman and a therapist, but also a researcher. These parts seemed in conflict; I wondered how I could meet this man where he was now when doing so somehow seemed to betray the survivors I had met. Negotiating this, and assessing and exploring any ongoing risk, required careful reflection and raised many issues about my relationship with my research. Nonetheless, my original research was a transformational experience and I had much to bring to this subsequent project.

Development through personal therapy and supervision

When I entered therapy, I felt more aware of my shortcomings than strengths and a part felt invalid and self-critical; I wondered what right I had to help others if I struggled myself. This stopped me from trusting my work and became the focus of much of my therapy. Working on my own difficulties and accepting my needs helped me empathise with my clients’ struggles to ‘get better’ and to recognise that I do not need to be ‘perfect’ to do this work, meaning that I feel more humble yet more anchored in meeting my clients (Dryden and Spurling, 1989; Gendlin, 1989).

Becoming ‘good enough’ was also a recurring theme in supervision and discussing examples of ‘mistakes’ (e.g. alliance ruptures) helped me reframe perfectionism / mistake-making; I recognised that such moments provide rich opportunities for clients to learn if I am able to go with it and explore their reaction rather than become fearful of doing harm. Developing my capacity to respond creatively and sensitively rather than rigidly strive to avoid ‘mistakes’ became a growing edge, helping me to trust myself. Becoming ‘good enough’ involves tolerating doubt or uncertainty and accepting my limits; working in time-limited contracts and recognising the value of a small piece of work (whilst accepting what I cannot help with) helped with this. It also involves developing confidence and robustness, keeping an eye on my typical traps (e.g. rescuing) as well as recognising my capacities.

Situations requiring thinking on my feet were helpful in developing an internal supervisor and sense of my personal resources. For instance, early in my second placement I worked supportively in primary care with a Kosovan woman, containing
her until she could be seen by a specialist trauma service. Her GP, and my supervisor, worked at another site. She arrived one morning in crisis, having received a date for her asylum hearing unexpectedly early. Convinced that she would be sent ‘home’, where she had experienced brutality, she revealed a suicide plan. I found this frightening and my initial urge was to rush and fetch a GP.

Assessing and exploring her risk within our relationship allowed me time to reflect on the best response; her plan was not immediate but contingent on being refused asylum, but I took her seriously. We agreed that I would talk with her GP and that she would see him that afternoon, and discussed the next step; referral to a CMHT for assessment. I was glad to have recovered myself and allowed time to explore her hopelessness and despair but also her fears of what would happen if she discussed suicide with an ‘authority figure’ e.g. a psychiatrist (that she would be sectioned and her children taken); we reflected on this in light of having been abused and persecuted by police in her country. I realised I was able to bear her distress and stay thinking and, without a supervisor immediately available, had much that I could draw on such as my training and experience, relationship with my client and ability to empathise and reflect.

I also found group supervision helpful. I found it interesting to observe the impact that clients made on a group, who were also a helpful resource for discussing ethical dilemmas, allowing me to consider different courses of action, their probable impact on the client and our alliance. I was grateful for such opportunities to reflect at length. I also thought of the video exercise as a sort of supervision, allowing detailed group feedback based on exposure to an example of my work. I was anxious about this - there seemed nowhere to hide - but found it containing to open up my work and recognise my strengths.

Therapy and supervision were also valuable when working with clients who unsettled me, allowing me to ‘unpick’ what might be happening for me and how this might impact on process. Reflecting overall on my therapeutic and supervisory relationships, I recognise that I feel most supported when I bring my whole self into the relationship. When supervisors adhere closely to a particular school, I sometimes felt that I must fit
around them, leading me consider the importance of responsiveness to my own clients' changing needs. On the other hand, experience within different schools allowed greater choice in selecting 'ingredients' for my integration, illustrated what models share and encouraged open-mindedness (Crawford-Wright and Hart, 1997; Lapworth, Sills and Fish, 2001; O'Brien and Houston, 2000).

Personal approach to integration

Part of integration involves assimilating theory into practice. Theory provides a framework or rationale for intervening; as my training progresses, I also increasingly trust my free associations, intuitions, bodily reactions and other subjective responses and view these as compatible with theory, helping make sense of what might be happening. Being initially concerned with working 'by the book', it was helpful to think of my self as an alternative source of information, encouraging my creativity and spontaneity (Dryden and Spurling, 1989). So whilst theory guides my practice, an equally valuable tool is my experience of being (and thinking) with clients, which becomes the basis of interventions. I experience myself as increasingly integrated in this respect, enabling me to come back and forth with my whole self. Integration can therefore also involve reflective activity grounded within the therapeutic relationship (Barkham, 1990; Hollanders, 2000b; O'Brien and Houston, 2000). Reflecting also enabled the integration of theory into my practice by considering in supervision what interventions helped / hindered the client's process, how they connected to theory and what other theory might guide the work (O'Brien and Houston, 2000).

The development of a personal approach that is truly owned and assimilated is the basis of integration (Dryden, 1998; Fear and Woolfe, 1996, 2000). Establishing a way of working that matches my worldview and way-of-being is important; when these fit, it has been easier to release myself and follow the client, reflecting an authentic use of self (Rowan, 2002; Rowan and Jacobs, 2002). My emphasis on relationship, view of therapy as a journey towards integration, attention to clients' embodied as well as verbal cues (Johnson, 1994; Orbach, 2003) and assumption that childhood development affects how
we are now means that I feel particularly at home with psychodynamic and humanistic perspectives, and prefer how these allow clients the freedom of a less structured space.

Integration also involves prioritising clients' needs and circumstances underpinned by a theoretical rationale, a continual process of development and adjustment. My first supervisor introduced me to the idea of clients as always in relationship, different models attending to different versions (alliance, person-to-person, transpersonal, transferential and developmentally-needed relationships). Clarkson (1994, 1996, 2003) seems the best-known exponent although Greenson (1965), Karasu (1992) and Lapworth, Sills and Fish (2001) propose similar ideas. Clarkson (2002) suggests that each version of relationship is valid and potentially available and that clients 'pull' for different relationships at different points; like Winnicott's adaptive mother, I see my task as responding by reading signs and meeting the client where he is, attending to shifts in relating before meeting again in a new place (Rowan and Jacobs, 2002).

I think that a flexible style considering clients' changing needs is important and like how this model suggests that different relationships can complement each other (e.g. offering clients genuineness and empathy as well as considering unconscious communications). It also allows a broad foundation for practice by drawing on multiple, sometimes contradictory, theories that can be integrated under the umbrella of relationship, encouraging 'cross fertilisation' between models. I value this perspective because of its emphasis on responsiveness and acknowledgement that no single theory provides all that clients need.

One of the difficulties I encountered when moving between a pure-form counselling training to an integrative training involved questioning how theories that differ fundamentally in their philosophy and focus can really be reconciled (theoretical integration: Hollanders, 2000a). My best effort to resolve this dilemma has been to 'pull back' and instead consider integration at the level of practice. As Horton (2000) suggests, psychological problems can be viewed as rarely attributable to one factor and experience of different models illustrated how clients' problems could be formulated from multiple perspectives. Welcoming and drawing on diverse and different models therefore seemed...
a way to develop my practice. Whilst initially I found the content and language of other models 'foreign', with experience I was able to recognise that theories frequently share common factors. Additionally, where they differ sometimes seems in terms of their 'way in' (for example, at the level of conscious thought, interpersonal or intrapersonal conflict) and viewing these areas as interrelated also encouraged me to consider clients' needs at multiple levels (Horton, 2000).

Training experiences

Having outlined my emerging approaches to integration, I will demonstrate how I have approached integration in practice using clinical examples, also suggesting the influence of theoretical orientations associated with my placements.

Year One

I worked in a student counselling service and my early integrative efforts involved taking my person-centred training as my starting point, establishing relationships based on the core conditions (Rogers, 1957) (a foundation that continues to underpin my practice). My supervisor (psychodynamic/integrative) helped me reformulate and broaden out my thinking and practice in response to clients' particular needs based on our formulation. Assimilating new ideas and practices into a familiar model was a comforting beginning and I found some psychodynamic perspectives, e.g. object relations and self-psychology, compatible with Rogers' theory (Kahn, 2000), complementing what I felt familiar with and valued such as people's need for acceptance, empathy and understanding before they can explore problematic styles of relating (Kohut, 1971; 1984, Rogers, 1951; 1957). It was also important for me not to present a seemingly uninvolved 'blank screen' as I consider this unnecessary and countertherapeutic (Kahn, 2000). Awareness of unconscious processes such as transference, countertransference and projective identification considerably deepened my understanding of the relationship and ability to use it therapeutically. This may be illustrated by my sessions with Mr O.

5 To protect confidentiality, any information that might identify clients, including details of the therapeutic context, has been removed or disguised.
Mr O presented in crisis, describing suicidal thoughts and commenting that his talking might cause me to become ‘depressed’, which I took as an early transference. After exploring and assessing these thoughts, I did not consider him at risk (although he seemed isolated, he had no plan or sense of immediacy; my supervisor later concurred with my assessment) but he decided to see his GP and I offered another appointment to contain him. We eventually met over fifteen weeks. Mr O explained that his father had demanded total compliance, crushing any signs of rebellion. He showed little spontaneity or joy and seemed defeated, his rather self-destructive, attacking relationship with himself suggesting he had internalised his father as a bad object (Johnson, 1994). Mr O was reluctant to discuss his mother, who seemed ghostly and fragile, reminding me of his concern for my emotional well-being. Supporting him to convey his emotions and showing that I could contain their appropriate expression formed an important aspect of our work.

Mr O seemed hopeless and stuck and the therapy was characterised by superficial improvements followed by reports that he felt worse than ever and wanted a ‘proper psychologist’. I experienced this as provocative, feeling increasingly controlled, withdrawn and hopeless. My supervisor helped me see how important it was not to become drawn into his morass by identifying with this projection, nor to seek crafty ways to retaliate. Instead, these experiences suggested how Mr O’s apparently domineering father made him feel, communicating what unmanageable feelings were happening for him (Hinshelwood, 1995). This helped me offer back something of my deeper, more emotionally-involved understanding (Bion, 1963; Ogden, 1982), using projective identification as the basis for interventions. Containing and transforming these projections into something manageable helped Mr O feel understood and supported to integrate these experiences.

Allowing Mr O to express negative feelings and reflecting on these encouraged him to consider how his experience of me seemed coloured by past relationships. Beginning to understand the transference and move to more authentic contact seemed healing. It was also possible to show that he did not need feel afraid of expressing feelings directly, because I would neither be harmed nor retaliate but could help him understand these.
My better understanding of our relationship, with supervisory support, also helped release my warmth (Rogers, 1951) and expressing empathy and mirroring seemed to help him feel accepted and valued, beginning the corrective emotional experience or ‘holding’ he seemed to need (Clarkson, 1994, 1996; Kohut, 1971, 1984; Winnicott, 1965).

As we prepared to end over several weeks, Mr O seemed sad and anxious and introduced his grandmother’s death. I suggested that he might also be saying that our relationship had become important, and he was able to talk about his feelings of loss, suggesting that he had internalised me as a good object. Given his fear that expressing emotions would destroy people or drive them away, disclosing that I was leaving the placement (rather than having had enough of him) seemed containing.

*Year Two*

My supervisor took an object-relations focus, encouraging me to adopt a style that would facilitate expression of unconscious material. I worked in primary care, the supportive relationships that clients often described with GPs underpinning our alliance, the surgery becoming a ‘secure base’ to contain the anxieties of short-term psychodynamic work (Smith, 2004). The client I remember most, because it was so important to work through impasses in our relationship, was Ms Dennis, who was twenty-four and explained that she could not stop restricting her calorie intake. She was seeing a nutritionist but implied that he was not helping, hinting at the transference she might develop with me. Ms Dennis painted a disturbed, disintegrated picture of family relationships; her way of managing feelings about this seemed by controlling what she took into her body. We decided to use sessions to prepare for referral to an eating disorders service by beginning a psychodynamic dialogue, considering what issues she might explore later.

Ms Dennis talked at great length whilst seeming to say little about herself; I felt that her words stopped me from thinking, perhaps because she could not bear to think herself. I felt silenced and resentful (Winnicott, 1947), recalling having taken a Staffordshire bull terrier for walk; its strength and determination to go its own way meant my efforts to be
in charge were wearing. I found balancing robustly stopping her whilst remaining attuned difficult but in putting words to this experience, hoped to convey my interest and desire to help.

Nonetheless, Ms Dennis seemed to position me as depriving and withholding. My urge was to prove her wrong by becoming reassuringly opposite (Milton, 1997) but in supervision realised the importance of allowing myself to be experienced negatively, understanding this as saying something about her internal world. I felt able to tentatively share my sense that I was offering something containing and nurturing, which she deprived herself of by coming late, talking over me and not taking herself seriously. This felt risky but framing this gently as a comment on process, rather than an attack, helped. Interrupting the transference this way helped us reconnect and establish an alliance (Clarkson, 2003; Jacobs, 1998); Ms Dennis seemed more able to consider her ambivalence and I felt less wary and more accepting of her need for her defences.

Ms Dennis seemed to need to know that she was held in mind and another important exchange occurred after she cancelled a session and I wrote, acknowledging her absence. She said that when she opened it, she ‘knew I existed for you’. I felt that I had become more real to her and that she had begun to recognise my concern. Ms Dennis gradually expressed her need for a reparative relationship, using metaphors such as ‘I need a plaster putting on me’, which I responded to by offering containment, allowing her to express some of her feelings. There were signs that she was internalising my help, such as her gradual development of insight. Contact, and anticipating separation, seemed thematic of our work and allowing her to express her pain about having begun to depend on me when I was going to leave her (as my placement ended) was important, as was acknowledging how miserable she still felt and her disappointment that we had not been able to solve that in twelve sessions. I was pleased however that she took her difficulties more seriously and had somewhere to explore these after our ending.

Working with clients such as Ms Dennis and Mr O, I recognised that clients often positioned me as ineffective and that I took that quite personally. My supervisor encouraged me to develop my internal supervisor (Casement, 1991), responding to
clients’ need for me to be close yet also to separate out again in order to think or observe how they worked ‘inside’ me, reflecting on unconscious processes before intervening with greater understanding. I also liked how he encouraged me to talk openly about my experience of clients and how these could be integrated into the therapy, becoming the basis of interventions.

Years 3a and 3b (part-time)

My decision to go part-time was difficult; I had hoped to complete my training within three years. However, ‘failing’ this goal by taking another year seemed a mark of success in terms of my development. I did not have a sense of ‘ripeness’ for graduation and felt very depleted following my second-year research and difficulties on my third placement, where I shared a problematic relationship with my supervisor. I sometimes think of this training as a marathon; I was unsure if I could go the distance although the marathon is also symbolic of taking on a challenge and self-actualisation. When you run alongside other people, you can support each other and tackle the steep uphill miles together. In going part-time I slowed to a walk, and whilst I welcomed recovering and experiencing a change of pace, watching most of my cohort gather speed as their final year moved on felt sad. To change metaphors, I felt like I had lost my oars and was drifting, feeling disconnected from my group and my placement. Fortunately, my final research project became my anchor until I was able to reconnect to a new placement and cohort.

In year 3a, I worked in a Community Mental Health Team, enabling me to observe other professionals’ roles and the dynamics of teamwork. I was required to use ‘treatment’ protocols and evaluate the effectiveness of therapy using psychometric tools, finding this ‘treatment culture’ at odds with my values. However, I found that psychometric tools could be used as the basis for dialogue and exploration and protocols treated as general guidelines whilst encouraging clients to lead the process. I therefore felt able to introduce some of the ethos of counselling psychology into my work although overall felt mismatched with this context and more comfortable returning to primary care in year 3b. This current placement is extremely demanding in terms of workload but
developmentally productive, for example in refining my assessment skills and awareness of other services.

I felt ambivalent about learning CBT but liked how my research supervisor suggested I consider it 'a journey to a foreign land, where they just do things differently'. I searched for what I appreciated in this new landscape, enjoying how CBT encourages true collaboration, its optimism and the creativity of experiments. However, adopting other local customs (e.g. a directive role) felt incongruent with my personal style and I struggled with how emotion seemed treated, as if feelings are messy or dangerous and need controlling with reason whereas I see emotion, intuition and felt senses as rich sources of information.

My supervisors in years 3a and 3b have been Consultant Clinical Psychologists taking a 'traditional' CBT approach (Beck, 1976; Beck et al., 1979) although both were open to me drawing on interpersonal and schema-focused therapy (Safran, 1998; Safran and Segal, 1990; Young, 1990; Young, Klosko and Weisharr, 2003). These cognitive models emphasise the link between past experiences of relationship and present difficulties, which broadened my thinking, symbolically reconnected me to psychodynamic perspectives and underlined these models' shared factors. I also received occasional supervision in year 3a from a Counselling Psychologist (Integrative) who encouraged me to consider CBT as a framework into which other ideas could be integrated in response to clients' needs. Translating 'foreign' concepts into CBT language helped make my work acceptable and understandable to my primary supervisor.

This approach may be illustrated by my work with Mrs Church, who presented with a fifteen-year history of severe depression and anxiety. She appeared tearful and child-like and I felt a "pull" to be gentle, as if challenge could harm her. Mrs Church had apparently always been 'a little adult', running the household as a child and continuing to feel that she could not do enough for her elderly mother. From a CBT perspective, it seemed that she held a number of core beliefs, seeing herself as incompetent and dependant yet subtly manoeuvring others into taking care of her (in light of her early experiences, perhaps her only way to get her needs met). She also seemed self-
sacrificing, perhaps maintaining her difficulties. The evidence suggested that a CBT approach would be helpful (Hawton et al., 2002; Roth and Fonagy, 1996; Padesky and Greenberger, 1995; Wells, 2003) although Mrs Church responded by resisting collaboration, crying and saying that she could not do the CBT exercises.

I decided to focus on our relationship, integrating ideas from Transactional Analysis and Interpersonal Therapy (Clarkson, 1992; Safran, 1998; Safran and Segal, 1990) to respond to difficulties building the alliance. I offered Mrs Church sensitive feedback about the strong cognitive-interpersonal “pull” I felt to treat her as a vulnerable child, encouraging her to think with me about this. We recognised how she typically approached others as a helpless “Child”, inviting “Parental” responses that maintained her vulnerable stance. We considered how our relationship could be different, supporting her to experiment with asking for what she needed more directly. I found collaborative empiricism helpful, encouraging Mrs Church to experience making her own links rather than wait for me to do this (Beck, Freeman et al., 2004). I was then able to reintroduce CBT techniques, allowing these to emerge naturally from between us, keeping our relationship responsive.

Incorporating ideas from other models enriched the cognitive work and a wider theme of integration also emerged. Mrs Church often appeared out-of-touch with her “Adult” self and I paid particular attention to her capacities, encouraging her “Adult” back when her “Child” appealed for care taking. Reconnecting with her Adult helped Mrs Church to see things differently, challenging her view of herself as unable to cope (Padesky, 2004). I also struggled to hold onto my capable, effective self this year, feeling muddled and overwhelmed. Part of my journey with Mrs Church was to find ways to re-integrate my sense of competency and potency, as well as seeking ways to engage with CBT in keeping with my personal style, a process continued in my final year.

Conclusion

After an unexpectedly extended journey in the land of CBT, it has been good to reflect on the other journeys I have made in the context of consolidating my learning. I am still
developing my personal integration, this paper 'freeze-framing' where I am at this point in time; the importance I place on offering the core conditions and foregrounding the relationship, use of psychodynamic perspectives to guide thinking about clients' internal worlds and my understanding of the relationship, and from CBT the value of generating a focus. I anticipate that my influences, how I understand and combine them and my engagement with theory, research and practice will evolve and expand over coming years as I also change; I see myself as constantly reflecting on myself and my development and hope to retain this attitude.

Although the process of becoming a counselling psychologist involves sacrifice, what sustains me is this constant process of taking in new ideas, being curious about my work and myself and learning from and developing with the people I meet on the way. Gendlin (1989) suggests that the essence of working with another person is to be present as a living being, setting aside theories, personal problems and any pretensions to wisdom. This may not help me know how best to work with each client, but underlines how therapy is, at heart, a process of relating.
References


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Introduction

This includes a literature review considering the concept of posttraumatic growth as applied to the experience of recovery from rape. The first qualitative research report explores women's experiences of recovery from rape, focusing on growth outcomes. The second considers the emotional impact on researchers who qualitatively research the trauma of rape.
Posttraumatic growth after the experience of being raped: a review of the literature
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Abstract

Research indicates that experiencing rape is an extremely traumatic event having a devastating impact on survivors. Whilst a growing literature suggests that the processes of coping with and recovering from traumatic events as diverse as bereavement, HIV infection and natural disasters may result in some individuals reporting valuable outcomes, the experiences of women struggling to recover from experiences of rape appear largely overlooked. This review explores the literature on growth outcomes associated with recovery from the trauma of rape, suggesting that many such changes correspond with those reported after other traumas (for example, deepened relationships, increased appreciation of life and an awareness of one’s personal strength and resourcefulness). However, other findings appear specific to sexual / domestic violence, such as a greater affinity with women. The limitations of this literature are discussed, and some speculative therapeutic implications for work with women who have experienced rape are suggested.

Keywords: rape; sexual violence; sexual assault; posttraumatic growth; thriving

Introduction

Traumas are events involving actual or threatened death or serious injury or which threaten the physical integrity of oneself or others, evoking intense fear, helplessness or horror (American Psychiatric Association, 1994). Thousands of studies point to the association between experiencing trauma and long-term difficulties. However, recent research suggests that some survivors of trauma may be stronger than psychologists perhaps acknowledge, suggesting that this literature may paint an incomplete picture of recovery (Tedeschi and Calhoun, 2000). For some people, traumatic experiences may be
developmental opportunities, offering potential for growth as well as involving suffering, damage and loss (Aldwin, 1994; 2000; Cordova, Cunningham, Carlson and Andrykowski, 2001). The term ‘posttraumatic growth’ (PTG) (Tedeschi and Calhoun, 1995) is often used to describe this phenomenon.

Individuals have reported at least something of value emerging from their struggles to cope with traumas as diverse as bereavement (Calhoun and Tedeschi, 1989-90; Schwartzberg and Janoff-Bulman, 1991), cancer (Cordova et al., 2001), HIV infection (Schwartzberg, 1994), heart attacks (Affleck, Tennen and Croog, 1987) and mass shootings (McMillen, Smith and Fisher, 1997). Reported rates vary, depending on methodology, definitions and trauma considered, but approximately two-thirds of survivors seem able to identify at least something valuable emerging from their attempts to cope with trauma (Tedeschi and Calhoun, 2000).

Yet the experiences of survivors6 of rape seem quite absent from this literature, despite research suggesting that this trauma is experienced by between 5% (Myhill and Allen, 2002) and 15% of women (Koss, Gidycz and Wisniewski, 1987). This may relate, in part, to suggestions that experiencing rape is a particularly damaging experience compared to other violent crimes (Kilpatrick, Veronen and Best, 1984). However, severe traumas, whilst producing extreme distress, may also offer greatest potential for growth (McMillen et al., 1997; Park, Cohen and Murch, 1996). Neglecting the experiences of survivors of rape may also relate to researchers' understandable concerns that they might be misconstrued as legitimising rape, or of minimising its devastating impact. Yet, rape therefore seems a trauma explored only in terms of its damaging legacy, although in struggling to cope with these difficulties, some women may identify areas of growth. This does not imply that rape is in any way "good for" women, but does assume that some women may find the resources to deal with this experience, and perhaps even to integrate it in new ways (Burt and Katz, 1987).

6 After some thought, I have decided to use 'survivor' to refer to those who have experienced the trauma of rape, despite the problems involved with this word (discussed below). Given the particular emphasis on growth in this review, it seems overall more appropriate than its alternative, 'victim'.

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Defining and measuring rape

Some feminist researchers have broadened definitions of sexual victimisation from "common sense" understandings, which seemed reflective of male understandings of sexual conduct and 'limited the range of male behaviour that is deemed unacceptable to the most extreme, gross and public forms' (Kelly, 1988, p. 138). Rape became re-conceptualised not as an act motivated by desire but by aggression, a means to maintain control and dominance over women (Brownmiller, 1975). Some feminist writers also propose that rape is an extreme act on a continuum with other coercive behaviours, such as unwanted touches and pressurised sex (Kelly, 1988), indicating the 'murky issues at the interface between (hetero)sex and sexual victimization' (Gavey, 1999, p. 57). These important developments mean that many experiences, which might previously have been dismissed as "just sex", are now recognised as sexual violence (Gavey, 1999).

However, whilst "rape myths"(Burt, 1980) suggest that rape involves an unknown, violent assailant, these attacks reflect the minority of experiences of rape (Myhill and Allen, 2002). Yet, the further an act of non-consensual sex is from this scenario, the less likely its victim (and others) may be to define it as rape (Kelly, 1988). Survivors themselves may experience shifting, uncertain responses to a non-consensual or pressurised sexual act occurring within the context of a relationship (and, indeed, towards the perpetrator) and may feel uncertain how to define their experience. There is also the problem of the 'unacknowledged rape victim' (see below).

With the exception of more recent feminist research (e.g. Koss, Gidycz and Wisniewski, 1987) most researchers do not define what they understand by "rape" or attend to how participants define their experiences. Kelly (1988) suggests that this assumes that distinguishing rape from other sexual encounters is unproblematic. Other researchers provide their own definitions, against which participants' experiences are compared. For example, Veronen and Kilpatrick (1983) define rape as 'non-consensual sexual activity obtained through coercion, threat of force, or force' (p. 169). Whilst undoubtedly a useful guideline, this definition does not acknowledge other ways in which consent may be missing (e.g. when women are sleeping or intoxicated). These authors also 'contend that
those rapists who use the most force or coercion are most culpable' (p. 169): again, rape myths seem implicit in this definition.

Rape is generally considered an under-reported offence (Koss, 1998). Whilst official statistics, such as the annual National Crime Survey (USA) place women's lifetime risk at under 1%, such figures may be inaccurate since they attempt to measure the scope of rape within the context of a survey on crime, yet many experiences of rape are perpetrated by acquaintances or within relationships and so not all survivors will use the word "rape" to describe what happened to them (Koss, 1998). Indeed, only 30-60% of women whose experiences meet legal definitions of rape actually define it as such (Gavey, 1991; Koss, 1998; Myhill and Allen, 2002).

Newer, feminist empirical research tries to overcome these factors by bringing in a methodological change that allows for women's reluctance to define some non-consensual sexual acts as rape. Rather than asking whether they have been raped, participants are asked whether their experiences match legal definitions of rape (e.g. whether they have ever had intercourse when they didn't want to, because a man threatened or used some degree of physical force, one of several such questions). Using these methods in a survey of over 6,000 students on 32 campuses, Koss et al. (1987) found that 53.8% reported some form of sexual victimisation during their lives (replicated by Gavey, 1991). Of these, 15.4% had experienced rape although few had contacted police or rape crisis centres. Others, using similar designs and random samples, suggest that between 14.5% and 24% of women in the community have experienced rape (Kilpatrick et al., 1984), mainly perpetrated by acquaintances (Ahrens and Campbell, 2000). Young women (16-24 years) seem particularly at risk (Myhill and Allen, 2002; Santello and Leitenberg, 1993).

These findings have been criticised, however. For example, 73% of the women identified as rape victims by Koss et al. (1987) did not describe themselves as such. Critics have suggested that, if a woman does not feel that she was raped, she probably was not, and that the experience would be better described as seduction (Hoff-Summers, 1994). Yet, defining categories to be measured, irrespective of how participants characterise these, is
consistent with positivist research enquiries (Gavey, 1999). These "unacknowledged rape victims" also report as much psychological distress as those who acknowledge that they were raped, and rate the experience as equally distressing (Frazier and Seales, 1997; Layman, Gidycz and Lynn, 1996). Unacknowledged rape victims seem also to blame their own behaviour more than acknowledged victims, perhaps because the latter feel more able to attribute responsibility to the assailant (Frazier and Seales, 1997).

Another criticism addresses the finding that 42% of women identified as having been raped by Koss et al. (1987) reported having had sex again with the man concerned. Podhoretz (1991) suggests that, had they "really" been raped, they would have avoided the man concerned. Yet, women may often be unsure of their role in rape, particularly immediately afterwards, and in this period of uncertainty may doubt and blame themselves (Thompson, 2000). This may be especially true of women who were raped by acquaintances (partners, dates, etc.), who seem more likely to conclude that what happened was their fault and so "not rape" (Frazier and Seales, 1997). Women raped by acquaintances may therefore lack ways to make sense of or define an experience, including their responses to it (Thompson, 2000).

The suffering, harm and damage associated with experiencing rape

A substantial literature attends to the immediate and long-term distress experienced by women who have been raped. Immediately afterwards, virtually every woman experiences traumatic responses including terror, anxiety and confusion, and bodily reactions including shaking, racing heartbeat and rapid breathing (Kilpatrick, Resick and Veronen, 1981). Nightmares, flashbacks, numbing and increased arousal may persist over several weeks or months and the diagnosis of posttraumatic stress disorder may be used to inform treatment (Foa, Riggs and Gershuny, 1995). Atkeson, Calhoun, Resick and Ellis (1982) also point to the depression that many experience during this period. It is said that for most, overall symptoms begin to fall approximately three months after the experience of rape (Atkeson et al., 1982; Burgess and Holmstrom, 1974) and that adjustment here may predict long-term adjustment (Cohen and Roth, 1987). Nonetheless, a year later, 75-80% still experience rape-related fear (Kilpatrick et al, 1984),
some using intoxicants to numb their feelings (Burgess and Holmstrom, 1979) and, years later, many continue to report severe distress (Cohen and Roth, 1987).

Rape is extremely traumatic, involving not only loss of control over one's body, but also over the course of events (Taylor, 1983). Many survivors report experiencing the situation as so out of control that they feared they could be killed, regardless of whether the assailant was a known person (Veronen and Kilpatrick, 1983). Another distressing aspect involves experiencing humiliation and degradation (Smith and Kelly, 2001). Victims must also deal with the stigma of rape (Burt and Katz, 1987) and the often uncertain, confused feelings of themselves and others regarding responsibility for the rape and how to respond to the survivor. Kulkoski and Kilian (1997) also draw attention to the potential impact on women's self-esteem and body esteem.

However, many studies addressing the negative effects of rape draw samples from emergency wards or rape crisis centres (e.g. Atkeson et al., 1982; Burgess and Holmstrom, 1974; Kilpatrick et al., 1981). Participants have therefore both identified their experience as outside the boundaries of normal or acceptable behaviour, and have made this known (Kelly, 1988). The experiences of women who do not seek help, probably the majority, are therefore neglected (Kimerling and Calhoun, 1994). Likewise, whilst most rapes are committed by acquaintances (Koss et al., 1987; Kirkpatrick and Kanin, 1957) most research samples participants who were raped by strangers (e.g. Atkeson et al., 1982; Burgess and Holmstrom, 1979; Meyer and Taylor, 1986).

Researchers also tend to try and separate and objectively measure specific changes after rape (e.g. physiological, emotional or behavioural) using psychological tests although this may give a very narrow picture of the range and complexity of responses to this trauma. It may also be impossible to isolate these impacts unless participants were raped only once (Kelly, 1988); prior experiences of being raped, or of childhood sexual abuse, will interact with a subsequent rape, making their separation difficult (Cohen and Roth, 1987; Frazier and Schauben, 1994). Similarly, coping responses (including social support) will influence the specific way that rape impacts on someone (Burgess and Holmstrom, 1979). Coping may depend on many factors, including how women define their
experience (which may relate to its context), her resources and the availability of social and professional support. Other problems (addiction, economic deprivation) may also influence the impacts of rape, as may the level of violence used against the woman, the sexual acts demanded of her and how many assailants were involved (Burgess and Holmstrom, 1979).

The processes of dealing with or recovering from being raped also seem underresearched and more hopeful messages seem missing (Smith and Kelly, 2001). In the coping literature, a “good” outcome is usually associated with a return to previous functioning yet, after trauma, life may never be the same again and sometimes growth may emerge as individuals try and rebuild what has been shattered. In struggling to cope with rape, some women may ‘make choices and come to understandings which they value positively’ (Kelly, 1988, p. 187). Neglecting this other side may mean that important aspects of recovery are minimised or go unrecognised (Thompson, 2000).

**Posttraumatic growth**

In the developing literature on PTG, self-reports of beneficial changes tend to fall into three broad areas (Aldwin, 2000; Tedeschi and Calhoun, 2000). **Self-perceptions** may be fundamentally altered: whilst individuals may acknowledge a heightened awareness of their mortality and vulnerability, they may also report an increased sense of resiliency and strength (Tedeschi and Calhoun, 1996). **Relationships** may change as some individuals experience increased closeness, expressiveness or greater empathy with others’ suffering (Calhoun and Tedeschi, 1989-1990). Finally, changes may occur in **philosophies of life**, minor issues put into perspective (Aldwin, 2000) or values reappraised (Aldwin and Sutton, 1998; Taylor 1983). Existential changes may also emerge, life being appreciated as precious and short, greater possibilities recognised and the inevitability of death acknowledged (Tedeschi and Calhoun, 1995). Changes in philosophy of life may also include the awakening or deepening of religious or spiritual beliefs (Park et al., 1996). These areas seem related: for example, receiving social support may increase self-esteem or self-efficacy; spiritual changes may deepen relationships, or reappraising one’s priorities may prompt changes to the self.
Some researchers conceptualise traumas as psychosocial transitions, requiring individuals to restructure [their] ways of looking at the world and [their] plans for living in it' (Parkes, 1971, p. 102). Some such changes may seem valuable: for example, ‘cancer [ ] is perceived by many to have been the catalytic agent for restructuring their lives along more meaningful lines with overall beneficial effect’(Taylor, 1983, p. 1163). Calhoun and Tedeschi (1998b) mirror this, suggesting a cognitive model occurring over two stages. In the immediate wake of trauma, the cognitive assumptive world (that bad things happen only to bad people, or that events are controllable) is shattered and the person feels distressed and traumatised (Janoff-Bulman, 1992). Over time, distress may be managed through coping, and by a process of ruminating, trauma-related thoughts and feelings may be processed and integrated and new assumptions about oneself, others and the world reconstructed. Here, experiences of valuable changes may occur.

This model may be criticised, however. Some changes, such as appreciation of life, seem rapid, rather than requiring lengthy rumination (Frazier, Conlon and Glaser, 2001). Distress may also reoccur rather than be “worked through” and perceptions of growth may represent attempts to preserve continuity with old beliefs or be positive illusions that foster coping (McFarland and Alvaro, 2000; Taylor, 1983). Nonetheless, such models reflect existential theory (Frankl, 1984) in which traumas are seen as forcing acknowledgement of mortality, a redefinition of priorities and a search for meaning.

**Recovery and growth after rape**

Several theorists suggest that non-victimising events (bereavements, life-threatening illnesses, etc.) contribute disproportionately to the development of growth (Janoff-Bulman, 1992). Whilst the PTG literature does rely heavily on such traumas for its claims, deliberate victimisations (e.g. a mass shooting) have been associated with high rates of PTG, although the community context may have influenced this (McMillen et al., 1997). However, whilst few studies address PTG after rape, their results suggest that, for some, efforts to cope with the aftermath of rape may also include discovering valuable ways in which they have changed (Veronen and Kilpatrick, 1983, p. 189).
For example, in a cross-sectional investigation of 113 rape victims, Burt and Katz (1987) asked participants to rate the changes associated with their recovery. These were measured using a questionnaire assessing how participants saw themselves now compared to before the rape. For 15 of 28 statements reflecting positively on themselves, half felt that they had changed at least “a little”, a quarter feeling “somewhat” or “a great deal” changed. Similarly, Frazier and Burnett (1994) also assessed coping strategies after experiencing rape, treating ‘finding positive meaning’ (p. 634) as an example, finding that over half of survivors report some valuable change during the first few days after having been raped including increased empathy, better appreciation of life and improved relationships.

Frazier et al. (2001) argue for examining growth outcomes common to many traumas, perhaps useful until the specific aspects of recovery from rape are better researched. Rape may in some ways resemble other traumas, all involving loss of control, of invulnerability and of self-worth (Taylor, 1983). However, certain features differentiate rape: it is a deliberate victimisation, inducing complex feelings of shame and degradation (Burgess and Holmstrom, 1974; Veronen and Kilpatrick, 1983). Feeling oneself to have been singled out may also reinforce feelings of isolation and the potential to personalise the rape or blame oneself. Survivors of rape may also perceive social support as lacking, as others ‘find it hard to understand what’s so distressing’ (Brison, 2002, p. 15). In addition, there is also the invasion of the body over which the person has no control. Such differences limit the extent to which findings from other traumas may be extrapolated. However, the following analysis is based on studies of growth after rape.

Changes to the self

Rape violates not only the body, but also assumptions of personal integrity and control, undermining self-confidence and esteem and impacting on identity (Cohen and Roth, 1987; McCann and Pearlman, 1990). Yet, transformation of the self may be associated with dehumanising, victimising traumas, perhaps even more so than (for example) accidents or natural disasters, where one’s fundamental sense of self may be less challenged (Aldwin, 1994; Silver, Boon and Stones, 1983). The ability to create a new
identity may therefore be a necessary task of successful coping, perhaps explaining why some people report valuable outcomes after such traumas (Aldwin, 1994). Changes here may emerge more slowly compared to those in other domains (Frazier et al., 2001), although perhaps are more enduring.

Recovering from rape may therefore necessitate the formation of a new self, providing an unwanted, yet nonetheless valuable opportunity to do this in strengthening ways. Certainly, survivors of rape seem often to speak of the death of their old self (e.g. Brison, 2002) and perhaps ‘when trust is lost, traumatized people feel that they belong more to the dead than to the living’ (Herman, 1997, p. 52). They may likewise undergo a process resembling bereavement, including mourning the loss of who they were (Burt and Katz, 1987), some even describing recovery as a “rebirth” (Smith and Kelly, 2001). Some mark this transition by changing residence or career (Burgess and Holmstrom, 1979).

In spite of the enormous losses involved in experiencing rape and its aftermath, some survivors may recognise positive self-change, suggested in remarks such as ‘I thought I had lost myself and that I would never come back. Well, now I love myself, whereas I certainly couldn’t after I had been raped. I don’t think I did before either’ (in Thompson, 2000, p. 336). Reports in this domain may include a sense of knowing oneself more or valuing and trusting oneself more or taking greater responsibility for events (Burt and Katz, 1987). In light of research highlighting the tendency to blame oneself for rape, however, this latter change appears ambiguous: yet, in recognising that what happened was not their fault, some women may also stop blaming themselves for other events in their lives (Smith and Kelly, 2001).

Recovery and growth may be partially dependant on women feeling able to draw on resources they may previously have been unaware of possessing. For some, this may produce a new view of themselves as capable and strong (Kelly, 1988; Thompson, 2000). In an influential study, Kelly (1988) interviewed 60 women who had experienced domestic or sexual violence (including rape) at least one year previously. Appreciation of their own strength and resilience was the most common valuable outcome reported,
expressed in comments such as 'I feel that I could cope with just about any crisis on earth having gone through that' (in Kelly, 1988, p. 226). Such feelings of increased self-regard and appreciation of one's strength in survival seem reasonably common during recovery from rape (Frazier and Burnett, 1994; Smith and Kelly, 2001), and are perhaps related to coping with distress (Schaefer and Moos, 1992, 1998).

Women may also describe feelings of personal development following successful recovery, such as increased self-awareness and self-acceptance. For example, Thompson (2000), interviewing five survivors, reports experiences associated with recovery such as 'I've learned to love myself and accept myself and these are things I didn't do before' and 'I see it as one of many events which has enriched me ... I've gained a lot of self-knowledge through it' (p. 331 - 332). Such developments resemble Calhoun and Tedeschi's (1996) findings of changes to the self following trauma. Women often stress that such changes are not a final product of recovery, but an ongoing, dynamic process (Thompson, 2000). Many appear only to recognise their strength and resourcefulness in retrospect (Kelly, 1988; Thompson, 2000) and it may be that these changes take time to consolidate (Frazier et al., 2001; McMillen et al., 1997). Nonetheless, 'whenever this recognition occurred [ ] it changed both the way the woman saw herself and other women' (Kelly, 1988, p. 225).

Such changes may be complex and paradoxical, however: commenting on her recovery from rape and attempted murder, Susan Brison notes that she 'began to feel stronger than ever before, and more vulnerable, more determined to fight to change the world, but more in need of several naps a day' (2002, p. 15). Whilst women often stress the importance of talking with others for recovery, 'their own strength and determination was, in fact, the crucial factor' (Kelly, 1988, p. 219). However, this may also this involve a painful quality: Veronen and Kilpatrick (1983) report the experiences of a woman who had been raped and who was frightened that exposing her vulnerability to others would cause her to "fall apart" and be shunned. It appeared that her reluctance to risk sharing her distress lead her to try and bear up alone, and that it was this that enabled her to feel 'stronger [and] more capable [ ] than she had ever felt' (p. 189). Perhaps this was at some
personal cost, however, suggesting the importance of closely examining reports of personal growth and the possible meanings for those involved.

Another change may involve the transition between a “victim” and a “survivor” identity. Some researchers argue for the advantages of adopting a “victim role” after experiencing rape, since it strongly implies blamelessness (Thompson, 2000) and ‘the right to claim assistance [and] sympathy’ (Burt and Estep, 1981, p. 16). Yet, some may also associate “victim” with being ‘weak, powerless, vulnerable and still affected by the rape’ (Thompson, 2000, p. 328), rejecting it because of its associations with shame and humiliation (Lamb, 1999). By contrast, “survivor” may suggest strength, recovery, and being “over” the rape (Thompson, 2000) and women may aspire to the self-agency and strength implicit in this. Being able to accomplish this change may also be viewed positively by society (Lamb, 1999) (and be expected, even after a relatively short period of time).

Drawing on victim/survivor identities may have paradoxical consequences, influencing how women are perceived (including by themselves) and how they are treated. A victim identity may increase the possibility that the trauma of being raped is appreciated (Thompson, 2000) yet victims may also be viewed as weak or pitiful (Lamb, 1999). Describing oneself as a survivor may generate respect and a positive self-concept, but stressing recovery may also preclude explorations of recurring distress and so inhibit social support (Thompson, 2000; Veronen and Kilpatrick, 1983). Women may be expected to choose between strength and vulnerability (Brison, 2002; Lamb, 1999), each determining their treatment at the expense of other responses.

Yet, recovery may involve both resiliency and vulnerability, although in reviewing their relationship to the rape, women may negate a previous self-concept. This paradox ‘creates difficulties ... if [women] wish to draw on both identities to reflect their own understanding of their experience and elicit a response that is both sympathetic and respectful’ (Thompson, 2000, p. 330). Reconstructing identity after rape may therefore be difficult although Kelly (1988) and Thompson (2000) suggest that it may be (partially) resolved by describing oneself as a victim immediately after rape, and increasingly
defining oneself as a survivor as recovery proceeds. However, this assumes a fairly linear process which is probably unreflective of many women's experiences, suggesting that it may be better to redefine 'survivor' so as to admit the possibility – indeed, likelihood - of ongoing intermittent distress.

*Changes to relationships*

Following trauma, some people may develop a confiding relationship in which distress is expressed, which can remain a resource in future crises (Schaefer and Moos, 1992). A specific person may be approached for help and, provided that they respond positively, this relationship may deepen (McMillen, 1999). However, survivors of rape are often shunned and stigmatised (McCann and Pearlman, 1990), many losing friends and family members. Burt and Katz (1987) also report that the loss of relationships can also occur as a result of growth, for example if women begin to assert themselves more in relationships. Friends may also expect survivors to continue to behave as before, responding with confusion or rejection when they cannot (Thompson, 2000; Veronen and Kilpatrick, 1983).

Nonetheless, many survivors report that talking with others is essential for recovery (Kelly, 1988; Symes, 2000; Thompson, 2000). Talking may help make sense of rape and normalise responses, particularly if others in the social network have also been raped (Ahrens and Campbell, 2000). Talking may also help dissolve some of the guilt and shame associated with rape (Kelly, 1988). In reaching out to others for support, survivors may also find themselves relating more openly (Smith and Kelly, 2001). Changed relationships seem the most consistent of benefits reported after traumas, including rape (Frazier and Burnett, 1994; McMillen, 1999), although it is not known how long these changes may last (McMillen et al., 1997). However, they appear at least somewhat durable, with roughly one-third of survivors reporting this as an area of growth two weeks after rape and again one year later (Frazier et al., 2001).

Recovery may also allow survivors to feel better able to choose supportive friends, talk with them about important issues and help with their crises (Burt and Katz, 1987).
Indeed, when asked about the impact of a friend's rape on their relationship, most friends report feelings of greater closeness, openness and empathy, particularly if they had responded empathically and avoided blaming. Female friends, especially those who have also experienced rape, seem most likely to report such changes. However, not all friendships deepen when rape is disclosed: male friends seem more prone to respond with blame, emotional disengagement or avoidance (Ahrens and Campbell, 2000).

Whilst friends may provide biased reports of relational changes because they were involved in providing support, these data do suggest that friendships may be enriched following disclosure of rape. Frazier and Burnett (1994) indicate that survivors of rape view their supporters, particularly other women, highly, although these data were obtained three days after the rape, at a time the authors acknowledge may be before helping failures emerge and when women may be highly selective about who they disclose to. Certainly, some women seem understandably cautious about disclosure, perhaps waiting several months before doing so (Ahrens and Campbell, 2000; Kelly, 1988; Symes, 2000). There may also be extensive variation within the general pattern of valuing friendships; for some, this may involve a change of outlook whereas for others it may be a more fundamental change involving choosing their own friendships and priorities for the first time (Kelly, 1988).

A particularly destructive outcome of experiencing rape involves its impact on sexuality, damaging heterosexual women's 'beliefs about herself as a partner and her ability to develop or sustain an intimate relationship with a man' (McCann and Pearlman, 1990, p. 290). Most find emotional and sexual relations difficult in the months and years after rape (Burgess and Holmstrom, 1979; Burt and Katz, 1987) and may continue to report anger at men, problems trusting them or discomfort around them (Kelly, 1988; Veronen and Kilpatrick, 1983). The experiences of lesbian survivors of male rape often seem overlooked, although for some the experience of having been raped may affect their ability to create a positive lesbian identity, and recovery may include establishing the capacity for intimate relationships with other women and focusing on developing a positive lesbian identity (Warwick, 1996).
Despite this, some heterosexual women may experience positive changes in their sexual relationships, a growth outcome appearing specific to rape. Some may choose celibacy (permanently or temporarily) as a means to regain control (Burgess and Holmstrom, 1979; Kelly, 1988), either directly because of the assault, or because of more general dissatisfaction with heterosexual relationships. Celibacy illustrates the complexity of growth outcomes, resembles a finding from research on PTG following experiences of childhood sexual abuse (McMillen, Zuravin and Rideout, 1995). Many childhood sexual abuse survivors described feeling 'cautious (and) ... suspicious' (p. 1040) around men, or a refusal to trust them at all. These changes may seem less valuable than developing a greater capacity to make judgments about men (Tedeschi and Calhoun, 1995). Yet, qualitative studies indicate that survivors of sexual abuse may experience mistrust as self-protective and realistic (McMillen et al., 1995), illustrating the importance of allowing participants their voices, rather than relying on researchers' post hoc classifications.

A related outcome concerns some women's increased confidence and determination in refusing sex if they do not want it (Kelly, 1988). However, although Burt and Katz (1987) state that 60% of women report feeling able to reject an "unsatisfying romantic partner" after having been raped, the rest do not, and over half still found sexual intimacy difficult on most occasions. It seems understandable however that any growth or change in this area would be difficult since here women may feel particularly vulnerable.

Nonetheless, women whose partners support any changes that they make to the relationship may experience increased confidence and self-efficacy:

It's much nicer, lovely to be able to say no and have no taken. Yes, that's been the nicest bit, learning to say no. It just changes you completely, it gives you so much more confidence (in Kelly, 1988, p. 224, emphasis in original).

For others, simply keeping an intimate relationship going through the aftermath of experiencing rape may be experienced by both as a considerable achievement, which is
strengthening (Frazier and Burnett, 1994; Smith and Kelly, 2001). However, sometimes this may be achieved through women's reluctance to share their feelings with a partner, relieving him of the need to offer support, rather than the relationship deepening through the exchange of support (Veronen and Kilpatrick, 1983).

Changes to philosophies of life

About half of survivors report an increased appreciation of life even just a few days after being raped (Frazier and Burnett, 1994; Frazier et al., 2001). Whilst this seems striking, previous researchers stressing the requirement for a lengthy period of rumination (Calhoun and Tedeschi, 1998b; O'Leary, Alday and Ickovics, 1998; Schaefer and Moos, 1998) others imply that changes here may be virtually instantaneous. Such growth may be associated with women's terror that they would be killed during the rape itself; surviving may rapidly induce a vivid appreciation of life's value, or even a reassessment of priorities (Schaefer and Moos, 1992; Veronen and Kilpatrick, 1983). The link between fearing for one's life and PTG has been noted in relation to a number of traumas (Calhoun and Tedeschi, 1998b; McMillen et al., 1997). Perhaps facing the possibility of death, particularly if there have been problems in one's life, increases commitment to approach life differently now (McMillen et al., 1997).

The experience of dealing with having been raped may therefore become viewed as a turning point for some, precipitating growth in several domains including a review of relationships (endeavouring to invest more in valued relationships or end unsatisfactory ones), a revision of past experiences or placing difficulties into perspective. Actions may also occur, such as making time for goals. Veronen and Kilpatrick suggest that this may eventually produce a 'richer, more satisfying life' (1983, p. 183).

People who describe themselves as religious or spiritual may be most likely to find "benefit" after trauma (Tedeschi and Calhoun, 1996). For example, Smith and Kelly (2001) and Frazier and Burnett (1994) report that some women attribute their survival to God's will, deepening religiosity. These changes, if they occur, may take some time to emerge, although increased spirituality or religiosity (like changes to the self) seem
consistently related to decreased distress after experiencing rape (Frazier et al., 2001). However, for others, ruminating on the question “why?” may be associated with distress if there seems no answer at all, or if the only answer seems to be that oneself is to blame (Frazier and Schauben, 1994; Silver et al., 1983).

Many survivors of rape report a concern for others in similar situations, an area of growth that rapidly emerges and persists for at least a year after rape (Frazier et al., 2001). Some may also become aware of a political perspective emerging from their experience, such as becoming less tolerant of male attitudes to women and sex, or abuses of power (Burt and Katz, 1987; Kelly, 1988). A few may act on these changes, finding meaning in becoming involved in social or political action or by supporting other survivors (Burt and Katz, 1987; McMillen et al., 1997; Veronen and Kilpatrick, 1983). In this way, women may also begin to see themselves as activists or helpers, rather than “victims” (McMillen, 1999). However, for many women who have been raped, supporting other survivors may feel too painful.

All survivors experience severe distress after the trauma of rape, and many remain seriously distressed by this experience. Some however may be able to use at least a few aspects of their recovery developmentally. However, Kelly (1988) reminds us that this, if it occurs, does so against the background of the devastating consequences of experiencing rape. Areas of “growth” seem linked in many cases with the suffering, harm and damage associated with the experience of being raped: however, some valuable understandings and choices may emerge for some people from their attempts to cope with the trauma of rape. Coping and PTG seem related but distinct: distress may need to be managed to some extent before any valuable outcomes of recovery can be identified (Park, 1998), although Calhoun and Tedeschi (1998b) suggest that, as coping reduces distress, the period of most growth may have ended.

Even just a few days after experiencing rape, some survivors seem able to report at least some valuable outcomes (e.g. greater appreciation of being alive), which increase steadily over time (Frazier and Burnett, 1994; Frazier et al., 2001). This is consistent with studies of other traumas (Affleck et al., 1987; McMillen et al., 1997; Tedeschi and
Calhoun, 1995), and Calhoun and Tedeschi (1998b) wonder if growth is most likely for those who find it quickly. Other benefits seem more specific to sexual (and domestic) violence, such as an increased intolerance of male power and a greater affinity with women. However, there is clearly a need for more studies of growth after the experience of sexual assault in order to supplement these findings.

Many quantitative studies of PTG are cross-sectional, retrospective and assess growth using a single open-ended question (Frazier et al., 2001). Longitudinal designs may better reveal sequences of growth (and perhaps its decline), particularly since PTG seems not a static outcome, but a process unfolding over time (Thompson, 2000). However, quantitative approaches may fail to do justice to the complexity of growth responses after the experience of being raped, or capture its sometimes-paradoxical quality. Survivors' experiences cannot necessarily be known a priori (as implied by quantitative methods) and some may not conform to theoretical expectations (Brison, 2002). Research including previously neglected survivors of rape (those who do not access services, or those raped by acquaintances) is also needed: whilst these are the majority of survivors of this experience, they appear often overlooked. However, a problem amongst all such studies remains that, when asked to evaluate growth, participants may compare their current functioning with that during the lowest point of their trauma (a particularly painful, prominent time), which may exaggerate the apparent degree of PTG (Cohen, Cimbolic, Armeli and Hettler, 1998).

An important question concerns whether reports of growth correlate with objective measures of emotional, spiritual or physical well being, although few researchers explore this. Some have found a small relationship (Affleck, Tennen and Rowe, 1991; McMillen et al., 1995). For example, Burt & Katz (1987) factor-analysed their measure of growth after the trauma of rape into three subscales: self-value, positive actions and interpersonal skills. Only self-value was positively associated with self-ratings of adjustment. However, Frazier et al. (2001) suggest that early reports of growth (2 weeks after rape) are predictive of less distress 12 months later. But not all studies associate PTG with adjustment (Cordova et al., 2001; Joseph, Williams and Yule, 1993) and the data seem few and inconsistent. Perhaps the relationship between PTG and adjustment
is only in certain areas, or there is no predictive relationship, although Calhoun and Tedeschi (1998a) point out that perceiving growth after trauma has at least not been associated with poor adjustment.

**Therapeutic implications**

Viewing trauma developmentally implies that therapists can be open to the possibility of growth (although not invested in this process), therapy perhaps facilitating this (Danish and D'Augelli, 1980). Psychologists who are familiar with PTG appreciate that reports of growth may not necessarily indicate denial, are ready when the client expresses any growth they have discovered and know that, whilst simultaneously experiencing distress and growth appears paradoxical and contradictory, valuable and negative outcomes are frequently reported and seem separate elements (Lehman, Davis, Delongis, Wortman, Bluck, Mandel and Ellard, 1993; Calhoun and Tedeschi, 1999). Therapists working with survivors of rape may also find it useful to be aware of the areas within which valuable changes may sometimes occur (Burt and Katz, 1987; Thompson, 2000). The knowledge that some women are able to identify some areas of growth through their struggle to cope with the aftermath of rape may also be empowering and even normalising for clients who have similar experiences (Lamb, 1999; Thompson, 2000). However, many women do not seek professional support after being raped, although some, entering therapy for other reasons, may also want to explore an experience which happened in their past.

Psychologists should not attempt to introduce the topic of PTG, or rush clients towards recovery or growth immediately following a trauma (Calhoun and Tedeschi, 1998a). Many clients will not experience PTG, and psychologists should avoid implying that growth is expected: cancer patients often protest against the tyranny of positive thinking (Cordova et al., 2001). It is also enough for women to have survived and coped with having been raped. Several researchers suggest that clinicians adopt a 'conscious focus on growth' with survivors of rape (Thompson, 2000, p. 340), perhaps turning identified dimensions of growth into therapeutic goals (working on issues of trust, or taking positive actions on one's own behalf) (Burt and Katz, 1987). However, this may risk
clients who do not experience growth feeling that they have failed. It also seems particularly important that survivors, who have experienced themselves as vulnerable and controlled by another person, be permitted to direct their own process of recovery, whether or not this involves growth. Yet, therapists aware of the possibility of PTG following rape may be able to help clarify the areas of development that clients identify, using thoughtful, appropriately timed interventions.

Working with PTG suggests an eclectic/integrative approach (Herman, 1997; Calhoun and Tedeschi, 1999), including an existential dimension in which meaning, vulnerability and mortality are examined. Traumas are experienced as unwanted and highly distressing, and particularly during early stages clients may need holding and containment (McCann and Pearlman, 1990). Anxiety (and perhaps posttraumatic stress disorder) may need to be addressed, perhaps using cognitive-behaviour therapy although for some, listening and supporting may be more important.

Psychologists working with survivors of trauma need to be able to contain high levels of distress - which may reoccur - and hear disturbing details without becoming disturbed themselves: adequate supervision and personal therapy therefore seem particularly important (Tedeschi and Calhoun, 1998a). Psychologists working with survivors of rape may experience particularly strong countertransference feelings of horror, repulsion or helplessness, and clients' processes of recovery or coping may be lengthy. Yet, awareness of the processes that some women undergo as they attempt to make sense of and recover from having been raped may help to understand clients' paradoxical, conflicting reactions. Powerful feelings such as hate or shame may persist and be as salient for women who were raped many years ago as in those who trauma was more recent. Likewise, thoughts, feelings and other responses that clients may have thought that they had already dealt with may re-emerge. Clients may also experience overwhelming shame and guilt when they try to explore the rape and may think about what they "should" have done to prevent it. It may be useful for these clients to build links between memories of the rape and ways in which they have successfully coped, even changed, as a result (McMillen, 1999).
As distress subsides, clients may turn to rebuilding their shattered assumptive world (Janoff-Bulman, 1992) and some may report initial experiences of growth. Survivors of rape may experience a period of acute distress followed by efforts to recover that may take time to consolidate or be delayed for many years (Burt and Katz, 1987). At this point, the major goal may be to find out who they are now and how this differs from before: during this period, there may be potential for change and growth (Burt and Katz, 1987). However, for many women, recovery will involve recurrent distress and suffering rather than an initial "acute" phase. Any personal insights that may have been gained through struggling to cope with having been raped may be helpful for some women to help repair negative self-schemas that arose because of the rape.

There may be few observable changes to validate early reports of growth, yet respecting clients' perceptions, even if they seem illusory, may sustain hope and self-esteem and help the reconstruction of beliefs (Calhoun and Tedeschi, 1998a). Asking clients how they have experienced and coped with traumas before may help identify an ability to use recovery from trauma developmentally (Calhoun and Tedeschi, 1998a). Psychologists should avoid mentioning growth unless clients do, to avoid leading or offending; such suggestions may be heard as insensitive and may place the alliance at risk. For similar reasons, most also initially use only tentative reflections (Calhoun and Tedeschi, 1998a) ('it sounds like you're saying that others really supported you when you needed it').

Reinforcers may be used later when reasonable growthful experiences are mentioned, helping to consolidate these (Calhoun and Tedeschi, 1998a), although examining any social pressure to abandon "victimhood" also seems important. Psychologists may help identify and clarify other areas of growth implied by clients, framing these as arising from the struggle to cope with rape and not from the rape itself. For instance, some women may not realise that they have made a "journey" of recovery following rape (Kelly, 1988; Thompson, 2000) and may be helped to recognise the ways in which they have coped or changed. The proper timing of such interventions and a cautious attitude and pace seem important to avoid them being rejected or misunderstood. It may also be necessary to communicate understanding of the rape as a profoundly unwanted trauma,
and that clients may see any growth as a relatively small and ultimately insignificant outcome compared to the devastation of experiencing rape.

Clients may also be helped to develop a narrative integrating the trauma with past and present experiences (Russell and van der Broek, 1992; Saakvitne, Tennen and Affleck, 1998). Through re-telling and revising narratives, meaning may be construed and links established between old and new identities (Saakvitne et al., 1998; Brison, 2002). Through narrative development, opportunities for change may emerge: for example, survivors of rape may wish to explore other instances in which they felt victimised (Veronen and Kilpatrick, 1983). However, attempting to find meaning in a trauma such as rape may involve self-blame (‘this wouldn’t have happened if I’d been more careful’) (Janoff-Bulman and Frantz, 1997). Blaming oneself may be less distressing than acknowledging one’s continuing vulnerability to rape simply because of being female (Brison, 2002; Kelly, 1988). Although therapy can challenge self-blame, it seems unwise to suggest that a search for meaning will always be rewarding.

Sometimes, developing a narrative involves using religious or spiritual schemas in the search for meaning. Religious beliefs seem highly robust: although faith may weaken immediately following trauma, it often deepens in the long-term (Frazier and Burnett, 1994; Smith and Kelly, 2001). Faith may provide a framework within which suffering can be assimilated and meaning generated. Psychologists can help clients explore how their faith has changed as a result of having been raped and struggling to recover, provided that psychologists are comfortable with engaging in discussions of such dimensions.

Such a therapy seems likely to be lengthy: justifying this may depend on establishing a firmer relationship between PTG and adjustment (though it seems likely that helping clients to consolidate any growth is strengthening). Clearly, research is needed to clarify the degree to which therapy can facilitate growth (if at all: the literature assuming that it is possible to facilitate PTG rather than simply coping), the nature and timing of interventions and whether there are any risks attached to working with traumatised clients in this way. Yet, assisting clients to rebuild their lives through greater self-
understanding, improved relationships or integrated life perspectives seems a legitimate therapeutic aim (Linley and Joseph, 2002).

Conclusions

In conclusion, it seems possible to argue that, for some women, their efforts to recover and cope after experiencing rape may in some ways be a developmental experience, involving growth and change as well as extensive suffering, damage and loss. This does not involve dismissal of the many destructive consequences of rape, but rather to offer some balance against psychology’s almost exclusive attention to these. Likewise, this argument does not imply that being raped can ultimately become a positive or worthwhile experience: rather, it is through coping with its distressing, unwanted aftermath that some women may emerge feeling stronger – and more fragile - or may make changes to their lives. Indeed, Ryff and Singer (1998) suggest that the deepest levels of meaning, purpose and connection may emerge from engagement with such challenges.

However, it remains the case that many people do not experience growth after traumas, including rape, and remain seriously damaged. What the difference may be is unclear, but for some people engagement with existential issues may be experienced as too threatening (Golsworthy and Coyle, 1999). Likewise, the particular dimensions along which growth may occur in recovery from being raped require further exploration, as does the issue of how long gains in each domain may last. Nonetheless, PTG remains a rapidly growing area of psychotraumatology, and a rewarding area of research and practice for counselling psychologists. Whilst rape and other victimisations seem largely neglected, their exploration seems justified and may produce interesting findings.
References


Appendix 1: Personal reflections
Personal reflections

My interest in PTG arose after reading an article by Tedeschi and Calhoun (2000) shortly before beginning the PsychD, when I was searching for a research topic. I had mixed reactions to this topic, liking the idea but not being completely sure about it, although feeling intrigued. I also thought that what these authors were suggesting was not an optimistic revision of trauma, but a balanced or widened perspective that was not intended to be every traumatised person’s “truth”. I liked the idea of gently challenging the picture painted by existing trauma theory not by undermining it, but by respecting its contribution whilst also adding to it.

A common criticism is that PTG reflects an extreme and caricatured version of humanistic theory, although this is perhaps based on misunderstanding since the concept has much older roots in the world religions, existential philosophy and in literature. I think this view might also misunderstand the actualising tendency (often misrepresented as a moral force for “good” or a “constructive drive”, but is just an amoral biological capacity to make the most one can from one’s living process; Mearns and Thorne, 2000). The actualising tendency doesn’t suggest that people develop beautifully in harsh conditions or that all is for the best; it acknowledges that people often develop in distorted ways but that this still reflects the actualising tendency’s attempt to express itself.

I suppose I have added this clarification because I do sometimes feel that I have to defend my interest in PTG, and am genuinely surprised by the animosity this idea sometimes stimulates. Presumably this is because it may seem to dismiss or play down the horror of trauma (a misreading) and so I have tried to make my case in the literature review cautiously and done my best to make it clear that I am not trying to minimise the trauma of rape or put a positive spin on this experience, but rather to reflect the growth that other researchers claim their participants discovered through coping with this experience.
I noticed, when writing this review, quite a few articles in the media about people who were apparently grateful that they had experienced trauma. These seemed people who had been living out-of-control lives and were involved in accidental traumas (e.g. becoming paralysed after car accidents), ending their old way of living and so diverting them from a self-destructive path. I imagine that people who feel glad that they were involved in trauma are very much in a minority, and that this sentiment would not be expressed by survivors of rape, for obvious reasons. But perhaps extreme examples like these are on people’s minds when they think about PTG, and if so then I can well understand the hostility felt about my seemingly applying a perspective that suggests that, in the end, being raped might be a worthwhile experience. This absolutely is not my view and I hope my review puts readers’ minds at rest in this respect.

My decision to address rape in particular came after I noticed how conspicuous this trauma seemed by its absence from the PTG literature, as if few researchers felt willing to extend the PTG concept to this experience. I could understand this - I have had to hold onto a lot of my own anxiety about doing this myself - but I started to become interested in what happens to women who have experiences of severe traumas. It seemed at least possible that some might find certain aspects of their struggle to recover from this trauma valuable (if not necessarily worthwhile), and that these would be associated with the suffering and harm of experiencing rape. I found it reassuring to read respected feminist researchers on sexual violence such as Kelly (1988) addressing the topic of growth during recovery from rape, and how she dealt with this by placing it in context by attending to the full extent of the negative aftermath of rape. As such, I do think that some of the research on PTG generally could be better worded; for example, I found titles such as “Better for it” and “Perceptions of benefit resulting from the loss of a child” left me feeling uneasy.

I did also wonder if I was trying to work out any of my own issues through this literature review; writing about this trauma has inevitably brought to mind some of my own experiences of what Kelly (1988) calls the “continuum of sexual violence”, from unwanted comments in the street through to feeling under pressure to sleep with a man
when I did not want to (when I was younger). It was therefore really helpful to have my personal therapy to reflect on this throughout the process.

I found writing this review a quite isolating experience because I did much of it at the end of the year when there was no more teaching and so little contact with my peers. I felt quite alone with my anxieties about whether I was doing the "right thing" by considering the trauma of rape from a growth perspective. Rape is an extremely emotive topic and I struggled with concern that others might misunderstand the perspective I was taking to this trauma. However, it did encourage me to reflect and become very clear about what I was, and was not, trying to say. The support of my supervisor was also important in that he recognised the balance I was trying to negotiate. I don’t feel that acknowledging growth outcomes makes this trauma seem more acceptable or less horrifying, nor that women who do not experience growth have failed in some way, because I see growth as a possible process occurring alongside acknowledgement of the damage done by traumatic experiences, rather than some kind of desirable / ideal end point.
Appendix 2: Details of target journal
Exploring growth outcomes in the aftermath of rape: an interpretative phenomenological analysis

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Abstract

This study examines recovery and growth after the experience of rape amongst a sample of women recruited from the UK. In-depth interviews were carried out with ten women who identified themselves as having been raped, addressing the impacts of this experience and ways in which participants may have felt changed by coping with this trauma. The data were analysed using Interpretative Phenomenological Analysis. Findings indicated that, whilst participants unanimously acknowledged the ongoing, damaging impacts of their experiences, all identified at least one valuable change in perspective attributed to their efforts to recover. Three broad domains of growth were identified; changes to relationships (such as strengthened relationships or mistrusting men, identified as a self-protective strategy), changed views of the self (feeling stronger or more self-aware) and changed outlooks on life or the world (existential changes or increased awareness of sexual violence). Certain outcomes appeared similar to those identified following other traumas; others appeared specific to the aftermath of sexual violence. The limitations of this study are discussed and clinical implications are suggested: findings may be of relevance to counselling psychologists who might find it useful to know the dimensions along which growth may occur after the trauma of rape.

Keywords: Rape; sexual violence; women; recovery; posttraumatic growth.

Introduction

A substantial literature explores the relationship between experiencing trauma and chronic physical, psychological and social difficulties. Whilst these are serious and worthy of investigation, other transformational outcomes of trauma seem largely overlooked. As such, Calhoun and Tedeschi (1998) encourage a paradigm shift in
psychology, stressing the importance of examining the valuable that sometimes also result from individuals’ efforts to deal with trauma. Indeed, this potential for valuable outcomes following trauma has long been acknowledged in history, religion and philosophy (Linley, 2000; Tedeschi and Calhoun, 1995) and is not completely unknown by psychology (Kobasa, 1979). The term ‘posttraumatic growth’ (PTG) (Tedeschi and Calhoun, 1995) is often used to describe this experience; others include ‘stress-related growth’, ‘thriving’ and ‘transformational coping’ (see McMillen, 1999 and Tedeschi, Park and Calhoun, 1998, for reviews).

Individuals have reported at least something of value emerging from their efforts to cope with traumas including bereavement, terminal illness and mass shootings (Calhoun and Tedeschi, 1989-90; Cordova, Cunningham, Carlson and Andrykowski, 2001; McMillen, Smith and Fisher, 1997; Schwartzberg, 1994). Rates vary, depending on methodology, definitions and the trauma considered but about two-thirds of people seem able to identify at least something valuable associated with coping with traumatic experiences (Tedeschi and Calhoun, 2000). Self-reports fall into three broad categories: changes to the self, to relationships and to philosophies of life (Tedeschi and Calhoun, 1995).

Yet, this literature says little about the experiences of survivors of rape, despite research suggesting that this shattering trauma is experienced by between 5% and 15% of women (Koss, 1993; Myhill and Allen, 2002). This perhaps relates to indications that experiencing rape is more distressing than experiencing other forms of violence (Kilpatrick, Veronen and Best, 1984). However, severe traumas seem also offer potential for growth (McMillen et al., 1997; Park, Cohen and Murch, 1996). Rape has been described as a uniquely traumatic event (Ullman and Filipas, 2001), the rapist’s purpose being to terrorise, dominate, humiliate and render victims utterly helpless (Herman, 1992). Rape is also a profoundly physically and psychologically intrusive experience, the situation experienced as so out of control that victims may fear for their lives, irrespective of whether the rapist is a known person (Veronen and Kilpatrick, 1983).

The distressing aftermath of rape is well documented, including immediate traumatic reactions (Burgess and Holmstrom, 1979b; Kilpatrick, Resick and Veronen, 1981) -
persisting in those who develop posttraumatic stress disorder - and depression (Atkeson, Calhoun, Resick and Ellis, 1982). Other painful aspects involve experiencing powerful, complex emotions including shame, humiliation, degradation, stigma and others' ambivalence concerning responsibility for the attack or how to respond (Burt and Katz, 1987; Smith and Kelly, 2001). There is also the invasion of the body over which the person has no control. The suffering of women raped by acquaintances has recently gained more consideration, the literature suggesting that these survivors feel as terrorised as those raped by strangers although often do not define their experience as rape. They may also blame themselves more, feeling less able to attribute responsibility to the perpetrator (Frazier and Seales, 1997).

The relative neglect of rape within the PTG literature perhaps also relates to researchers' understandable concerns to avoid misinterpretation as legitimising rape or minimising its destructive impact. Yet, rape therefore appears a trauma explored only in terms of its negative impacts although it is possible that, by struggling to find ways to cope with these difficulties, some women may identify areas where valuable changes have occurred. This does not imply that rape is in any way "good for" women but asks whether, in facing the challenges of healing, some women may make choices or reach understandings that they value (Burt and Katz, 1987; Veronen and Kilpatrick, 1983). Ignoring this may mean that some aspects of healing are overlooked or minimised (Thompson, 2000).

Few studies address growth after rape: however, results suggest that, for some, recovery can involve certain valuable outcomes, including appreciating one's resiliency, valuing and trusting oneself more, deepened relationships and a concern for other survivors. Some may become more intolerant of sexism and abuses of power (Burt and Katz, 1987; Frazier, Conlon and Glaser, 2001; Kelly, 1988; Smith and Kelly, 2001; Veronen and Kilpatrick, 1983. See Ashley, 2002, for review). Therefore, whilst psychologists might assume that long-term outcomes are exclusively negative, these may not always be survivors' experiences (Burt and Katz, 1987).

7 Hereafter, the term 'survivor' will be used to refer to women who have experienced rape.
It is imperative to stress however that any valuable outcomes occur against 'the background of the profoundly negative consequences' of rape (Kelly, 1988, p. 189). However, some studies in this area focus exclusively on growth outcomes without assessing negative life changes within these domains. As such, they may inadvertently construct a picture of healing as an ultimately beneficial, even worthwhile, process. It seems important to allow survivors to describe their processes of recovery in terms of both harmful and valuable outcomes in order to obtain a fuller sense of the aftermath of this trauma. The significance of any growth outcomes for survivors themselves also remains unclear.

A literature review (Ashley, 2002) indicated that most studies of growth outcomes after rape are American (see Kelly, 1988, for an exception). It is unclear how far results generalise to British samples. Systematic research of posttraumatic growth is still relatively new; although standardised measures exist (McMillen and Fisher, 1998; Tedeschi and Calhoun, 1996), there are few descriptive studies, especially in the area of rape. Qualitative research may make an important contribution; quantitative studies by definition confine responses to researchers' pre-defined categories, restricting opportunities for unexpected, interesting reactions. Qualitative approaches allow such responses to be analysed rather than discarded as uncatagorisable because they do not conform to theoretical expectations (Cohen, Hettler and Pane, 1998; Massey, Cameron, Ouellette and Fine, 1998). By exploring their perspectives and experiences, participants may also illuminate the processes by which growth and damage occur. The literature review (Ashley, 2002) also indicated that most participants are recruited from rape crisis centres / hospitals (Frazier and Burnett, 1994; Frazier et al., 2001; Kimerling and Calhoun, 1994) yet most survivors do not approach services, particularly if they were raped by acquaintances. Research including participants from previously neglected groups is therefore needed.

This research aims to explore processes of recovery from the perspectives of survivors of rape, specifically addressing valuable outcomes, to address what factors may facilitate recovery and growth and examine the significance of growth outcomes for survivors.
Method

Recruiting participants

Ten participants were recruited via advertisements placed in local and national newspapers and women's lifestyle magazines/websites. Posters were also placed in libraries and universities. Participants were required to be female, to define themselves as having been raped and to consider themselves to be "dealing with, or to have dealt with", this experience (implying that respondents should have addressed this trauma to some extent. Terms were purposefully not further defined to encourage respondents at different stages of recovery). Respondents were excluded and referred to supportive agencies if they had been raped before the age of 18, had experienced childhood sexual abuse or had been raped less than three years ago (which, it was felt, might preclude sufficient time to begin processing this experience). One woman, raped 18 months previously, was included, having indicated that she was in ongoing psychological therapy focusing on this experience. Respondents were not excluded if they described multiple experiences of rape, the literature suggesting that this is common (Cohen and Roth, 1987).

At first contact, respondents were offered more information. Those who still wished to participate were screened by telephone to ascertain their readiness to be interviewed (see Appendix 1, p. 142). If interviewing did not seem appropriate, sources of help and support were provided.

Interview schedule

A semi-structured schedule was developed by reviewing the literature on PTG and recovery/coping after rape. A draft schedule was developed based on recurring themes within these sources, also addressing areas that seemed overlooked such as the significance of growth outcomes to survivors. This was piloted with workers with survivors of rape at two centres, approached because of their expertise (analogous to key informant interviewing; Gilchrist, 1999; Marshall, 1996) and because of the risk of
otherwise “using up” participants. They provided feedback and offered practical suggestions regarding interviewees' well-being. The schedule was further amended based on participants' feedback.

The final schedule consisted of open-ended, broad questions relating to impacts of the rape experience, milestones in recovery and ways in which women felt changed by this experience (Appendix 2, p. 148). A key question, towards the end, prompted for valuable changes identified in the course of recovery although many participants spontaneously mentioned these earlier in the interview. Questions encouraged reflection, processing and disclosure of perspectives, supplemented by reflections on emotion/content, requests for clarification, and prompts.

**Interviews**

Respondents participated in individual, face-to-face interviews, which were audiotaped (with consent). These lasted 2-3 hours, all participants choosing to be interviewed at home. The interview style was informed by Coyle and Wright (1996) who recommend employing counselling skills to collect data on sensitive topics. Participants were given a sheet of local agencies from which they could obtain support, if necessary, afterwards. Towards the end, a series of questions encouraged reflection on the experience of being interviewed, including exploration of any upsetting feelings raised. All participants were offered a telephone call afterwards to ascertain their well-being or discuss how they might address any persistent concerns.

Interviews were transcribed orthographically, after which the tapes were erased. Pseudonyms were assigned to ensure confidentiality and any potentially identifying information was removed / disguised. Participants were offered their transcript and invited to suggest additions, amendments or reflections. Four did so; minor transcription errors were identified and participants also discussed the impact of reading their words (three commenting that having their transcription returned enhanced the “therapeutic” value of telling their story, the forth indicating that reading her transcript was sad but helped prepare her for re-starting therapy).
Data analysis

Transcripts were analysed using Interpretative Phenomenological Analysis (IPA) (Smith, 1996; Smith, Flowers and Osborn, 1997; Smith and Osborn, 2003). IPA engages with how participants think, attempting to adopt an “insider perspective”. It enables detailed explorations of participants’ understandings of experiences using small, well-defined samples: whilst reasonably strong claims are possible for that group, claims for the wider population are made only with the greatest caution. Whilst IPA does not claim that participants’ thoughts are transparent within verbal reports, analysis proceeds on the assumption that meaningful interpretations are possible about that thinking (Smith, Jarman and Osborn, 1999).

Analysis involved repeatedly reading each transcript, noting any key phrases or processes. These notes included attempts at summarising, making links to other parts of the transcript or initial interpretations. The resulting key words/phrases represented the initial themes for each transcript. These were then analysed alongside themes from other transcripts, producing a list of shared themes. Idiosyncratic experiences were retained however, as these broadened understandings of the complexities of the shared themes and the processes underpinning them. Attempts to account for variability amongst the data also sometimes led to the creation of new themes. Thematic categories were examined to see if ‘higher-order’ categories could be created, meaningfully subsuming others. An interest in understanding process also meant that attention was paid to the connections that interviewees made between different elements of their experience, enabling links to be established between themes (although unambiguous lines of causation were rarely made). IPA recognises the influence of the researcher’s interpretative framework: therefore, whilst one researcher took prime responsibility for analysis, another checked that the emergent themes and interpretations were congruent with participants’ accounts.

Qualitative research is embedded in a philosophy of knowledge development distinct from the positivist tradition. Whilst positivist research attempts to establish objective knowledge ‘represented as regularities, even laws’ (Elliott, Fischer and Rennie, 1999, p. 217), qualitative research relativises the knowledge gained to the participants, situation
studied and the researcher. Therefore, traditional evaluative criteria (validity, reliability) become inappropriate. Elliott et al. (1999) suggest alternative criteria by which to evaluate "trustworthiness" such as persuasiveness, coherency and resonance with readers who have undergone similar experiences. In the following presentation of findings, interpretations are therefore accompanied by quotations to convey their basis and enable readers to evaluate their persuasiveness. Empty square brackets indicate the omission of material (to protect anonymity, or render quotations more concise). Material in square brackets is added for clarification, and ellipses indicate pauses in speech. I have attempted not to over-interpret participants' accounts, but - to the extent that this is possible - to enable participants to speak for themselves whilst giving shape to the analytic narrative.

Results

Sample characteristics

The ten participants were aged between 25 and 54 years (mean = 35.70, SD = 9.08). Seven described themselves as heterosexual, two as bisexual and one as lesbian. Seven were in relationships (three of these marriages/cohabitations). Six were White British, the remainder from other white European backgrounds. Five were educated to postgraduate level, three to degree level and two held vocational qualifications.

The rapes occurred between 18 months and 20 years before the interviews. Seven women had been raped on one occasion (Susan, Marie, Amy and Ailsa by strangers; Camille, Charlotte and Lene by acquaintances). Louise was raped on three occasions (once by a stranger; on two occasions by acquaintances). The remaining participants, Natasha and Lillian, were raped on several occasions by their then-partners. Nine had reported the rape(s) to police, GPs or hospital staff.

The analysis produced a variety of themes. A full list of themes appears in Table A (in Appendix 3, p. 161). Because of word limitations, only a subset are presented; those offering interesting insights, that seem less well covered by the literature or that help to contextualise experiences are presented rather than those which seem well-described already. To avoid constructing a false picture of recovery as an unproblematic, even
ultimately beneficial process, findings are presented in terms of trajectories of growth and ongoing harm; however, because of the focus of this research and word limitations, only findings of growth are presented in detail.

Impacts on the Self

Before presenting growth findings for this theme, it is important to contextualise these by presenting the negative impacts, which every participant stressed. Whilst these were extensive, and often ongoing, word limitations permit only a brief description. Traumatic reactions and self-blame were common during early stages (see Burgess and Holmstrom, 1974, for discussion) although two participants reported ongoing self-blame for having been raped (see Frazier, 1990, 1991; Frazier and Seales, 1997 for discussions). Several described ongoing suffering, loss of confidence or enjoyment in life and continuing fear and unease. Anxiety about wanted sexual contact was also mentioned although positive sexual experiences were described as milestones in recovery.

Extensive losses were also reported, including the loss of years to the aftermath and the loss of rewarding, professional careers which were, reluctantly, abandoned due to continuing suffering, distress or physical injuries. Others described “losing touch” with themselves after being raped (although by addressing their difficulties, some described knowing themselves better: discussed below). Rape involves experiencing profound loss and survivors may experience a process like mourning, or feel that they are no longer the person they were (Burt and Katz, 1987). As the following subtheme explores, a sense of being in some ways a stronger person than before may also emerge from this process.

Self-reliance and feeling stronger

A sense of achievement in having carried on or regained what was lost

Several participants felt that their persistence and determination not to give up through the aftermath of rape had fostered a tentative sense of achievement. When asked whether she felt changed by dealing with having been raped, Natasha replied:
Maybe there's something about knowing that you can cope with it, knowing you've survived it [ ] and perhaps I didn't think I would before it ever happened. I mean, if someone had asked me, "Do you think that you could cope with being raped?" I would probably have said, "No, no, no. I can't cope". But obviously I can. I didn't even realise I was.

As Natasha suggests, coping may only be appreciated in retrospect. Amy also explained a sense of satisfaction in having kept going, despite many setbacks:

There's almost a pride in getting through what's knocked you down time and time again, to get up even when you feel so exhausted and so beaten down and so bored with the whole thing.

Some mentioned pride in having negotiated a path whereby they had moved from a position of intense neediness to coping, even consolidating elements of growth. Sometimes, this was framed in terms of having regained what had been lost:

As I started to begin to address the issues and try to recover from it in various ways, I think I started to establish a much stronger feeling of self-esteem and I feel now I've come to a place where really, I feel a bit proud of myself [laughs]. [ ] I think I've finally started to cope actually really quite well with the things that have happened and that's like ... I feel much stronger and more stable. Not that I would like to think that I would like to be raped in order to feel strong and stable, but I think that was something that was taken away from me and I've managed to get it back (Susan).

Confidence about coping with other crises

People dealing with trauma sometimes describe changes in self-perception, including feeling more hopeful about future crises: that "if I can cope with this, I can cope with anything". Such perceptions occurred amongst this sample:
I think that's a positive thing, to know you can get over something that is so massive [ ]. You know that whatever happens, you can come out the other side of it, no matter how bad things get (Amy).

It's probably reinforced that, that I can deal with situations and that I can get through things because I've got through this (Louise).

Louise's comment implies a renewed sense of self-efficacy, an ability to survive and cope. Indeed, dealing with trauma and surviving it may mean that individuals feel able to use their insight and experience to face future difficulties (Tedeschi and Calhoun, 1995).

Marie described how, after being raped, she had trained in self-defence; subsequently, during an attempted rape, she had successfully defended herself. She described how 'It felt fantastic, it felt like I had power [ ]. I just felt really good about myself, like nobody is ever going to do it again'. Marie's experience suggests that she was able to restore a sense of control. Indeed, Gavey (1999) suggests that sometimes, successfully defending oneself against attempted rape leaves women feeling 'strong, determined, and invulnerable' (p. 71).

Some participants also reported feeling more self-sufficient after successfully coping, their comments suggesting a regained sense of self-efficacy:

I think I was very frightened for a long time and I wanted someone to look after me and it's taken me a really long time to realise I can look after myself. That's really important to me now, to know that I can deal with all this and stand on my own two feet [ ]. I've taken control of my life [ ] and I think that now I do, I feel a lot less frightened (Susan).

I had to rely on people quite a lot, just because I wanted other people there quite a lot as a support basis. It's taken a few years [ ] [but] I find it easier to cope on my own a bit more. Much more self-sufficient now (Amy).
Whilst most saw increased self-sufficiency as beneficial, Lene’s experience seemed less positive, springing from a disappointing response when she had expected support and protection after disclosing to her partner that his friend had raped her. Instead, he considered blackmailing his friend. She felt that “Obviously I cannot trust this man [my partner].” [ ] I became very emotionally self-sufficient in spite of the fact that there was a lot of negative emotions and negative self-esteem. I did not really rely on people emotionally’. Lene appeared to withdraw following an exploitative response to disclosure; as she suggests, such responses can trigger withdrawal into silence (Filipas & Ullman, 2001; Symes, 2000) rather than greater independence.

Exploring, understanding or accepting oneself

Finally, seven participants described exploring, understanding or accepting themselves more through coping. Marie felt that her self-defence training - in response to having been raped - enabled greater awareness of her physical capacities: ‘I’ve really been able to explore all the power I have [ ]. I believed more in myself and discovered what I could do and how strong I could be’. Indeed, becoming aware of their physical strength may be empowering for some women.

For others, recovery involved understanding and normalising their responses. Susan undertook research for a piece of theatre on sexual violence, immersing herself in literature:

I don’t think I would ever want to read all of that stuff again, because it was pretty harrowing [ ]. But I’m glad that I did do it because I feel it’s given me a very stable base. I think it’s just made me understand myself more and also what’s happened to me.

Susan also described how recovery had resulted in self-awareness beyond normalising her responses, leading her to examine other areas of her life that needed attention:

I think that what it’s also done is to make me look at a lot of other experiences because part of me felt that was the one experience that I needed to sort out but actually there were lots of other things too, to do
The impacts of rape reverberate through many aspects of women's lives and in the process of managing these, some may increase self-understanding. Echoing Susan, Veronen and Kilpatrick (1983) suggest that sometimes, survivors identify and address other issues of concern during recovery, becoming more self-aware or feeling more in control. Trauma may therefore offer opportunities to examine oneself and increase self-knowledge (Beardslee, 1989) or (like Susan) to make use of external resources. Therefore, whilst experiencing severe losses, sometimes participants gained important insights as they rebuilt their lives.

It may seem that the stance assumed by several interviewees – locating areas of strength whilst highlighting ongoing harm and suffering – is unsustainable or paradoxical. However, 'a unidimensional view of self is not adequate to account for how people respond to life transitions' (Tedeschi et al., 1998, p. 11) and those who preserve complex views of self often withstand transitions effectively (Showers and Ryff, 1996). Participants imply that recovery involves resilience and vulnerability, states which may co-exist or temporarily obscure each other at different points during the aftermath. Feeling self-reliant, whilst also appreciating one's vulnerability, may be complementary and mean that survivors continue to use coping strategies (see Table A, p. 161) and social support (Tedeschi and Calhoun, 1995). A sense of vulnerability existing alongside changed views of oneself may also prompt growth within in relationships, discussed below.

**Impacts on interpersonal relationships**

**Self-protection**

Mistrusting men

Every participant described feeling anxious to protect herself from further harm. Several described mistrusting men, experiencing this as a positive adjustment which might prevent further abuse. This seemed a matter of degree - Natasha adopted a somewhat
more guarded stance with strangers, saying, 'I'm a bit less trusting. I'm a bit more wary when I meet new men. Cautious.' Others described a deeper mistrust and suspicion:

You're much more wary of people [ ] No matter how innocuous people seem, I'm looking for what they really want, what they really mean - their hidden agenda.

**Interviewer:** Is this with people generally, or mainly with men?

Mainly men, yes (Camille).

Camille described herself as previously 'cosseted' and 'naïve', implying that her faith in others' trustworthiness had made her more vulnerable. Adjusting these beliefs - and presumably the associated behaviours - seemed an attempt to avoid further abuse. Whilst describing her 'caution' as necessary, Charlotte nonetheless saw it as regrettable, commenting, 'I'm sad that it's come to that, but at the same time I suppose it's a strategy for trying to protect myself and ensuring that something like that won't happen again'.

However, some participants trusted certain men: Marie felt that her belief in her male self-defence trainer enabled her to 'stay in contact with men' and 'realise there's other men' besides those who rape. Others described intimacy with men whose 'qualities shone out' (Charlotte) or who offered more 'sexually equal' relationships than previous partners (Natasha). Perhaps, for some, discovering who can be trusted and being intimate with them occurs in the aftermath of rape. Related to this, participants also described attending to vigilance responses in particular circumstances, described next.

**Attending to vigilance responses**

Half of participants reported a preparedness to trust vigilance responses about particular situations, describing this as their 'antennae', 'gut instinct' or 'radar'. Louise described how, after being raped, 'I've probably learned to value that a lot more and trust it.' She recalled how, when travelling with a girlfriend, she had refused to involve herself in situations if she felt uneasy, even if this irritated her companion. A preparedness to trust one's hunches seems a significant outcome when trust has been betrayed.
This sometimes guided participants to depart from situations even when unsure why they felt uneasy. Charlotte mentioned how ‘sometimes I get twitchy for no reason, like if I’m with some male friends [ ], for no justified reason - I might have known them for a while - and I’ll just be alone with them and [ ] a feeling will come over me and I’ll have to diplomatically leave or whatever because I have to trust my instincts’. Trusting herself seemed important, even if perhaps erring on the side of caution, although Charlotte described sometimes ‘hat[ing] myself for [ ] almost pointing the finger’.

On balance however, participants viewed these changes as valuable. Lene described ‘self-confidence’ in her ability to detect ‘the more subtle forms of sexual assault or sexual exploitation’, recalling a slyly sexual remark made to her by a colleague:

Maybe other people would think, “Oh, he didn’t mean anything by that comment”. Maybe he didn’t consciously mean anything [ ] but subconsciously he meant to do something [ ]. Maybe we don’t scrutinise that enough. I feel very confident of my ability to scrutinise them [laughs]. It is positive for me in my own development as a person [ ] and my security because I will not be taken for a fool again.

Lene viewed other women as potentially vulnerable, saying that ‘sometimes I do not feel they have their antennae open, or they do not see how men are behaving towards them. That’s everything from invading their personal space to ... [ ] Everything begins with a thought [ ]. You must keep your antennae open for these things.’

Findings of mistrust challenge definitions of growth (Park, 1998) and whether or not to accept such reports at face value depends on how “ideal functioning” is defined. However, Kelly (1988) suggests that researchers seldom consider ‘that mistrust of men might be a rational and self-protective response’ (p. 202), more often seeing this as evidence of distortion rather than ‘active and adaptive attempts to cope with the reality of sexual violence’ (p. 216). Several investigators have subsequently viewed mistrust, caution and vigilance as valued, adaptive outcomes of experiencing rape or sexual abuse (Frazier and Burnett, 1994; McMillen et al., 1997; Veronen and Kilpatrick, 1983).
Certainly, these participants described such changes as important, viewing their previous ways of relating as naïve. Rape may seriously challenge schema about men's trustworthiness yet growth may occur if women feel better able to protect themselves or assess men's motives. Perhaps increased tolerance of ambiguity and paradox is needed when evaluating growth after victimisations, which may precipitate complex pathways to growth in terms of relationships (Tedeschi and Calhoun, 1995).

_Deepened relationships_

Traumatic experiences exceed individuals' coping abilities, depleting personal resources. Consequently, they may express fears and weaknesses, share feelings and seek help from certain others. If people respond, more meaningful relationships may develop. Half the participants described how, over time, relationships with female friends/family deepened because of the support received. Sometimes, this was provided by one friend, who responded to survivors' immediate needs for safety, care-taking and practical support:

I was struck by how remarkable one friend was. [ ] She just literally dropped everything [ ]. She let me stay in her house for as long as I wanted, witnessed with the police [ ] - she did everything for me. It was just really nice to know that you've got friends like that. I think I'll always love her for that, no matter what. I will always think about what she did for me then (Natasha).

After experiencing rape, women may feel highly vulnerable and reliant on others' protection, care and tangible aid (Filipas and Ullman, 2001; Sudderth, 1998). Supporters also helped over the longer-term, offering encouragement, listening and acceptance. Sometimes, this was provided despite the supporter's own difficulties. Ailsa's sister is 'mentally ill' and yet, 'amazingly, she was the most non-judgemental and supportive person throughout [ ]. That's incredible: somebody so ill herself, being so supportive. The most supportive'. As Ailsa suggests, participants were often touched by some people's depth of concern, perhaps also because so many others had responded
negatively (responses that could not be reported because of word limitations; but see Table A p. 161). Indeed, Ailsa pointed out how the many damaged or lost relationships went ‘hand-in-hand’ with the strengthening of the few supportive relationships. Nonetheless, such positive responses often prompted renewed appreciation of these relationships which were described as ‘deepened’, ‘extended’ or ‘cemented’. Perhaps a combination of being vulnerable, alongside another’s willingness to help, produces a sense of the availability and significance of certain relationships (Calhoun and Tedeschi, 1989-1990).

Compassion for others’ suffering

Experiencing trauma provides first-hand knowledge of the pain and suffering of others experiencing similar difficulties, which may produce empathy, compassion or altruism (Tedeschi et al., 1998). Certainly, most participants described a change of outlook regarding others’ suffering.

Empathy and experiential knowledge of suffering

Compassion and empathy for other survivors have been reported even two weeks after experiencing rape (Frazier and Burnett, 1994). Longer-term suffering and coping “failures” may also confront survivors with their vulnerability, generating empathy for those experiencing similar difficulties (Tedeschi et al., 1998). Charlotte illustrates both processes:

I really relate to people that have also been in trauma. [ ] [I] can really understand what they’ve been through and what they’re going to face now trying to get through that experience [ ]. I’m glad I’ve developed into this person that can try and really feel what other people are going through [ ]. I wouldn’t say that I was an uncompassionate person before but I think when you feel really powerless and helpless and there’s nothing you can do to stop something from happening, it’s a very fearful place to be in and whilst some people can try to understand it, I really do feel quite like I know it.
Like Charlotte, participants often stressed that they had not been uncompassionate before but that their experiences had deepened their empathy, or provided experiential knowledge that only survivors of trauma can truly access.

After an extremely violent experience of rape, Ailsa developed posttraumatic stress disorder, describing this as a 'humbling' experience offering insight into her sister's mental illness: 'my ability to relate to her was increased enormously, not only from personal experience - since this was the closest that I have ever come to something that I could describe as a mental illness - but also because of your [impaired] ability to work and think, being able to relate to her position and her condition'. Subsequently, Ailsa used these insights to work in mental health, suggesting that from empathy may come a desire to help others: turning one's experiences to others' advantage like this is explored below.

Using the experience to benefit others

Virtually everyone hoped that others would be helped through their involvement in the research. Camille commented that, 'When I saw [the ad], I just thought, well maybe it's time to try and do something. [ ] I thought, some threads could be drawn out of this so that lessons could be learned, things could be better'. Others mentioned that, when they had needed books on recovery from rape, they had been unable to locate many; being interviewed represented their contribution towards redressing this.

Several felt that counselling other survivors would be too distressing. However, Marie teaches self-defence classes and others described creative ways to help. Susan’s involvement in a play addressing sexual violence took her into schools where she led discussion groups and workshops. Charlotte described feeling 'much stronger about what's happened and [I] have the feeling that I want to try and do something to help'. She planned a book for survivors:

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* Although it was made clear that this research was intended for academic consumption, if published.
I really want it to be empowering [ ] so that [readers] will know it's kind of about the journey that you go on and saying yeah, there's going to be really horrible bits on this journey but I've made it, I hope [laughs] and, as I say, offer hope [ ]. I want to help in that kind of way. Also I think there's so little support, it's awful, the way that you're just so traumatised and there's nothing there [ ]. You can't understand the feelings that you're going through. And if you were just to be made aware that it's part of the process [ ], it won't make it easier but it would help you to understand.

Reaching out to those isolated by rape, offering hope and guidance, suggests compassion and a desire to offer what Charlotte lacked during her recovery. A desire to help others has been described following various traumas, including rape and sexual abuse (Burt and Katz, 1987; Russell, 1986) and recognising that one has something to offer, such as empathy and "insider" knowledge, may be experienced as valuable. Although time seems needed to reach this point, altruism may help manage ongoing difficulties by demonstrating personal strength: it may contribute something positive to others and enable survivors to find some meaning in their experience (Tedeschi and Calhoun, 1995). Comparing oneself with others whose traumatic experience is more recent, or who seem to suffer more, may also enable a sense of coping or healing (Taylor, 1983).

Impacts on outlooks on life / the world

Appreciating being alive

Women frequently experience rape as a confrontation with death (Burgess and Holmstrom, 1979a). Indeed, participants described having been threatened with weapons, beaten (sometimes to unconsciousness) or experienced the situation as so out-of-control that they feared being murdered. Experiencing oneself as terrifyingly close to death occasionally prompted an appreciation of survival:

Because he threatened me with a knife, I have a deep sense of making the most of my life. [ ] I thought [ ] that he was going to kill me. And I think whilst in a lot of the healing process I kind of lost myself and wanted to
lose myself and not deal with life, having come out of that I feel a real
sense of going forth and making the most of my life (Charlotte).

Realising that I've been close to death - that also makes you sometimes very
happy that you're alive. That was really after I saw that film9, because she
dies in that film and I thought, well, I didn't. [ ] I think I really value every
day that I'm alive. And you also realise that suddenly it can end, it can end
really quick (Marie).

As Marie suggests, feeling close to death can remind survivors of their vulnerability and
life's fragility. Appreciating being alive can be an almost immediate response to
experiencing rape (Frazier et al., 2001) although Charlotte suggests this can also happen
slowly as she emerged from a protective cocoon during healing. However, ongoing
suffering may impede this appreciation and the world may be experienced as harsh and
dangerous. Charlotte also raised the constraints on women's behaviour:

We have so many standards imposed on us, of how we should act and
how we should be. So many rules and yet inside of myself I feel quite
aggressive about that, you know, like I really want to be myself and be
free and yet that is always set in a juxtaposition of fear.

For Charlotte, this bind was 'frustrating'; surviving rape led her to seek the most from
life, yet fearing further attacks, blame or disapproval threatened to curtail this
development.

Existential changes

By contrast, Camille felt that she 'would rather he [rapist] had killed me'. Being raped
was 'catastrophic', so horrific as to be - in some ways - worse than death: 'I don't fear
dying now because nothing worse can possibly happen to me.' Camille also explained
how:

9 Irreversibile was on release at the time of interviews. It was discussed widely in the media as it contained a lengthy
and apparently graphic rape scene perpetrated by a stranger in an underpass (very similar to the circumstances in
which Marie was raped).
That, in a sense, helps you cope with people who’ve been bereaved. I’ve got two friends who are terminally ill and I can cope with that now. It may be part of getting older but I would say that it’s more a result of this - that actually I do operate at a different level now - perhaps a more profound level. Whereas before I would have been a bit embarrassed, maybe, and just tried to be of practical help, now I can sit down and if they want to say, “I don’t think I will be here next year”, we can sit and talk about it.

Camille’s experience indicates how, sometimes, trauma triggers existential changes that may be considered growth although the person involved may not experience them as pleasant or wanted (Yalom and Leiberman, 1991).

*Increased awareness of sexism / sexual violence*

Three participants seemed more aware of issues of sexual violence / sexism, developing a wider political perspective from their experience. Marie felt that rape ‘is really a power issue’. Lene extrapolated further, pointing out how power is expressed more generally, subtly reminding women of their vulnerability:

> You can get power over somebody else by the way you behave in conversation, the way you are thinking and through very subtle psychological means - by looking them up and down or just by staring at them. Make them self-conscious - make them want to change to the other side of the street. You have already exerted your influence over them.

Discussing sexual violence with other women was described as not only helping to normalise some participants’ responses but also demonstrated its prevalence, ‘from somebody grabbing at [women], or being sexually attacked walking home, men exposing themselves, or following them’ (Lene). This recognition may be a powerful outcome of experiencing rape and has been noted elsewhere (Burt and Katz, 1987; McMillen et al., 1997; Russell, 1986).
Expressions of intolerance of inappropriate behaviours were also mentioned: sometimes, this involved simply walking away, sending a powerful message: 'I was invited out for a drink [ ] and it was quite obvious what he wanted. I just stood up and walked out. And even a month before that, I probably would have sat there and been very cowering' (Lillian). Marie also mentioned the freedom involved in refusing to tolerate unwelcome advances politely, saying, 'I don't care what people think of me any more'. Likewise, Lene described correcting a man who attempted to involve her in a sexualised exchange, describing how 'I had the instinct to laugh and say, “[ ] I don’t need to hear all of that” and put him in his place'.

These women seemed to describe a willingness to stand their ground, arising (as Lene suggests) from a preparedness to act on instinct and wish to be treated respectfully. Charlotte described how fear can be involved too, recalling 'yelling' at a taxi driver who had stared at her throughout her journey. She had felt 'really afraid [ ], very unsafe and very vulnerable', her outburst 'just really about protecting myself.' Resistance may therefore also arise from an understandable fear of being re-victimised. Women’s self-protective strategies (calling public attention to unwanted behaviours, shouting or physically retaliating) are discussed more fully by Kelly (1988), who also points to the risk that many women feel when resisting men’s behaviours towards them.

Participants’ evaluations of growth

To conclude, it is important to stress that, whilst each participant identified at least something of value emerging from their efforts to cope with having been raped, ultimately these were considered unwanted outcomes when set against the horrifying experience of being raped. Most wished that they could return to how things had been before:

In the end, you wish it had never happened (Marie)

If I could have it undone, I would (Natasha).
Natasha also pointed out how any valuable changes are ‘not huge compared to the experience of being raped’. Ailsa seemed divided, considering her compassion valuable yet feeling that ‘It’s horrible really. My forte is now relating to people with trauma. [ ] That’s awful. I didn’t want to become an expert on that.’ The “tyranny of positive thinking” (Cordova et al., 2001) was also raised. Some participants had received advice to “look on the bright side”, precipitating anger:

Why should I [ ]? The only positive that I’ve got out of this is to trust myself and look after myself more but, you know, I don’t feel like I’m a better person because this happened to me (Louise).

Rape is a deeply unwanted experience and (as Ailsa and Louise suggest) survivors may feel ambivalent about developing in its aftermath (see below). Yet for Amy, such developments arose ‘not because of the rape, certainly, but because of what I chose to do afterwards’. As Amy suggests, taking ownership of these changes may also renew feelings of self-efficacy.

Discussion

This research explores processes of recovery from rape from the perspectives of survivors themselves, specifically addressing growth outcomes. Findings provide additional support for the existence of growth after dealing with the trauma of rape, replicating other findings (Frazier et al., 2001; Smith and Kelly, 2001). As is repeatedly stressed by researchers in this field, recording such changes does not imply that rape - or its aftermath - are ultimately positive, worthwhile experiences. Nor does it encourage a “look on the bright side” approach to this trauma. The inclusion of evidence of ongoing damage represents a consequent attempt to contextualise these findings of growth as far as possible.

Whilst every participant identified at least something of value from dealing with this trauma, each stressed the negative aftermath of rape. It seems possible that individuals who report only positive outcomes from trauma protect themselves by denying its damaging legacy. Perceptions of growth - balanced with an awareness of negative
changes – may predict better adjustment and denying one’s difficulties may be problematic (Lehman, Davis, Delongis, Wortman, Bluck, Mandel and Ellard, 1993). Perhaps acknowledging the impact of a traumatic event is essential groundwork before any development can occur (Tedeschi, 1999).

Researchers have made sense of reports of growth in several ways. One has been to accept these at face value as accurate perceptions of genuine changes (Affleck, Tennen and Rowe, 1991). There were suggestions of behavioural changes amongst participants: for example, Louise mentioned refusing to ignore her gut instinct about potentially unsafe situations when travelling and Camille spoke of feeling more willing to engage with discussions of death with some terminally-ill friends. In the absence of, for example, corroboration from others who know the participants well, the “truth” of such reports cannot be evaluated although assessing subjective experience (such as knowing oneself more) would seem difficult anyway. Other researchers suggest that reports of growth may be illusions but that experiencing oneself as having grown is precious in and of itself (Taylor, 1983; Taylor and Brown, 1988). Another explanation is that experiences of growth reflect emotion-focused coping strategies allowing individuals to re-evaluate their experience as less meaningless and malevolent or oneself as less vulnerable (Tennen and Affleck, 1999). Reports of growth, however, do not necessarily imply reductions in distress or increases in happiness, and Calhoun and Tedeschi (1998) suggest that this raises issues about how to understand someone who describes feeling more frightened yet also reports feeling stronger.

In this study, growth was apparent in various forms including interpersonal changes (such as compassion for others), changed views of self (such as feeling stronger) and changed outlooks on life (such as appreciating life). Whilst different traumas may produce different patterns of growth, these domains broadly correspond to those identified following other traumatic experiences. However, certain changes within these - mistrusting men, trusting vigilance responses and an understanding of issues of sexual violence and sexism – seem specific to experiences of sexual violence and may reflect important re-evaluations enabling women to feel safer in the world.
Although this study contributes to research on PTG after rape - and is unusual in that findings are qualitative – the findings may be limited. Participants were White and most were highly educated. The results cannot be generalised to all survivors of rape, although are meaningful amongst this sample and perhaps transferable to other groups with similar characteristics. Likewise, although this sample was taken from the community (rather than clinical sources), most participants had reported being raped yet it is thought that around a four-fifths of survivors do not, numbers further rising amongst those raped by acquaintances (Myhill and Allen, 2002). Some women may also have participated in order to publicise the aversive reactions that they had received from police and other authorities in the hope of changing professionals’ attitudes (regrettably, word limitations did not allow these findings to be reported).

Therapeutic implications

Counselling psychologists may find it helpful to be aware of the potential patterns of growth after this trauma, which may inform their work with survivors of rape. Whilst the literature often assumes that women present for therapy soon after experiencing rape, many – if seeking help at all – often do so when another event e.g. losing a supportive attachment precipitates further distress. Immediate interventions are discussed by Wiehe and Richards (1995). Whenever clients present, the main concern must be to acknowledge and allow the client to repeatedly explore the harmful impacts of their experience(s). Clients may later wish to explore who they are now and how this differs from before: in this period, there may be potential for growth (Burt and Katz, 1987).

Psychologists may need to be willing to support clients’ experiences of growth - and recognise their therapeutic value - even if they consider these illusory (Taylor and Brown, 1988). Often, such reports precede observable change. An awareness of the possibility of PTG may also enable psychologists to appreciate that reports of growth do not necessarily indicate denial, particularly if clients also acknowledge the ongoing, damaging impacts of rape. Psychologists who are aware of PTG may also sensitively recognise and support clients’ own perceptions of growth. Whilst some such outcomes may not immediately appear “healthy”, e.g. mistrusting men, it may help to respect
these as adaptive, whilst supporting clients' efforts to be intimate with trusted others. Additionally, it is important to consider that the variability of growth amongst participants was broad and that different individuals may develop strikingly different perspectives after similar traumas. The meaning that clients make of their traumatic experience may be relevant here.

Supporting growth should be client-led; Calhoun and Tedeschi (1998; 1999) suggest that psychologists can help clients to identify areas of development using thoughtful, tentative and well-timed interventions which highlight the client's own movements towards growth, if these seem reasonable ("It seems that you're saying that this person really helped you when you needed it"). Attempting to initiate growth or rush clients towards this may be experienced as the psychologist being dismissive of the horror of having been raped and of ongoing harm and suffering (Calhoun and Tedeschi, 1998). The psychologist's role is therefore of 'bringing into sharper focus' any growth implicit in clients' words whilst also acknowledging loss and harm (Tedeschi and Calhoun, 1995, p. 105). In this study, participants often recognised growth in retrospect. By sensitively exploring the rape and its aftermath, some clients may identify their "journey" of recovery and recognise ways in which they have coped and even changed.

Experiencing sexual violence produces powerful, complex responses and will always remain a profoundly unwanted experience. It may be difficult for some clients to perceive – or want to perceive - growth in its aftermath. Confronting this issue directly may be helpful, as may stressing that any growth identified arose not from the rape itself, but from clients' efforts to deal with it (Tedeschi and Calhoun, 1995). Finally, psychologists must avoid perceiving clients who do not report growth as having failed in some way: to have survived and coped is enough (Calhoun and Tedeschi, 1999). For fuller discussion of interventions, see Ashley (2002) and Calhoun and Tedeschi (1998, 1999).
In summary, participants identified some areas of growth following their engagement with the aftermath having been raped, specific outcomes often seeming related to the experience of victimisation. Identifying typical patterns of growth and damage after the trauma of rape seems important and future research might determine how the forms of growth described here might vary amongst different populations (e.g. men who have experienced this trauma) or establish which patterns appear more or less adaptive in different circumstances.
References


Appendix 1: Further information provided to respondents at first contact and screening questions used to evaluate whether being interviewed was appropriate for respondents.
INFORMATION SHEET FOR VOLUNTEERS

You are invited to take part in a research project that I am conducting for my practitioner doctorate in Counselling Psychology. This will explore the experiences of women who feel that they are dealing with the experience of being raped and who are willing to discuss this in a one-to-one interview. Interviews will be fully confidential and conducted in a sensitive and flexible manner.

Here is some information to help you decide whether or not to take part. Please take time to read it carefully. Ask me if there is anything that you do not understand, or if you would like more information. Take time to decide whether or not to take part.

This research involves one interview. This will take place at a suitable location convenient for you. I will ask you questions about your experience of dealing with the aftermath of being raped. Interviews will be audio-taped (so that I can cite your experiences accurately) and written up, after which the audiotape will be erased. All data will be handled in accordance with the Data Protection Act (1988).

Why are you carrying out this research? It forms part of the research component of my practitioner doctorate in Counselling Psychology. The findings will be discussed in a research report which will be completed by September 2003. If published, they may be of use to help psychologists understand more of the issues involved when working with women who have been raped.

How long will interviews take? I would anticipate between sixty and ninety minutes.

Who will be doing the interviewing? I will: there will be no-one else present.

Is this research confidential? All the information collected during the interviews will be kept strictly confidential. My written report will not identify you in any way.
Why have I been chosen to take part? This information sheet is available to potential volunteers so that you can obtain more information before deciding whether or not to take part. I am looking for women aged over 21, whose experience of rape occurred at least three years ago, who consider themselves to be dealing with this trauma and who feel able to discuss their experiences.

Do I have to take part? No. Participation is entirely voluntary. There is no financial remuneration for taking part.

Can I change my mind? If you want to stop the interview, you may say so at any time without giving a reason and I will destroy your data. You may also decide to change your mind after the interviews: again, your data will be destroyed.

What are the possible disadvantages of taking part? Some women who have been raped may find this experience too painful and distressing to talk about. It is important to take time to consider whether participation seems right for you.

Thank you for taking the time to read this. If you would like to take part, or would like more information to help you decide, then please contact me:

- directly on psm1ha@surrey.ac.uk
- or leave a message for me with Mrs Kay Hambleton on 01483 689176 and I will call you back.

- Heidi Ashley (Trainee Counselling Psychologist, University of Surrey).

Supervised by Dr Adrian Coyle. You are invited to contact Dr Coyle to verify any aspect of this research at A.Coyle@surrey.ac.uk or on the number above)
Screening / assessment procedure during initial telephone contact

(Offer to ring her back).

*Broad areas to cover (in informal, conversational style):*

Introduce myself and the research (investigating women’s experiences of dealing with rape and its aftermath).

This research involves one interview, taking place over the next few weeks at your convenience. The interview will take place at a location convenient to you and should take about ninety minutes.

It’s important to be really clear that what I’m inviting you to be involved in is a piece of research and not therapy. That means that whilst I’ll be taking care to ensure the well-being of interviewees, I’m not offering anything longer term, and being interviewed might not be the right thing for some women to get involved in. We can think about that together in a moment.

Unfortunately, I can’t involve anyone who was raped before the age of eighteen, who was sexually abused as a child or who was raped less than three years ago. You might not want to say anymore about it, but perhaps one or more of these criteria apply to you?

If yes: Explain (sensitively) that unfortunately I can’t invite her to take part. Thank her for her time and interest anyway. Mention that I’m aware that she has taken the time to make contact and might feel disappointed not to have an opportunity to tell her story (allow her to respond).

If seems appropriate: would she like me to provide information on services that she can get in touch with? (Ask for her address and explain that I won’t keep it on record).

Take time over this so that she doesn’t feel brushed off.
If no: Just so that we can make sure that this is the right thing for you to get involved in, do you mind if I ask you a few questions? Are you able to talk for a short while?

Maybe you can start off by telling me something about why you’ve responded to my advert?

Is there anything in particular that you’re hoping to get out of taking part?

How are you at the moment with friends and other supportive people in your life? Could you talk to him / her / them after the interview if you needed to?

What's your view on how ready you might be to take part in something like this?

Are you in therapy / counselling at the moment? (If yes) That’s great in that if you do decide to take part, you have somewhere to take any difficult feelings that might be raised. But you might want to think about discussing taking part with your therapist first so that you can explore how it might affect your therapeutic work together?

The interview begins with a question asking you about the events surrounding and following your experience of rape. However, the interview will be conducted sensitively and is going to be pretty flexible in terms of letting participants decide what and how much they want to say. I hope that there might be some benefit to those talking part. But, there is a possibility that taking part in this research could trigger unexpectedly powerful emotions in you (does she seem able to hear that?).

If you did get upset, how would you like me to respond?

I won’t be starting interviews for a couple of weeks yet so what I suggest is that I send you some information so that you can reflect on what we’ve talked about. Then, you can get back in touch if you’re still interested and we can set up an interview date. There’s no need to get hold of me again if you decide to give it a miss after all.
If being interviewed doesn't seem suitable for her:
Thank her for getting in touch and for showing an interest. Say that, on reflection, I'm wondering if being interviewed is the right thing to get involved in at present. Suggest that perhaps there are other ways she might address her needs. Mention that there are other people that she could speak with who are able to offer more than I can. Offer information on resources that may be useful (take address) or if appropriate suggest that her GP may be a good first port of call.

Let her respond and take time so that she doesn't feel rejected or as if she somehow isn't "coping properly".

If woman contacts me again wishing to be interviewed:
Arrange a place, date and time for this.
Take her mobile number (if permitted) and offer mine in case of delays, etc.
Remind her of her right to withdraw at any time: she can text me to cancel the interview if she wishes and I will understand.
Ask if I can take the first part of her postcode; explain that this is because, just in case we need to make use of it, I can prepare a list of services in her locality that she can contact if she wants to speak to someone after the interview.
Appendix 2: Interview schedule, consent form socio-demographic information form.
Interview schedule

Spend some time informally introducing myself and the nature and aims of the research. Use this time to build rapport and convey a warm, "real" person who is interested in the interviewee, values her experiences and is also resilient enough to hear what she has to say. This allows us to gradually warm up to the interview itself.

Offer (as a printed sheet) some contact details for further support that she might like to consider. Important to offer this now and not later as some women may mistakenly think that sources of support given later are an indication that she needs help (and that this may be withdrawn if she does not take it). Easier to avoid misunderstandings if the information is given early and she can take it away and then the choice is hers.

Reiterate the personal and potentially distressing nature of the interview material and that, if at any point she would like to stop (for a break, or completely) then please let me know. Remind ourselves of the ways in which we agreed (during our initial telephone contact) that I would respond if she becomes distressed. Explain her right to withdraw at any point without needing to give a reason in which case I will destroy her tape.

Explain confidentiality procedures.

My plan is that we'll spend about ninety minutes together. However, I'd like you to determine exactly how long we spend on this, so you have the scope to take your time when you need to, or to end earlier if you want.

Have participant complete the socio-demographic questionnaire: To begin with, I'd like to gather some information about you, like your age, education and occupation. This is so that I can show the people who read my report something about the range of women that I've been speaking to. The information that you give won't be used to identify you in any way. But if you don't wish to answer any of the questions, just leave them blank.

Before we begin, perhaps you have some questions or concerns you'd like to address?
Obtain signed consent to begin the interview. Begin taping.

The rape and its context

I envisaged that we might start by asking about the events surrounding and following your experience of rape. However I want to know how you feel about this; whilst this information helps me to try and understand the context of how you dealt with the rape and its aftermath, I want to be guided by you, so how does this seem as a place to start?

Prompt (if woman seems unhappy with this start): The reason I ask about this is because knowing a bit about your experience of rape helps me put the rest of what you say into context, so I can try and get a sense of things. But it might be that starting this way isn't right for you. It's OK for us to go back to this later if you like, or for you not to talk about this at all.

Prompt (if woman seems happy enough with this start but unsure what is being asked of her): What I am hoping is that you might be able to find some way to summarise your experience of rape – what happened that day, and what things were like for you afterwards. When you feel ready, perhaps you could start to tell me something about that.

Allow participant to determine her own response to this question, and to offer as much detail as she feels OK with. Avoid promoting for details that she may find too distressing to recall, but look out for;

- Whether she knew the assailant or not (and if so, whether the rape occurred in the context of a relationship)
- Her age when it happened
- Whether this was her first “sexual” experience

N.B. listen out for the words the participant uses to describe processes and events e.g. “dealing with it”, “getting on”, “the assault” or “what happened to me”, etc. and reflect these back in later questions.
Timeline

Let’s move now to explore a longer time period, that between your experience of rape and where you feel you are now in terms of dealing with it. Looking back on the whole experience, can you talk me through the major milestones in terms of how you dealt with having been raped?

Prompt: For example, maybe we could start with what it was like for you day-to-day after the rape; things like getting up, going to work, caring for the children (where relevant).

Can you tell me something about your feelings about yourself and others at this point?

Prompt: For example, perhaps your experience changed the way you felt about yourself, or others, or had some impact on how you related to other people?

What strategies, if any, did you develop that helped take you beyond this first point?

(Prompt): In other words, what helped you carry on and start dealing with what had happened to you?

(Elicit information on whether the woman told anyone about the rape and the significance, if any, of telling for dealing with the experience. Also explore the significance of the (re)attribution of blame for what happened and how this may / may not have helped her to move forwards).

Is there anything that you can identify in yourself that has helped you to deal with the rape?

Prompt: Perhaps for example you felt that certain personality characteristics, or social support, or other things that you can think of were important to help you get through this time?

Is there anything else that helped you to move along from one point to the next?
(Prompt): Tell me something about how that helped you to move along, or why it was important to you.

(Elicit information on process – feelings, responses, what happened, events over time; the major factor(s) which carried the process along e.g.:

- Personal factors, including religious / spiritual beliefs
- The significance of others – who, why they were / are significant
- Role of men (if any) e.g. partner / family members, friends etc
- Role of women (if any)
- Professional help/ support groups
- Contacting police and reporting event (if relevant)
- Writing / other creative expressions

Was there anything that stopped or blocked you from dealing with the rape?

Prompt: For example, perhaps there was something about how a person you confided in responded to what you had told them?

Can you tell me how you’d describe you’re doing at the moment?

Prompt: For example, how would you say you get through your days at present? Elicit information on ongoing difficulties as well as any sense of progress having been made.

Overall, elicit information which identifies major milestones, and which explains them and the process taking her from one to the other, up to date.

Effects of rape and aftermath: outcomes

Do you feel that you have been changed at all by dealing with having been raped?

In what ways do you feel that you have changed?

Elicit information on losses e.g. of friendships or aspirations, as well as any valued changes.
Are there any ways in which you see yourself or your life differently through dealing with having been raped?

(Elicit information on negative / positive changes to self and life, including what these changes meant to interviewee, if anything)

Even though this may seem like a very strange question, sometimes people report that, in their efforts to deal with even the most appalling, unwanted events, they look back and recognise ways in which they have changed that seem quite valuable. On the other hand, many people don't identify with this at all. Which, if either, of these descriptions seems closest to your experience?

(Prompt): What I mean by this is that sometimes people feel that they have managed to retrieve something of value from a terrible experience, such as taking their life in a new direction. Having said that, many others don't share this. Can you tell me something of where you'd place yourself along this pole?

*If interviewee clearly states that she does not identify with the idea of valuable changes, move to ***

If yes: Can you tell me some more about that?

Are there any other areas of your life in which you can identify those kinds of changes as a result of dealing with the rape?

Prompt: For example, perhaps your experience has changed the way that you look at things, or your relationships with other people?

Can you tell me something about how big a part, if any, these changes have played in your life?

(Prompt): For example, I'm wondering if these changes you've talked about are still important to you, or whether they've receded into the background rather more?
Do you think that other women who have been raped experience these sorts of valuable changes (or use interviewee's own words for this) that you describe? Can you explain why you think that?

*** Let's move now to take a wider perspective. I wonder if you have any thoughts on how you think people view a woman who has experienced rape? What makes you say that?

How do you think this differs, if at all, from how other women who have been raped might view her? What makes you say that?

Is there anything that you feel that other women should know about dealing with rape? By other women, I mean both those who have experienced rape and those who have not. Can you tell me something about why you say that?

Reflecting on the interview experience

That's the end of my questions, but before we finish, I'd like to spend some time reflecting on what it's been like for you to take part in this interview. We can take some time over this if you would like. Firstly, was there anything that you expected us to cover today that you were surprised to see left out? If yes: Can you tell me why you feel that this should have been part of our discussion?

Were there any moments in the interview when you felt that I didn't understand, or when I used the wrong language? If yes: When did that happen in the interview? What was it that I didn't seem to grasp? What language would you have rather I had used? Can you tell me something about why "..." seems the better word to you? (Welcome these insights)

Has there been anything negative for you about doing this interview?

If interviewees appears upset, acknowledge this. Offer some unhurried time during which she is free to say in an unrestricted way how she is feeling and what issues, if any, the interview has
raised. Don’t expand on these but reflect back that I have heard and take them seriously and, when she is ready, look at what she can do to address her concerns. Indicate sources of support that I can help her get in touch with (c.f. her printed sheet) and explain why I think they may be of use. Enquire who, if anyone, is at home or if there is anyone she could contact when she gets home).

Has there been anything useful or valuable about doing this interview that you can take away with you?

Is there anything else that you would like to add, or to ask me?

Thank participant. Say that I would like to phone her tonight or over the next couple of days to see how she is. Ascertain when she would like me to do this – if at all. Arrange to send transcript if she wishes to see this. Offer to send a copy of the research later in the year. Ask if she would like me to keep her contact details in a secure place or whether she would prefer me to destroy these and for her to contact me herself in August for a copy.

Spend some time debriefing and moving to a point where she is ready to leave/to have me leave.

Linking statements

Is there anything else that seems important to say about that? What is it you’d like to add? OK, in that case let’s move on now to talk about ...

Earlier you mentioned … and I was wondering if you feel this relates to ...

Prompts

What makes you say that?

Can you tell me some more about that, if you’re comfortable?

How did that make you feel? What effect did that have on you?

Could you give me an example of that? Are there any other examples you feel OK to talk about?
Caveats / reassurances

It’s by no means expected that you would have had these sorts of experiences or have been affected in this way.

Like you, many other women report that they haven’t had these sorts of experiences and don’t identify with them.
Research consent form

The aim of this research is to explore the experience of recovery from rape. The accompanying Information Sheet provides further details. Please take time to read this now if you have not already done so.

You will be asked to take part in an informal interview about your experience of rape and the ways in which you feel you may have coped with or recovered from this. This will include a question considering the rape itself, as well as its aftermath. The interview will be conducted sensitively and I will encourage you to say no more than you are comfortable with. We will also look at the ways in which you may feel you have changed through dealing with having been raped.

The interview will be recorded on audiotape so that, when I am writing up the research, I can quote your experiences accurately. Of course, to protect your confidentiality I will not quote in my report any information that might identify you. When I write up your interviews therefore, your name, the names of anyone you refer to, locations or other identifiable information will not be recorded. Once transcribed, the audiotape will be erased. The data will be handled in accordance with the Data Protection Act (1988).

At this point, you may have questions or concerns, or feel that you would like some more information: if so, do please ask me before reading on. Take some time at this point if you need to.

Please read the following paragraph, and if you are in agreement, then sign where indicated.

I have read and understood the Information Sheet provided. I agree that the purpose of this research, and what my participation in it will involve, has been made clear to me. I agree that have been given an opportunity to ask questions about the study and have understood the responses given as a result, and that I have been given adequate time to consider my participation.
I understand that I am free to withdraw from this study at any time (including afterwards) without having to offer a reason, and that my data will be destroyed as a result.

I therefore consent to be interviewed about my experience of rape, how I coped with it, and the ways in which I may feel that I have changed as a result of coping with having been raped. I also agree that an audiotape of this interview may be made, on the understanding that this recording will be transcribed for research purposes only and then erased and that my data will be handled in accordance with the Data Protection Act (1988).

Interviewee signs: .............................................................................................................

Name (block capitals) .............................................................................................................

Date: .......................................................................................................................................}

On behalf of those involved with this research project, I undertake that, in respect of the audiotapes made with the above participant, professional confidentiality will be ensured. Likewise, any use of the audiotapes or transcribed material made from the audiotapes will be for the purposes of research only. The anonymity of the above participant will be protected and all data will be treated in accordance with the Data Protection Act (1988).

Researcher signs: .............................................................................................................

Name (block capitals) .............................................................................................................

Date: .......................................................................................................................................
Socio-demographic information form

Please could you respond to the following questions (leave out any that you would prefer not to answer). This information will help me show the people who read my report something of the range of interviewees that I have been speaking to. Please ask if anything seems unclear.

1. What is your age? [ ] years.

2. Which (if any) of the following terms best describes your ethnic background?

(Please circle the appropriate answer)

Black
African
Caribbean
Other Black background

Mixed
White and Black Caribbean
White and Black African
White and Asian
Other mixed background

White
British
Irish
Other White background

Asian
Indian
Pakistani
Bangladeshi
Other Asian background

Prefer not to say

Other ethnic groups
Chinese
Other ethnic group (please state) __________________________

3. How would you describe your sexuality at present?

Lesbian / bisexual / heterosexual / prefer not to say (please circle).

4. Are you currently: (please circle)

Single (not in a relationship) In a relationship but not cohabiting
Cohabiting Married
Divorced - separated
5. What is your highest educational qualification?

(Please circle the appropriate answer)

None
A'levels
Undergraduate degree
Masters degree
Other

GCSEs/O'levels/CSEs
Diploma (HND/SRN, etc.)
Postgraduate degree / Diploma
Doctorate

(please specify)________________________________________________________

6. What is your current occupation (or, if you are no longer working, what was your last occupation)? (Please write your occupation below; homemaker / full-time mother may be entered if appropriate):

________________________________________________________

7. Where did you hear about this research? (Please circle)

Poster at UniS campus
Magazine / newspaper ad
Word of mouth

Poster elsewhere
Internet advert

Other (please state): ________________________________________
Appendix 3: Table A: Complete set of themes and subthemes developed from the analysis of transcripts. Illustrative quotes are provided for those themes and subthemes which are not presented in the analysis.
Theme 1: Dealing with the aftermath

Immediate traumatic responses
Fear, horror, vigilance, disbelief

Reporting the rape
Deciding to report / not to report to police
Costs and benefits of reporting

Coping strategies
Rationalising
Forgetting/blocking
Distraction
Distancing self
Downward social comparisons
Self-enhancing statements
Expressive activities (reading, writing, dancing, talking)

Illustrative quote:
I just felt shell-shocked (Charlotte)
I only had a matter of hours [to decide]. You can’t think about what informing the police means (Ailsa)
Reporting meant opening up all the hurt and the wounds (Charlotte)
I used to say, pretend there was a car accident: you were totally not to blame (Camille)
I just didn’t process it. That was my way of coping (Louise)
I was taking drugs [ ]. I just wanted to lose myself (Amy)
I can forgive him and understand why he’s doing it [ ]. Maybe that makes me feel a bit superior (Natasha)
It could be so much worse, I wasn’t one of the women in Serbia raped multiply by men with guns (Amy)
I think now, I actually do quite well (Camille)
I would write every time I couldn’t sleep (Ailsa)

(For discussion, see Burgess & Holmstrom, 1979a, 1979b; Frazier & Burnett, 1994; Janoff-Bulman, 1992; Ullman, 1996a, 1996b.)
### Theme 2: Impacts on the self

**Experiencing self as humiliated / powerless (inc. during police medical examinations / questions)**

- **Disgust: feeling dirtied or tainted**
  - *I felt dirty – I only wanted to wash myself* (Maria)
- **Self-blame**
  - *I feel I didn’t say, “No” early enough. I think that’s still quite a major problem for me* (Amy)

**Losses**

- **Loss of time to the recovery process**
  - *I haven’t had a life for four years [...]. This person had ruined, taken away four years of my life* (Amy)
- **Loss of professional careers, and the status / identity derived from these**
  - *I can’t exceed or excel in my work like I used to* (Ailsa)
- **Losing touch with oneself**
  - *When did she go and when did I become this?* (Lillian)
- **Loss of personal values**
  - *I’d kept myself very holy and intact [...]. It doesn’t matter if it wasn’t through my choice; that side of me had totally gone* (Camille)

**Self-reliance and feeling stronger**

- A sense of achievement in carrying on/regaining what was lost
- Confidence about coping with other crises
- Exploring, understanding / accepting self

**Ongoing fear, vulnerability and suffering**

- **Ongoing suffering, loss of confidence or enjoyment in life**
  - *In relation to who I was, my loss of enjoyment in life is enormous* (Ailsa)
- **Ongoing fear and unease**
  - *I still have moments when I’m scared for no reason* (Charlotte)
- **Ongoing anxiety about sexual intimacy**
  - *To me now, sex is rape* (Louise)

*(For discussion, see Burgess & Holmstrom, 1974, 1979a, 1979b; Davis, Lehman, Silver, Wortman, & Ellard, 1996; Pitts & Schwartz, 1997; Wiehe & Richards, 1995)*
Theme 3: Impacts on interpersonal relationships

<table>
<thead>
<tr>
<th>Self-protection</th>
<th>See analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mistrusting men</td>
<td></td>
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<tr>
<td>Attending to vigilance responses</td>
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The unsayable and unhearable: the silence surrounding rape

| Rape as an unspeakable / unhearable subject    | I told [my husband]. He just treated me like I was a glass doll or something [ ]. Then he just sort of forgot, it just sort of disappeared (Camille) |
| Retreating from the subject, or from the woman herself | Instead of getting support, they [parents] backed off completely (Ailsa) |
| Curtailing further talk                        | When I’ve actually spoken to people about it, they don’t want to hear (Louise) |
| Self-silencing to preserve support / avoid blame | You do find yourself not wanting to burden your friends (Charlotte) |
| Speaking out: personal voice becomes political  | The whole issue of gender relations is about a struggle of power and they would seek to make you voiceless (Lene) |
| Therapists’ roles in silencing; colluding to avoid discussing the rape, subtly blaming, suggesting that client avoid telling others. | I don’t think the psychiatrist wanted to talk about it any more than I did. He avoided it like the plague (Camille) |

Deepened relationships

| See analysis |

Compassion for others’ suffering

| See analysis |

Empathy and experiential knowledge of suffering

Using experience to benefit others

(For discussion, see Brison, 2002; Fox & Carey, 1999; Sudderth, 1998; Symes, 2000; Ullman, 1996a, 1996b)
Theme 4: Impacts on outlooks on life / the world

Appreciating being alive  
Existential changes

Increased awareness of sexism / sexual violence

See analysis for all these subthemes
Appendix 4: Personal reflections
Personal reflections

These reflections have been rewritten for my portfolio, two years after this report was submitted. The original reflections were described by the markers as having:

... a "professional" focus [. The rest of the report is [ ] sensitive to other's experiences and yet this section frequently veers away from a similar engagement with your own experiences.

I include this (and am rewriting this section) because I agree, and I recognised my reluctance to engage reflectively when I originally submitted my report. Back then, the experience felt too threatening and upsetting to do any more with, and feeling overwhelmed and distressed also felt shameful to me; as a researcher, I wanted to feel able to manage. I tried to cope by avoidance and being invited to reflect on my experiences seemed an unwelcome challenge to this defence. However, I am pleased to come back to this now, when the topic seems "cooler".

Returning to the very beginnings of this research, I was very concerned about participants' welfare and went to lengths to try and ensure this. Looking back, I wonder if this also represented a disguised anxiety about my own well-being. It certainly was painful to listen to stories of rape as I collected data. I sometimes felt like a voyeur, passively standing by and recording others' suffering so that I could further my doctorate. It felt uncomfortably close at times to the other professionals and para-professionals some women described who hadn't intervened sufficiently (psychodynamically, I wonder now if these stories were also an unconscious comment on a possible parallel process being repeated with me; I did wonder if some women hoped for more from me, knowing that I was also a Trainee psychologist, although I had been as clear as I could about my role from the outset). Sometimes I even cynically wondered if I wasn't also a bit like the rapists, who took from the women and then left. I found these countertransferences upsetting and disturbing.

It also felt sad to let go of my therapeutic skills and understanding with interviewees when an intervention "automatically" came to mind and yet I wasn't there to help "work through" a process or to question beliefs such as blaming themselves for having been
raped (as most still did). I also felt that I was taking in a lot of pain. One way I cope with painful countertransference as a therapist is to treat it as an useful way of “feeling” what things are like for a client which can become the basis for intervening with greater appreciation. As a researcher, I felt as if I was holding onto suffering without being able to take this next step. It felt strange and sad to feel so emotionally involved and feel an attachment developing because of painful and personal things having been shared, yet to know that this relationship had no future in terms of underpinning any therapeutic work.

I felt lonely travelling long distances to interviews, and seeing participants in their own context could be unsettling. Lillian for example had left her husband to live alone after an abusive marriage. Her home had a painfully lonely, “abandoned” feel and indeed she later mentioned that many of her friends and family no longer spoke to her after her decision not to conceal why she had left her husband. I also found it difficult to leave; I had decided that an unhurried pace that interviewees could control was important, which usually worked well. However, Lillian seemed to want me to stay, finding even more to say when I tried to move the interview along. I wondered if I was becoming some sort of befriender or losing my boundaries, and realised how much value I place on the therapeutic frame in my practice, meeting on my own territory and the sense of rhythm and familiarity a fifty-minute session gives. As time passed with Lillian, I realised I had had enough and wanted to go home now, back to my own life, and how very sad and lonely it felt being a guest in her world. I also wondered about seeing people at home; every participant requested this, which I could understand, yet as the interviews progressed I questioned what it might be like for them to return to their sitting rooms where we had just held a difficult interview: might our conversation still be in the air?

My predominant feeling during the interviews was grief; after I had left, I often felt enormous rage about what I had heard. Over time, I also experienced changes to my belief systems much like those described by participants in my final research project. Often, the ways I tried to cope (such as by running) became tainted by the research; when I ran, I felt frightened and vulnerable, and then angry about this. At the time, there was also heavy media coverage about a very violent rapist attacking women on,
amongst other places, Wimbledon Common. I had enjoyed my peaceful early morning walks to my placement through the Common and struggled for a long time with what to do. The police were advising women to avoid the area, and I was terrified of making myself vulnerable. At the same time, I was furious that my freedom was being restricted yet men were still enjoying theirs. Even though I, thankfully, never encountered him, this rapist had still exerted power over me. Likewise, being alone in my flat writing up most days (time alone which I usually enjoy) also became frightening; on one occasion, I became convinced that a man was somewhere inside. It turned out to be pigeons nesting in the attic, and I eventually saw the funny side, but at the time was literally paralysed with terror. I also found my own identifications with interviewees disturbing; there often seemed something to connect with in a story and in almost every interview, I found myself thinking, “That could so easily have been me”.
Copy of original reflections for this research (July 2003)
Personal reflections: I was surprised by how difficult it was to recruit participants. There was plenty of initial response but a high drop-out rate - perhaps because many women ultimately decided that this experience was too difficult to discuss - and many respondents seemed unsuitable (for example, too vulnerable to be interviewed). Others, who seemed keen to be involved (perhaps because of the promise of contact with an interviewer who was also a counselling psychologist in-training) were disappointed to be turned down and it was difficult to find the words to do this sensitively and to maintain this position in the face of occasional pressure.

Whilst I encouraged interviewees to think with me in an adult fashion about the possible impacts of being interviewed, I was aware that ultimately I held the power to say no, and sometimes did so. Susan good-naturedly challenged this, saying that 'if you give [respondents] the time to think about it and to reflect, and then they come back and they still want to do it [ ], then they're probably pretty sure that they can cope'. On the other hand, other women seemed to appreciate the screening questions: Charlotte commented that:

I really liked the question that you asked me about if I got upset, how would you like me [Heidi] to deal with it, because I hadn't thought of that. [ ] That really made me feel at ease with you from the start, because clearly you'd thought about how you were going to - you wanted it to be as painless an experience as possible for your interviewees and really, that one question for me was, I just knew I could trust you.

During the interviews, no interviewee became seriously distressed, although sometimes, understandably, seemed tearful and it was important to stay and talk this through and offer to call them later. A few stories were so disturbing to hear as to be quite upsetting afterwards and I was aware of also delaying transcribing them. These involved extreme violence or betrayal by trusted persons and the aftermath had seemed so difficult that I was also left amazed by how casually these women's lives had been shattered by their rapists.
It was important to me that all the interviewees in this research who provided feedback stated that the experience had been meaningful and that they experienced the research as a medium through which they were provided with a voice. Similarly, I felt, from many participants' comments that they saw my role not only as a witness to their trauma but also as a recorder of their stories; a person with (potential) access to a specific and powerful audience (readers of academic journals, some of whom work with survivors of rape). Several, as detailed, wanted to change things; others simply wanted to go "on record". I found this understandable but also felt some anxiety to do a good job, often feeling very concerned not to misrepresent participants' words. Clearly, it is important that researchers don't stray from the data; however, I often wondered "Would this participant approve of my interpretation here?"

I decided not to recruit from Rape Crisis Centres but approached many, seeking advice and guidance for the interviews in return for a copy of the research. I experienced a great deal of resistance - in most cases, agencies were silently unresponsive, offering no reasons for remaining uninvolved. I also felt that, before providing participants with a help sheet listing local services, I would make telephone contact with each service first in case participants, who may have needed to telephone in distress, dialled out-of-date numbers. I was unnerved when often, after leaving my details on services' answer machines - whose messages often promised that they would call me back - asking for more information, this rarely happened. If I was called back, I usually passed to a different service or told that they couldn't be of help, and the struggle to reach someone began again. I rejected other services because of the response I got; occasionally, I felt as though I were being made to feel a burden, and did not wish any participants calling on my advice to experience this too. Had I been a caller in a state of distress, I might have given up hope of ever reaching someone to talk to, a frustrating process paralleling that described by some participants (these experiences were not reported because of word limitations).

Discussions of burnout, psychic drain and vicarious traumatisation of therapists who work with survivors of rape exist in the literature (Schauben & Frazier, 1995) and it may be that researchers experience similar difficulties. Certainly, I am aware of feeling
drained by researching this topic, not only from hearing these stories and spending an extensive period transcribing, analysing and writing about them but also from experiencing powerful feelings of anger. It recently occurred to me that anger is virtually absent from participants’ stories (yet one might expect this to be inevitable when one has been manipulated or victimised). Perhaps this is because feeling anger at one’s rapist requires imagining oneself in proximity to them, which is too terrifying for many women (Brison, 2002). Whatever the reason, I wondered if containing their own anger was too much for many participants, and that I have been holding this for them throughout the research process (suggesting that sexual violence might be a topic better suited to groups of researchers, so that no one carries all the projections. Likewise, a group of researchers might choose to meet regularly to discuss the personal impacts of investigating this issue). Nonetheless, I think there has been a lot of learning for me personally in doing this research (in conjunction with seeing a number of quite disturbed clients in my practice) which has led me to reflect - privately, in therapy and supervision - about how I might develop ways to keep myself safer when working with very demanding clients / research participants.
Appendix 5: Ethical approval letter and details of target journal
14 February 2003

Ms Heidi Ashley
PsychD Student
Department of Psychology
University of Surrey

Dear Ms Ashley

The aftermath of rape: considering growth outcomes (ACE/2002/106/Psych)

I am writing to inform you that the Advisory Committee on Ethics has considered the above protocol (and the subsequent information supplied) and has approved it on the understanding that the Ethical Guidelines for Teaching and Research are observed. For your information, and future reference, these Guidelines can be downloaded from the Committee’s website at http://www.surrey.ac.uk/Surrey/ACE/.

This letter of approval relates only to the study specified in your research protocol (ACE/2002/106/Psych). The Committee should be notified of any changes to the proposal, any adverse reactions, and if the study is terminated earlier than expected, with reasons.

Date of approval by the Advisory Committee on Ethics: 14 February 2003
Date of expiry of approval by the Advisory Committee on Ethics: 13 February 2008

Please inform me when the research has been completed.

Yours sincerely

Catherine Ashbee (Mrs)
Secretary, University Advisory Committee on Ethics

cc: Chairman, ACE
    Dr A Coyle, Supervisor, Dept of Psychology
Social Science & Medicine

Guide for Authors

Submission of Papers

Two types of contribution are welcomed: full papers (original research reports or critical reviews of a field, preferably in no more than 8000 words) and short items (short reports of research findings, commentaries on topical issues or correspondence, of no more than 2000 words in length). Authors are requested to submit their original manuscript and figures with two copies to the Editor-in-Chief, Professor Sally McCartney, MRC Social and Public Health Sciences Unit, 4 Lilybank Gardens, Glasgow G12 8ZK, UK; or to the relevant Senior Editor.

Submissions will be considered on the understanding that they comprise original, unpublished material and are not under consideration for publication elsewhere. All submission to be enclosed with each submission, signed by all authors of the paper. Social Science & Medicine does not normally list more than six authors to a paper, and special justification must be provided for doing so. Further information on criteria for authorship can be found in MacIntyre (1997, Vol. 45(1), 1-2).

All submissions may be subject to initial assessment by the appropriate Senior Editor to determine their suitability for consideration by Social Science & Medicine. Papers accepted for formal review will be sent anonymously to at least two independent referees. Authors are requested to alert the Editors in cases where rapid publication is especially appropriate.

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Abstract and Keywords: An abstract of up to 300 words is to be supplied, followed by up to six keywords.

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Contact details for questions arising after acceptance of an article, especially those relating to proofs, are provided when an article is accepted for publication.
Little attention seems paid to researchers' experiences of investigating sensitive or traumatic topics. This study considers how qualitatively researching the trauma of rape may personally affect researchers. In-depth interviews were conducted with ten researchers and the data analysed using grounded theory, producing a localised theoretical model. Central to this are the significance of empathically engaging with or identifying with survivors of rape, processes that seemed associated with powerful emotions and intrusive imagery. Participants also reported disrupted beliefs including feeling more vulnerable to rape, cynical about intimate relationships or despairing of human nature. How researchers coped with these impacts was also addressed. The findings are discussed in terms of the analogous literature concerning the vicarious traumatisation of therapists working with traumatised clients. Whilst the theory produced is specific to the participants involved, findings nonetheless seem useful to inform researchers of the potential risks attached to investigating other sensitive or traumatic topics.

Key words: Vicarious traumatisation; secondary traumatisation; sensitive research; sexual violence; reflexive research; grounded theory.
Introduction

Over recent years, the impacts of traumatic experiences on individuals have been well researched, attention turning to exploring the secondary impact on friends, family, partners and others who support survivors of trauma (Ahrens and Campbell, 2000; Wasco and Campbell, 2002). Indeed, the reverberations of the original traumatic event seem widespread, a growing literature acknowledging the “hidden victims” of trauma (Stewart and Hodgkinson, 1990, p 53), including rescue workers, therapists and psychiatric staff (Brady et al., 1999; Chrestman, 1995; Kassam-Adams, 1995; Lyon, 1993; Raphael and Wilson, 1994). The terms “vicarious traumatisation” or “secondary traumatisation” describe this process (McCann and Pearlman, 1990; Pearlman and Mac Ian, 1995; Pearlman and Saakvitne, 1995a, 1995b; Schauben and Frazier, 1995).

Vicarious traumatisation is a ‘cumulative transformation in the inner experience of the therapist [ ] as a result of empathic engagement with the client’s traumatic material’ (Pearlman and Saakvitne, 1995a, p. 31), associated with distressing emotions and disturbed beliefs about oneself, others and the world. For example, McCann and Pearlman (1990) report experiences resembling those of traumatised clients – including flashing, violent images, nightmares and fearfulness - amongst trauma counsellors, those seeing greater numbers of traumatised clients describing greatest disturbance. Schauben and Frazier (1995) support these findings in a study of rape counsellors, who also describe disrupted beliefs regarding other people’s goodness or trustworthiness and the difficulty of dealing with survivors’ emotions in addition to managing their own. Indeed, therapists’ emotional reactions to trauma material seem powerful, including
hopelessness, despair, terror and fear (Comas-Diaz and Padilla, 1990) and guilt, rage, grief and horror (Danieli, 1988).

In fact, a considerable literature documents how therapists feel disturbed by engaging with traumatised people (Figley, 1995, 1999; McCann and Pearlman, 1990; Pearlman and Saakvitne, 1995a, 1995b). However, another group of trauma workers seem overlooked; little attention seems paid to the potential vulnerability of researchers investigating traumatic topics, yet their work may also be distressing. Indeed, there seems 'little recognition that carrying out research on sensitive topics [ ] can produce responses on the part of researchers similar to those experienced by clinicians' (Kinard, 1996, p. 65).

A small body of reflective articles, based on researchers' experiences of investigating trauma using qualitative methodologies, support this suggestion. For example, Stanko (1997) recalls 'harboring anger, frustration, fear and pain' (p. 75) during her research on sexual violence, and Kelly (1988) likewise reports anger, grief, flashbacks, fears for her personal safety and a sense of being emotionally overwhelmed. Researching child abuse, Moran-Ellis (1996) describes feeling shocked, outraged, angry and isolated and Etherington (1996) recalls the 'intrusive dreams and images left over from the painful stories I heard day after day, anxieties about responsibility [and] almost los[ing] my faith in human goodness' (p. 345). Adding another perspective, Stoler (2002) describes experiencing panic attacks and flashbacks of her own memories of being sexually abused as she researched this area. Once again, suggesting how trauma powerfully reverberates beyond its original victim, friends and family may also feel affected when a researcher
chooses to study trauma (Etherington, 1996). Indeed, Etherington suggests that 'none of this [...] should be underestimated when researching difficult subject matter' (p. 345).

Whilst qualitative methodologies form an important part of researchers' repertoire, when the subject of investigation is trauma, researchers must repeatedly engage with distressed people during interviews and may find this upsetting. Campbell (2002) provides a qualitative exploration of the reactions of her research team as they conducted in-depth interviews with over a hundred female survivors of rape. She describes their emotions - spanning horror, shock, grief, numbness, pain, fear and anger - the researchers also experiencing transformations in their belief systems, losing faith in the police force and becoming increasingly pessimistic about the possibility of recovery from rape. Campbell organises her findings around the central theme of feeling the trauma of rape "second-hand", conveying the impossibility (and undesirability, epistemologically) of investigating this devastating experience in the objective, detached terms typically associated with research.

In summary, little attention seems paid to systematically exploring the process of sensitive research, particularly its emotional aspects (Campbell, 2002; Harris and Huntingdon, 2001; Stoler, 2002). This grounded theory analysis addresses the impact on researchers of investigating rape, chosen because of the particularly distressing nature of this trauma and because of the author's personal experience of researching this topic using a qualitative methodology (Ashley, 2003). This study aims to explore the potential consequences to researchers of inviting participants to share experiences of sexual violence during in-depth interviews; to explore researchers' (and institutions') reactions
to any personal impacts; to consider coping and to develop a localised theory of the experience of qualitatively researching rape grounded in participants' accounts.

Method

Sample recruitment

Researchers were contacted following internet / PsycINFO database searches for research on aspects of women's / men's experiences of rape using qualitative methodologies. The inclusion criteria were researchers who had been involved in at least interviewing, but preferably the entire research process from planning to write-up. Respondents were offered further information, a telephone conversation exploring their readiness to be interviewed about their experiences (see Appendix 1, p. 227)

Analysis began once the first interview was transcribed. Once six researchers were recruited, theoretical sampling was implemented whereby new participants were approached for their potential to generate new theory by extending / deepening emerging understandings (Glaser and Strauss, 1967). Researchers who had investigated male rape or were assistants or psychologists were sought. Additional male participants were sought, unfortunately unsuccessfully.

Procedure

Ten researchers were interviewed separately at their workplaces. The interviews were audiotaped, with consent, taking sixty to ninety minutes. Participants were offered
information on support services and a telephone call afterwards to ascertain their well-being. The interview style was informed by Coyle (1998), who recommends using counselling skills to collect data on sensitive topics. A series of questions towards the end encouraged reflection on the experience of being interviewed including any emotions raised. The interviews were transcribed orthographically, the tapes then erased and pseudonyms assigned to ensure confidentiality. Any potentially identifying information was removed or disguised.

**Interview schedule**

The semi-structured schedule was developed by reviewing researchers' published reflections on their experiences of investigating sensitive topics and the author's reflections on researching the trauma of rape. It consisted of open-ended questions relating to the personal impacts of investigating rape, issues involved in topic selection, role dilemmas and coping strategies (see Appendix, 2 p. 234). This guided the conversation, but allowed participants to elaborate on areas of interest.

Two pilot interviews were conducted with researchers of child abuse, approached because of their experience researching an interpersonal trauma whilst avoiding "using up" participants (analogous to key informant interviewing - Gilchrist, 1992; Marshall, 1996). Minor amendments were made to the schedule, and subsequently following participants' insights and analytic "hunches" during data collection.
Data analysis

The data were analysed using Grounded Theory (GT) (Charmaz, 1995; Glaser and Strauss, 1967; Henwood and Pidgeon, 1992; Pigeon, 1996; Pidgeon and Henwood, 1996). GT involves closely inspecting transcripts in order to generate localised theory (i.e. specific to the context it was developed in). This is ‘grounded’ in participants’ accounts rather than dependant on constructs / variables obtained from pre-existing theories. There is therefore a move from data to theory so that new theories may emerge or existing ones be refined. GT was selected since there seemed no existing theory concerning researchers’ experiences of investigating trauma; the theory of vicarious traumatisation concerns clinicians, who may have resources, frameworks or training to better manage their reactions. To facilitate a more naïve attitude to the data, the author chose not to read the literature on vicarious traumatisation until analysis was complete, when this literature was used to interpret findings, relate them back to an empirically-based body of work and consider how the theory of vicarious traumatisation might be modified or extended.

GT involves the progressive identification and integration of categories of meaning from data in order to produce theory (Willig, 2001). Starting with one transcript, an indexing system was developed by examining each unit of meaning - a phrase, sentence or longer extract seen as representing a particular point - in turn. Each was given a category name suggesting its essence. As analysis progressed, the numbers of categories expanded although data considered examples of existing categories were simply added to these, the category name sometimes changed to accommodate the new data. As the categories developed, they were constantly compared and links recorded which might be valuable
later in the analysis (Glaser & Strauss, 1967). Name changes, splitting / merging of categories, possible links with existing theories or hunches about emerging theory were also recorded (see Appendix 6, p. 259 for an account and model of the development of the theory).

Once categories became saturated (when there seemed no more examples that might contribute to their range or depth), a detailed definition of each was recorded and a diagrammatic representation created. Themes and categories seeming central to the development of a theory concerning how researchers may become personally affected by their research were the focus of the interpretation, the relationships between these described in the findings and overview.

**Evaluative criteria**

Grounded theory depends upon the researcher’s interpretation and subjectivity and different researchers may develop somewhat different categories – and, by extension, different theories - from the data. This is acceptable, provided the researcher owns her perspective (see Appendix 5, p. 255) and can persuade readers that the analysis remains grounded in the data (Elliott et al., 1999; Glaser and Strauss, 1967; Rennie, 1994). The findings are therefore accompanied by quotations from the data. Empty square brackets indicate the omission of material (to protect anonymity, or render quotations concise). Material in square brackets is added for clarification and ellipses indicate pauses in speech. For clarity, ‘participant’ refers to the researchers involved in this study, ‘interviewee’ denoting the survivors of rape whom they had interviewed.
Findings

Demographic information

There were nine women and one man, ranging from 22–43 years old (mean = 32, SD = 7.36). All were white British. Four were involved in psychology (two as Chartered clinical psychologists, two as assistant psychologists) and three in sociology (two as senior researchers, one as an undergraduate). Of the remaining, one participant was involved in sexual health, one in criminology and one in researching violence against women. In total, two had investigated male rape. The researchers had between one and ten years' experience researching trauma; for five, their research had been their first experience of a traumatic topic.

The analysis resulted in the construction of a diagrammatic theoretical model of the personal impacts of researching rape. The data set and analysis were complex; to convey the findings accessibly, this was simplified to offer just the "landscape" of the overall story. To avoid overcomplicating a single diagram, Figure A (p. 214) depicts the "heart" of this main model, showing a circle containing two symbols connected by an arrow, representing the interpersonal processes involved in "transmitting" traumatic material between interviewees and researchers. These are considered first.

Interpersonal processes involved in transmitting trauma to researchers

Empathic engagement with traumatised people

The researchers reported that they did not wish to convey a 'clinical' or 'distant' presence, but wanted to demonstrate interest, concern and sensitivity. This was often
done by empathically attuning to interviewees, also helping researchers to ‘feel the story and really get an insight’ (Kate). Empathy therefore seems an important resource (Coyle, 1998; Draucker, 1999), yet one means by which traumatic emotions and imagery were inadvertently passed to researchers, linking these categories.

Empathising with people who have experienced rape may involve hearing graphic descriptions of brutalisation and interviewees’ ongoing suffering and distress. Indeed, Carol wondered if ‘people realise sometimes the intensity of talking to and empathising with people who have experienced that level of violence’. By empathising, researchers sometimes felt as if they were ‘experiencing [the rape] again with them, to a certain extent’ (Zoe). These emotions may linger, as if, by empathising, the researchers had ‘in a way, [ ] absorbed some of what [the interviewee] went through’ (Diane). Indeed, empathising was often likened to “holding” emotional distress:

I went to interview a woman the day after she’d taken an overdose [ ]. That stayed with me for a while because [ ] I had to take on all her sadness to keep the interview going. [We were] both very much in the same place and those emotions stayed with me [ ]. The next day I felt very low (Zoe).

“Containing” such deep distress seemed supportive, yet an extreme experience for Zoe. New researchers in particular may not yet have found ways to negotiate allowing themselves to be moved whilst avoiding being overwhelmed (Gilbert, 2001). Megan, an experienced researcher, suggested the need to ‘be able to step back, otherwise you just get overwhelmed and you become the receptacle for everybody’s stories’, a balance
seeming important to locate. Nonetheless, as long as researchers engage empathically with traumatised people, the risk of experiencing distressing emotions remains (Figley, 1999; McCann and Pearlman, 1990; Pearlman, 1999).

**Identifying with interviewees**

Returning to Figure A, identification was another process involving “picking up” interviewees' traumatic emotions. Zoe shared a difficult example of feeling powerfully drawn into an interviewee’s emotional world:

I found it very difficult to get out. [T]he agenda had changed and she wanted her needs to be met and that involved the interview not ever ending. I felt I had lost control and that scared me. I didn’t feel we were having an interview any more; the boundaries had gone. She had the power, very much so. That was the most extreme experience I had. [ ] I felt like I had entered her life, I identified, I was bonded with her emotionally. And I didn’t want to reach out; that was the thing she brought out in me, I was drawn into her world.

Zoe’s interviewee seemed ‘needy’ yet also quite powerful; feeling somehow induced to identify with her experience involved a frightening loss of boundaries and Zoe felt powerless, wanting to get away but feeling trapped and fearful. She considered a possible connection to the subject matter:
Interviewer: It’s interesting that you experienced yourself as frightened and losing control when the interview topic was rape.

Zoe: I hadn’t actually thought of it like that. That’s very interesting, because that must be how she felt. That’s an interesting dynamic that built up between us.

Psychodynamic concepts seem rarely applied to research yet, as Zoe shows, interviews on traumatic topics can involve powerful emotions on both sides or painful re-enactments of trauma (King, 1997). Concepts such as transference, countertransference or projective identification (Cashdan, 1988) may help researchers understand what may be happening; indeed, Clare felt that discussing ‘psychodynamic stuff like transference [or] how your responses were elicited by patterns from that person’s past’ with her supervisor provided a ‘broader understanding’ of the dynamics of interviews.

Researchers also felt disturbed to recognise something “like me” in an interviewee, which they associated with having their own vulnerability to rape brought into sharper focus (Kitson et al., 1996; Neumann and Gamble, 1995; Wasco and Campbell, 2002). Natalie, a young research assistant and an undergraduate, recalled a particular interviewee who

... was young and she wanted to go to university [so] I could relate to her. And that did upset me.

Interviewer: What was it about having something in common that upset you?
Natalie: I couldn't get my head around the fact that rape could affect her so badly. You think about how you would handle it if it did happen to you. She had reacted in that way and [...] it could happen to me. I connected to that. I did get upset about that.

Identifying by imagining herself in her interviewee's situation seemed disturbing, leading Natalie to imagine how she might cope were she ever raped, precipitating distress (Janoff-Bulman, 1992; Kitson et al., 1996). Witnessing the ongoing devastating impact on someone resembling herself also seemed to shatter Natalie's assumptions about the possibility of easily recovering from this trauma. As Carol put it, 'it is a case of, there but for the grace of God go I, because it could happen to any of us [.]. Just like that [clicks fingers]. And your confidence and your perceptions of yourself are gone'.

Resonance with personal experiences of sexual violence

Interviewing survivors of rape seemed understandably painful for researchers who had personal experiences of being raped. Diane's interviewee described an experience of rape that shared features with her own. She experienced 'an anxiety dream' because the story 'did resonate [with me], so that was probably why that freaked me out as much as it did'. Such similarities of experience could be distressing:

The things they were saying were very similar to the things I had been through [ ]. I suppose it was reliving all the stuff that you went through at the time [and it] opened up the wound for me (Olivia).
As interviewees explore their assault or its aftermath, “survivor-researchers” may be carried back to their own experiences (Grafanaki, 1996; Kitson et al., 1996; Robertson, 2000), linking this category with the emotional impacts of researching rape. However, Olivia also felt that having worked through her own experience of rape in therapy rendered her emotions more manageable and that these became resources, allowing ‘empathy for the things that people were saying [which] helped the interview to flow [and helped] when I was working through the transcripts as well’. Other researchers also described treating their emotional reactions as resources (considered later). Olivia’s very personal, emotional connection to this topic seemed painful, yet deepened her understanding and sensitivity. Indeed, Stoler (2002), a survivor-researcher of child sexual abuse, also describes how her personal experience ‘increased my effectiveness as an interviewer and an analyst’ (p. 270). Perhaps unexamined personal experiences place researchers at particular risk.

As Diane suggests, ‘being somebody who works in this field and has had a personal experience is probably not unusual’. Considering the emotional significance behind topic selection seems important for researchers (Kitson et al., 1996; Robertson, 2000; Stoler, 2002) since emotions ‘might affect our responses or our ability to deal with what we’re hearing’ (Diane). Diane felt that this should be ‘factored into research’ by project directors, regretting that ‘it wasn’t by the people around me. It never came up’, leaving her feeling unsupported.

This concludes discussion of the interpersonal processes identified as involved in transmitting traumatic material or emotions. The analysis now turns to the emotional
and other personal impacts of researching rape, represented by Figure B (p. 215). At its centre, Figure B depicts the interpersonal processes occurring between researcher and interviewee, already discussed. Radiating out from this centre are waves or ripples of impacts, which have these processes as their origin. However, the outer rings do not subsume the experiences represented by inner rings. The analysis begins by considering the inner ring, the emotional impacts of researching rape.

The emotional impacts of researching rape

Researching rape is an emotional task (Stanko, 1997). Because word limitations preclude full discussion of researchers' emotional reactions, only those clearly linked with other findings are discussed but for a complete summary, see Table 1 (Appendix 3, p. 249).

Feeling unprepared for the intensity of interviewing

Most participants stressed how unprepared they had felt for the emotional intensity of interviewing survivors of rape, despite expecting that meetings could be hard-going:

[I had] no idea. No idea at all. I expected to hear some quite difficult things [,] but it's much different when you're talking to someone face to face and they say, this happened to me. [J] That is much more emotive (Zoe).

Other researchers also report feeling shocked by the strength of their emotional reactions to this topic (Alexander et al., 1989; Campbell, 2002). Perhaps, as Zoe suggests, it is one thing to expect that interviewing will be difficult but quite another to actually experience
the powerful emotions involved. Likewise, forming relationships with interviewees based on empathy and identifications may mean that rape is no longer an abstract topic of enquiry, as names and faces attach to stories (Campbell, 2002).

Many researchers described feeling emotionally flooded as they listened empathically to graphic descriptions of violence and suffering, experiencing complex reactions including sadness, numbness and detachment, fear, horror and shock. As Carol said, ‘There were so many emotions involved, really [and] when you’ve got all of them running together, that’s difficult, that is difficult’. The interviews were described as emotionally exhausting, several researchers developing headaches or feeling ‘drained’ ‘exhausted’, ‘spaced out’ or even ‘crazed’ by hearing so much distress. Therapists report similar reactions, which may mirror clients’ reactions to trauma (Pearlman and Saakvitne, 1995a; Schauben and Frazier, 1995).

**Anger**

Anger was commonly reported, for example regarding the numbers of women victimised and women’s vulnerability. Anger was also felt powerfully towards perpetrators or others seen as responsible for interviewees’ suffering. For example, one of Carol’s interviewees experienced ‘a horrendous rape’, yet her treatment by a police officer left her feeling ‘like a prostitute, a whore, was her words. She felt dirty; she felt that it was her fault. [...] And I was just absolutely furious about it’. Diane also

... felt tremendous hatred for the perpetrator. And I thought, how can
[the police] listen to an account like this and tear holes in it and try and make out you were asking for it? That would make me really angry.

Intense anger towards perpetrators, police officers or judges has been noted amongst researchers, rape advocates\(^1\) and counsellors involved with survivors of rape, the latter describing this as a difficult aspect of their work (Alexander \textit{et al.}, 1989; Campbell, 2002; Schauben and Frazier, 1995; Wasco and Campbell, 2002). However, some researchers used their anger as a source of energy, although others found themselves transferring it onto others (explored later).

\textit{Guilt and anxiety}

Additionally, some researchers experienced guilt and anxiety because, occasionally, interviewees found being interviewed disturbing:

> I feel we did more damage. It brought up such a lot that we had to stop [ ] because she couldn’t, she just couldn’t do it. [ ] I just felt, ooh, you know, and when we left the young research assistant I had with me [ ] burst into tears and said, what have we done? And I felt like that as well. It was difficult, it was difficult (Carol).

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\(^1\) 'Women who assist rape victims in obtaining medical, criminal justice and mental health services' (Wasco and Campbell, 2002, p. 120).
Researchers may hope that being interviewed will be a positive experience for interviewees and feeling that they have inadvertently re-opened wounds may be very painful (Crothers, 1995; Draucker, 1999; Wincup, 2001).

**Powerlessness and frustration**

Several participants described feeling powerless and frustrated because they could not change interviewees’ circumstances or remove their suffering. Feeling like a helpless bystander seemed distressing:

As a researcher, I can [ ] try to move things forward for other people [ ]
but no, I couldn’t do anything for them. [I was] so sad about what they had
experienced and angry and frustrated that I couldn’t do anything to
change it; frustrated that I couldn’t do anything to stop the violence [ ]
still continuing for some (Carol).

Whilst Carol’s research might change things for others, her contribution to her interviewees sometimes felt wholly inadequate. Exploring suffering and distress with interviewees yet being powerless to intervene seems difficult, the researcher role sometimes experienced as frustrating or limiting. Clare, who had a counselling training, felt this acutely:

[A] woman that told me the worst kind of description of sexual violence; I
found that really difficult [ ]. I realised I was a researcher and not in a
therapeutic role. [She] seemed so disturbed and yet I was just there to collect information. And that was a challenge, to walk away from that feeling so powerless to actually help her.

Using counselling skills in research interviews can facilitate depth, quality and sensitivity (Coyle, 1998) but feeling constrained against fully using these when faced with distressed people may cause strain; therapist-researchers may feel that they could have done more, or were a passive bystander to someone’s pain (Ahlenius, 2003; Etherington, 1996). Sometimes, however, participants coped with feeling powerless / helpless either by taking action, or by considering what they had done for interviewees (discussed later).

*Feeling isolated or unsupported*

The wider context to researching rape was that researchers often described feeling isolated as they held interviewees’ confidences, or as others withdrew from hearing about their research:

[I]t was almost like no-one wanted to know, and that was quite stressful for me, the response from other people [in the university]. Sometimes I felt I was being silenced as a researcher. There was this feeling [of being] isolated and not understood (Susan).
Etherington also describes how others found her research on sexual abuse difficult to hear and distanced themselves, ‘so I withdrew and felt alone with it’ (2000, p. 380). Feeling isolated or stigmatised may be particularly difficult when researching sensitive topics.

Although some researchers considered their emotions natural outcomes of having ‘empathy [ ], because if you didn’t feel it then you wouldn’t be human’ (Clare), others isolated themselves from support because they felt ashamed;

[Part of me thought, this is a weakness of mine. I didn’t want to say I found anything hard [to my supervisor]. I thought, I should be able to cope with this (Zoe).]

Despite validating their interviewees’ feelings, several researchers seemed anxious about their own, describing them as ‘abnormal’. Like many therapists, researchers may prefer to think of themselves as resilient (Astin, 1997; Etherington, 2000; Neumann and Gamble, 1995; Robertson, 2000), or as detached observers, inhibiting them from acknowledging that sometimes they need support. As Carol commented, ‘you want to be able to handle anything’. Others did not acknowledge their need for support until they felt overwhelmed; Euan wondered if this was because of ‘the way that it accrues in small amounts over time, [which] works against the recognition of what’s going on’.
Several researchers felt inadequately supervised, wondering where to take their responses. Pointing to how researchers’ and therapists’ needs overlap, Diane commented:


"\text{Counsellors must have a very tough time but it's somehow accepted that they'll have supervision. And I think it should be accepted that we have [ ] supervision, because sometimes we [ ] do some of those things that a counsellor might do, like support people.}"

Indeed, research supervision on sensitive topics could usefully involve an emotionally supportive function (Brannen, 1988; Coyle, 1998) although the "culture" of research may not always recognise this need.

\textit{Feeling immersed in horror}

Qualitative approaches require immersion in data during interviewing, analysis and write-up. Some researchers described this process as disturbing, given the subject matter:

\"Filling your head with shit experiences and cogitating them round all the time and sorting it in your head into logical categories is [ ] a real problem if, if, if the content is ... horror (Euan)."

Some researchers also described feeling unable to stop thinking about their work, even "off duty". Carol suggested that:
Researching rape is not a job where you go home [ ] and shut the door, when you have got women exposing the most horrible things all day [ ]. You go home and you think about it all night. You know, all week, all month.

Given the difficulty compartmentalising this topic, it is perhaps unsurprising that every researcher described their work gradually “leaking into” their personal lives, explored next. Before moving along however, it is interesting to note Euan’s observation that some of his emotional reactions seemed to mirror those experienced by survivors of rape:

I’ve run through my head today images and stories [ ] that I haven’t thought about for several years. It’s funny, isn’t it? I can feel it; I can feel it coming up. It’s anger, it’s ... all the feelings you feel when you’ve been sexually assaulted.

The ripple effect of researching rape; impacts on personal lives and perspectives

Every researcher described experiencing a gradual ‘spilling over’ or ‘rippling outwards’ of the research topic into their personal lives; indeed, such language inspired the model shown in Figure B, where the impacts of researching rape are shown as waves rippling out beyond the original context of the research interviews. Moran-Ellis also notes this ‘potential for research to impact on domains [ ] outside the academic sphere’ (1996, p. 178). These impacts are considered next.
Experiencing “haunting” imagery

An immediate intrusion often came in the form of vivid images as interviewees described their experiences and researchers listened empathically. For some, these returned later as dreams (as Diane described, above) or as sudden interruptions into waking thoughts, having a private, haunting quality;

Often things come unbidden to my thoughts [. It’s ] a mishmash of the [ ] experience of interviewing them [and] my constructed memory of the experience of the assault. [I]t’s kind of a Salvador Dali of those. [The] things that haunt me are the images of the assaults.

Megan also felt ‘haunted’ by images from research that had long been completed, which still followed her and could ‘pop up’ unexpectedly. Dreams and lingering images are also reported by researchers of bereavement through domestic fire (Kitson et al., 1996) and by trauma therapists (Astin, 1997; Crothers, 1997; Danieli, 1988; Figley, 1999). The fragmented, surreal quality that Euan describes perhaps mirrors survivors’ disjointed, not-yet-processed memories of trauma (Lyon, 1993), which also seem difficult for researchers to integrate.

Fears about vulnerability to rape

Just as personal vulnerability concerns survivors of sexual violence, so it troubled several female researchers. Several linked this with their identifications with interviewees
(detailed above), but also with an increased awareness of the threat of rape. Diane for example described feeling 'on heightened-sensitivity mode' during her research and anxiety in situations in which interviewees reported having been raped (e.g. riding in taxis). Despite being aware of 'the statistics' (stranger rapes being relatively rare), Kate also described feeling more aware of possible danger:

I was more wary when I left work [ ], because we did do a lot of late nights.

I was more aware, more aware of the possibilities.

Kelly (1988) also talks of feeling vulnerable and frightened during her research on sexual violence, also describing this as a 'heightened awareness'. Likewise, rape advocates report heightened anxiety as a consequence of becoming more aware of the threat of rape (Wasco and Campbell, 2002). Fear was sometimes expressed as concern for children. Megan recalled worrying about her teenage daughter:

At that time, my daughter was [ ] starting to go out. And we did have a few cases of survivors of spiked drinks. I just got absolutely – you know. I was just – I was so worried about her.

Indirect exposure to trauma may therefore shift frames of reference, researchers becoming increasingly aware that terrible things do happen, including in public spaces, and beginning to feel less safe (Pearlman, 1999). However, fear was described as an early, transitory reaction rather than permanently changed perspective.
**Impacts on relationships**

*Becoming cynical about relationships*

However, as their research progressed and rape within relationships (rather than stranger rape) seemed more 'the sort of experiences we would be recording', some researchers began to feel 'much more cynical about men and relationships' (Natalie). Clare felt that this

... can skew your perspective [ ] and you can become quite cynical because it reveals a lot of things that you wouldn't normally be aware of [ ] – that sense of going past people's houses and not knowing what could be going on inside (Clare).

Crothers (1995) also reports that nurses working with survivors of abuse sometimes wonder if the people that they pass on the street are child abusers. Zoe also explained how:

Over time, I became [ ] much more cynical [about] people's motives and quite pessimistic about relationships. I became a lot less tolerant of friends' relationships when they were having minor issues. [ ] I was saying, this could be an indication of something [ ] sinister in your boyfriend [and] they would say, all he did was ask where I was.

Zoe's anxiety seemed based on concern, but suggests that her previous views of relationships had changed, becoming out-of-step with her friends'. Feeling that her experience no longer supported a benevolent view of other people and relationships
seems a painful transition, associated with feeling jaded (Astin, 1997; Iliffe and Steed, 2000; Pearlman, 1999).

Displacing anger onto other men

The intense anger that many researchers felt sometimes found its outlet in their relationships with men. Euan recalled how:

Sex was rubbish [laughs]. Sex was rubbish. Any kind of sniff of erotic power play immediately turned me off. The anger I felt towards the assailant would quite often be directed towards my [male] sexual partners.

Euan describes how sensitised to power dynamics he became, triggering anger which was then displaced onto his partners. Perhaps, given the emotionality of researching rape, it is unsurprising that strong feelings become entangled with personal relationships. Indeed, Megan commented:

You really at times wonder how you can have [ ] relationships with men.

[T]hat’s probably been difficult for my partner at times, and for my [ ] son as well, where I suppose [ ] they can feel how hostile I have felt.

It seems difficult to bear witness to so many stories of rape, and researchers may want someone to answer for these horrifying things, ‘even if occasionally it was [ ] somebody
we actually liked and cared about’ (Campbell, 2002, p. 82). Several also mentioned heated exchanges with acquaintances who espoused blaming or ill-informed views; indeed, Carol suggested that researching rape ‘does affect your life outside because I am so passionate about it’.

*An awareness of human cruelty*

Interviewees’ vivid, graphic descriptions of their victimisations seemed disturbing, confronting researchers with the ‘undeniable realities of people’s cruelty to one another’ (Pearlman and Saakvitne, 1995a, p. 298). For example, researching rape occurring in war, Susan heard women speak of

... being multiply raped and being cut and having their babies taken out of their stomachs when they were pregnant. It was awful. [ ] I suppose it heightens your awareness of what men are capable of.

Euan also acknowledged that

...the sexual assault research was the most horrific stuff that I’ve done. It really was. It really pushed how horrible people can be to each other in your face, and how fucked-up people get if you do that to them.

Euan’s interviews seemed a shocking confrontation with the appalling realities of sexual violence; how deeply people suffer, and how this was inflicted deliberately. In the face of
this, it may be hard to maintain beliefs of people as mainly good or benign and researchers may feel in horrifying contact with the depth of human perversity (Danieli, 1988; McCann and Pearlman, 1990).

In summary, the impacts of trauma may ripple out beyond survivors, precipitating extreme emotions in researchers who engage empathically or identify with their stories, creeping into their personal lives and affecting their belief systems in ways that echo some of the issues that survivors of rape describe (although seem far less debilitating) (McCann and Pearlman, 1990; Pearlman and Mac Ian, 1995). The analysis now considers coping, represented by Figure B as arrows pointing inwards to suggest researchers’ attempts to ameliorate the impacts of their research.

Coping strategies

Several coping strategies were identified; two seem well-covered already by the trauma therapy literature (self-care e.g. by exercising / journaling, and obtaining support e.g. from supervisors / peers; see Pearlman, 1999; Pearlman and Saakvitne, 1995b; Yassen, 1995; Williams and Sommer, 1999). Therefore only those seeming specific to researchers are reported in depth but for the complete findings, see Table 1 (p. 249).

Putting emotional reactions to use

Distressing emotional reactions seem a difficult aspect of researching sexual violence, but some researchers also treated them as a resource (Campbell, 2002; Stanko, 1997). Olivia’s emotional resonance with her research topic allowed her particular insight and
empathy. Megan also felt that her emotional responses increased her understanding of the data:

[R]eflectivity is [a] way of putting to work how you're feeling. I might say, why does this make me angry, and what could I look for analytically in the data that might be important there, that it's sensitised me to? But it probably also is a personal coping strategy, because feeling powerless is probably the thing I find hardest [and] a way of not being so powerless in terms of how something makes you feel is to say, oh, I could use this analytically.

Emotions can therefore guide researchers; as Megan suggests, moving between the data and one's emotional reactions to them may deepen understanding (Campbell, 2002; Harris and Huntingdon, 2001; Kelly, 1988; Stanko, 1997), also enabling Megan to feel active and in charge of her feelings rather than immobilised by powerlessness. Carol also channelled her feelings into writing, using her anger to produce a report that captures the emotionality of rape yet remains digestible to readers:

I'm probably quite aggressive in my writing style and I get [my anger] out on paper then I go back obviously and mellow it down because I've got to get people to listen to it.
Channelling emotion into writing, using it to alert others to the devastation of rape, seems a positive use of feelings (Stanko, 1997). Other participants used their emotions as sources of energy or motivation:

[T]he way you keep going – because you feel like giving up, don’t you? [laughs] – was to think about the [interviewees], and that was all I needed to do. I just felt, no, I have to do this, it’s really important to make sure their voices are heard []. So, I couldn’t give up (Susan).

[T]he negative emotions [] spurred me on – [] it is important to make this [subject] known (Diane).

Emotions may therefore mobilise researchers, stimulating action or becoming a reason to stay involved (Gilbert, 2001; Hercus, 1999).

Taking action

Most researchers felt proud of their research, hoping that it would make a difference, even if they could not directly assist their interviewees:

[I could] at least put the research to practical use []. At least I had that. And that was important to me, that it was applied, applied research (Carol).
Producing research is one way that researchers can express their concern or emotional involvement (Campbell, 2002) and may provide a sense of meaning or purpose, helping them feel less powerless; as Susan remarked, 'when I feel like I'm doing something about it, that's also how I deal with it'.

Occasionally, taking action was more direct, associated with feeling unable to bear feeling powerless in the face of interviewees' vulnerability. Carol made a complaint about a police officer's offensive behaviour towards a survivor (mentioned above), 'because I was so angry. And I felt a lot better after I'd done it [laughs]'. Another interviewee made a further allegation of rape at interview and Carol again felt pressed into action:

I had to do something [ ]; she was clearly just exceptionally vulnerable. [ ] I went back to the office and [was] there till half ten, eleven at night making this report [to the police]. [ ] And all I wanted to do was kind of [ ] get her and take her home.

Taking action this way seems understandable, given how painful it seemed to otherwise feel like a helpless bystander. Acting may also be linked with identifying with interviewees' vulnerability and adopting a protective (rather than data-gathering) role, based on a desire to help (Crothers, 1995; Danieli, 1988; Pearlman and Saakvitne, 1995a). However, becoming "pulled" into action this way may make researchers more vulnerable to feeling emotionally affected by researching rape (Brannen, 1988; Figley, 1989), linking these categories. Megan suggested another route, offering interviewees
information on sources of support. She described this as ethical, but also 'a way of managing your own anxiety. You [ ] say, I'm doing this for this person, [ ] but actually it's a way to hold things for you as well [and] making yourself feel a bit safer again'.

_Appreciating the intrinsic rewards of researching trauma_

Finally, several researchers pointed to the worthwhile, even transformational aspects of researching trauma. Some felt that they had grown in knowledge and understanding of the issues involved. Others dealt with their pain by considering how they had supported interviewees, offering a relationship in which they had been listened to and taken seriously which was often described by interviewees as 'therapeutic'. Several researchers talked of feeling 'inspired', 'uplifted', 'touched' and 'humbled' to have been part of this:

Sometimes people said [ ], nobody has ever listened to me before. [ ] It made me feel quite special, that they trusted me to do that (Diane).

One woman said, I know I've helped you, but I think you've helped me more (Zoe).

Being told that their involvement was helpful may ameliorate helplessness or powerlessness in the face of interviewees' pain; indeed, Carol suggested that 'every time I had positive feedback at the end of an interview, that did make me feel better'. Certainly, when interviewees confide in researchers, powerful bonds may develop (Campbell, 2002). Some researchers would 'never forget' their interviewees or the
confidences they were entrusted with. Zoe wondered if keeping these connections alive inside

... is something I do because it makes me feel better as well. Like, even though they don’t know it, I still remember them, I remember they told me that important thing and I haven’t let them down.

Feeling touched by the sharing of something so personal, and having responded helpfully, may also foster hope in researchers, surfacing most powerfully when genuine attachments develop (Campbell, 2002).

Witnessing interviewees' growth, despite their suffering, also seemed hopeful and inspiring. Susan’s research sometimes led her to feel ‘cynical about the world’, yet

...the other side of it was that these women have survived and got on with their lives and doesn’t that tell you about the strength of women who have suffered? That was very powerful for me [and] maybe that counterbalanced it.

Understanding the suffering involved in experiencing rape may lead researchers to treasure signs of the ‘tremendous strength and resiliency women have to survive rape’ (Campbell, 2002, p.89). Likewise, holding onto the possibility of healing may be a powerful antidote to the creeping cynicism described above (Lyon, 2003; Pearlman and Saakvitne, 1995a; Schauben and Frazier, 1995).
Overview

These findings explore the personal impacts of qualitatively researching rape, producing a localised theory suggesting that, during in-depth interviews, relationships based on empathy can encourage depth to discussions and close bonds to develop, yet researchers may also "take in" or "contain" traumatic emotions. Likewise, shared characteristics may encourage identifications, associated with an acknowledgement of personal vulnerability to rape and correspondingly with fear. Some interviewees may also "pull" for a deeper identification with their experience, which may feel disturbing and overwhelming. Interviewing survivors of rape may also distress researchers with personal experiences of rape, although was also linked to greater empathy with interviewees' experiences. These interpersonal processes resulted in an array of distressing emotions, the research often conducted within a context of feeling isolated whilst also immersed in horror.

The impacts, having their origins in empathy and identifications, rippled out still further into researchers' personal lives, resulting in intrusive imagery or changed belief systems (feeling more vulnerable, more cynical about relationships or despairing of human nature). Strong feelings of anger sometimes also found their outlet in researchers' relationships, although many described not recognising such impacts until later. Whether these are enduring changes seemed unclear and could be further investigated; however, some experienced persistent imagery whilst fearing rape seemed a temporary reaction. The researchers coped by treating some emotions as resources, countering feelings of helplessness by taking action or offsetting some of the cynicism and despair associated with this topic by appreciating the intrinsic rewards of researching rape.
Therefore, this research sought to generate a localised theory of the impacts of researching rape and (within the analysis of the findings) delineated a series of relationships between the various categories.

Such experiences appear to parallel survivors’ responses to the trauma of rape (see Burgess and Holmstrom, 1974); indeed, several participants noted this. This intriguing observation was also made by Alexander et al. (1989), who associate the ‘parallel reactions’ of a group of researchers reviewing records from rape crisis centre files with their ‘identifications’ (p.60) with survivors, despite the impersonal method of data collection. Likewise, in psychodynamic theory, ‘parallel process’ and ‘projective identification’ refer to therapists’ experiences of “mirroring” aspects of clients’ process, based on powerful identifications (Morrissey and Tribe, 2001; Sachs and Shapiro, 1976; Searles, 1955).

Related theories exist within the trauma therapy literature, supporting these findings. These recognise that therapists are vulnerable to experiencing similar responses to traumatised clients, including disrupted beliefs, intrusive thoughts / images, painful feelings or the re-activation of personal memories of trauma. ‘Compassion fatigue’ (Figley, 1995; 1999) and ‘vicarious traumatisation’ (McCann and Pearlman, 1989, 1990a; Pearlman and Saakvitne, 1995a, 1995b) emphasise the accumulated impacts of trauma therapy, suggesting that the empathic connections underpinning therapeutic relationships can transform therapists in ways paralleling clients’ experiences (Williams and Sommer, 1999).
This study therefore receives support from diverse sources but extends these, offering an in-depth analysis of a group of researchers and producing a theory grounded in their lived experiences. Vicarious traumatisation / compassion fatigue are theories largely applied to therapists; whilst both groups experience repeated contact with traumatised people (Dutton and Rubinstein, 1995), therapists receive regular supervision, personal therapy, offer time-limited meetings on their own territory and their training and experience may help them to conceptualise and respond to the personal impacts of their work (Brannen, 1988; Hart and Crawford-Wright, 1999).

Whilst using researchers as emotional confidantes may be “therapeutic” for interviewees, confiding may also burden or disturb researchers who often lack adequate support (Brannen, 1988; Cieurzo and Keitel, 1999; Gilbert, 2001; Grafanaki, 1996). Additionally, some researchers may be drawn to topics of personal significance for reasons they cannot fully articulate, feeling shaken by the re-activation of their own traumatic memories and lacking outlets to process these (Grafanaki, 1996; Kitson et al., 1996; Robertson, 2000). This research also suggests that a series of brief relationships with traumatised people can disturb, the theory of vicarious traumatisation seemingly based upon observations of the accumulated impacts of longer-term, therapeutic relationships.

These findings also extend Coyle’s (1998) argument for employing humanistic counselling skills to collect data on sensitive topics; awareness of the psychodynamics of research interviews (e.g. transference and countertransference) may also aid researchers, given that the strong emotions aroused may upset researchers and influence the data.
obtained (King, 1997; Kitson et al., 1996; Laslett and Rapoport, 1975). These findings therefore seem relevant for counselling psychologists, whose training may render them well-placed to study trauma qualitatively (McLeod, 1996). Indeed, many Trainee counselling psychologists conduct “sensitive” research yet may be supervised by non-practitioner academics who may not appreciate the emotional demands of such research. These findings may therefore better inform research supervisors about the need to support Trainees undertaking such research. Future research might also explore how psychologists negotiate the boundary between research and therapy during sensitive investigations (particularly when using a counselling style of interviewing) and how they experience and manage the role strain involved.

Little attention seems paid to recording the research process, and turning the focus around to research researchers seems an important new area of enquiry (Campbell, 2002; Harris and Huntingdon, 2001). This study considers the experience of researching rape, likely to be challenging; however, other sensitive topics or enquiries of personal significance may also be risky. The theory could be further developed by exploring whether sensitive (but non-traumatic) topics (e.g. “mental illness”, pain, bereavement, etc.) have comparable / different impacts on researchers, or indeed traumatic topics that lack an interpersonal dimension (e.g. deaths resulting from road traffic accidents).

These findings should, of course, be interpreted carefully. Newer researchers seem over-represented, their relative inexperience perhaps rendering them more vulnerable (Pearlman and Mac Ian, 1995). Only one man was recruited, although the predominantly
female sample may reflect the population of researchers currently involved in investigating rape (although the parameters of this population are unknown).

**Recommendations**

Given that trauma research is distressing, and that many researchers do not foresee this, research directors / ethics committees may have a duty to warn (Munroe, 1999; Neumann and Gamble, 1995), so should be aware of these findings. Acknowledging the risks involved also ensures the provision of adequate support. Researchers may require emotional support from supervisors, this work seeming too demanding to cope without it (Coyle, 1998; Kitson et al., 1996). This might involve validating emotions, providing theoretical frameworks to understand the impacts of trauma research and discussing coping plans. Researchers who draw on a network of supporters (including peers) may avoid overburdening supervisors and reduce isolation, and should monitor and respond to signs of emotional distress themselves (Munroe, 1999; Sexton, 1999; Williams and Sommer, 1999).

**Conclusions**

This research focuses on the negative impacts of researching trauma but, rather than dishearten, may encourage researchers to consider the issues involved and establish support before beginning. Additionally, whilst these participants felt traumatised and overwhelmed, they also reported feeling moved, inspired and informed by their interviewees. Indeed, investigating trauma seems a transformational experience, researchers coming away ‘sadder but wiser’ (McCann and Pearlman, 1990, p.147).
Perhaps this potential for reward, as well as difficulty, is part of what keeps researchers engaged in this challenging area.

Acknowledgements

This paper was written to fulfil part of the research component for my doctorate in Counselling Psychology, and the help and support of my research supervisor Dr. Adrian Coyle is gratefully acknowledged. I would also like to thank the ten researchers involved for their insightful contributions and both researchers who generously offered feedback during the piloting of the interview schedule.
Figure A: Diagrammatic theoretical model of the interpersonal processes involved in "transmitting" trauma to researchers.
Figure B: Diagrammatic theoretica model of the personal impacts of researching rape

- Awareness of human cruelty
- Displacing anger
- Impacts on relationships
- Guilt
- Fear about vulnerability to rape
- Haunting imagery
- Rape

Emotional impacts of researching rape

Self-care

Support

Obtaining

Taking action

Use reactions to emotion

Pulling the intrinsic rewards

Supporting
References


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About the author: Heidi Ashley is currently completing her PsychD in Psychotherapeutic and Counselling Psychology at the University of Surrey, UK. Her research interests also include women's experiences of recovery from rape and posttraumatic growth.
Appendix 1: Further information provided at first contact and screening questions used to evaluate whether being interviewed was appropriate for respondents
You are invited to take part in a research project that I am conducting for my practitioner doctorate in Counselling Psychology. This will explore the experiences of researchers who have investigated sexual violence or rape and who are willing to discuss these in a one-to-one interview. Interviews will be fully confidential and conducted in a sensitive manner.

Here is some information to help you decide whether or not to take part. Please take time to read it carefully, and discuss it with someone if you wish. Ask me if there is anything that you do not understand, or if you would like more information. Take time to decide whether or not to take part.

This research involves one interview. This will take place at a suitable location convenient for you (e.g. your home, your university or workplace). I will ask you questions about your experiences of researching sexual violence, what drew you to this topic of research, any personal impacts of doing this work that you may have become aware of and ways in which you may have coped with these. Interviews will be audio-taped (so that I can cite your experiences accurately) and written up, after which the audiotape will be erased. All data will be handled in accordance with the Data Protection Act (1988).

Why are you carrying out this research? It forms part of the research component of my practitioner doctorate in Counselling Psychology. The particular topic arose from my personal reflections after carrying out interview-based research last year on women’s experiences of recovery from rape.

How long will interviews take? I would anticipate between sixty and ninety minutes.

Who will be doing the interviewing? I will: there will be no-one else present.
What is the information for? I will be using this information to develop a better understanding of how investigating sexual violence may impact upon researchers. The findings will be discussed in a research report that will be completed in 2005. They may be of use to help researchers understand more of the issues involved in carrying out interview-based research on sensitive or traumatic topics sexual violence and to assist future researchers to develop plans and strategies to address potential difficulties before interviews begin.

Is this research confidential? All the information collected during the interviews will be kept strictly confidential. My written report will not identify you in any way.

Why have I been chosen to take part? This information sheet is available to potential volunteers so that you can obtain more information before deciding whether or not to take part. I am looking for researchers (male and female) who have carried out interview-based research into the topic of sexual violence or rape; who conducted face-to-face (not telephone) interviews and whose research was carried out at least three months ago.

Do I have to take part? No. Participation is entirely voluntary. There is no financial remuneration for taking part.

Can I change my mind? If you want to stop the interview, you may say so at any time without giving a reason and I will destroy your data. You may also decide to change your mind after the interviews: again, your data will be destroyed.

What are the possible disadvantages of taking part? Some researchers who have investigated sexual violence may find this a difficult or distressing topic to talk about and may prefer not to take part. This may be particularly true of researchers who have had personal experience of sexual violence. It is important to take time to consider whether participation seems right for you.

Thank you for taking the time to read this. If you would like to take part, or would like more information to help you decide, then please contact me:
• directly on psmlha@surrey.ac.uk
• by writing to me care of Mrs Kay Hambleton, at Room 1-AD-02, Department of Psychology, School of Human Sciences, University of Surrey, Guildford.
• or, leave a message for me care of Mrs Kay Hambleton on 01483 689176 and I will call you back.

- Heidi Ashley
  (Trainee Counselling Psychologist, University of Surrey).

Supervised by Dr Adrian Coyle. You are invited to contact Dr Coyle to verify any aspect of this research at A.Coyle@surrey.ac.uk or c/o Mrs Kay Hambleton at the number above.)
Screening / assessment procedure during initial telephone contact

(Offer to ring her back).

Broad areas to cover (in informal, conversational style):

Introduce myself and the research (investigating researchers’ experiences of researching the subject of sexual violence).

This research involves one interview, taking place over the next few weeks at your convenience. The interview will take place at a location convenient to you and shouldn't take longer than ninety minutes.

I'm hoping to interview women or men who have carried out interview-based research on the topic of sexual violence (rape). That might have been as a psychologist, trainee, social worker, research fellow and so on. The people I'm hoping to interview might have carried out the whole research project themselves or only have been involved in part of it, but should have been involved in at least interviewing participants. Does that fit the research you did?

Can you very briefly summarise your research, so that I can get a sense of it?

OK. Unfortunately, I can’t involve anyone who carried out their research less than three months ago. This is to allow sufficient time for some processing and reflection of the research experience.

I also can’t include anyone who carried out all interviews by telephone since face-to-face encounters seem more conducive to developing relationships with interviewees, which is an important aspect of this research.

Do any of these exclusion criteria apply to you?

If yes: I'm sorry that I can’t invite you to take part and I hope that you don’t feel too disappointed. But thank you for offering your time to help me with my research.
If no: Just so that we can make sure that this is the right thing for you to get involved in, do you mind if I ask you a few questions? These let us think together about whether taking part seems the right thing for you to do.

Maybe you could start off by telling me something about why you responded to my advert/letter?

Is there anything in particular that you’re hoping to get out of taking part?

One of the areas I’ll cover at interview involves asking what attracted you to this topic of research. I’m expecting that people will give very different answers to this question, but that some might indicate having had a personal experience of rape or sexual abuse of some kind themselves.

Without asking you whether or not this has been a personal experience of yours, it’s important to point out that, whilst the interviews will be conducted sensitively and I won’t be asking anyone to open up and discuss any personal experiences they may have had, it is possible that this part of the interview might be difficult for some people, simply because of the topic having been raised.

Perhaps, if sexual violence or abuse of any kind has been an issue in your life, you would take time after our conversation to reflect on how ready you might be to participate in research that touches on this area?

[Does s/he seem able to hear that?]

Another important thing to mention is that it seems very possible that researching trauma is an emotionally demanding experience, and that talking about this at interview might be draining or even quite unsettling. If you did agree to be interviewed, would there be someone you could offload with after the interview, if you felt that you needed to? I’m thinking of a partner, friend, colleague or supervisor, that sort of thing.

If you did become upset during the interview, how would you like me to respond?
OK, what I suggest is that you take some time to reflect on our conversation today and then, if you like, you can contact me again to set up an interview date. There’s no need to get back to me if you decide to give it a miss after all.

Do you still have my contact details?

If being interviewed doesn’t seem suitable:

Thank you for getting in touch and for showing an interest in my research. I’m wondering if being interviewed is the best thing for you to get involved in at present. Your research seemed an unsettling experience, which I can understand, and I’m concerned that asking you to go through it again with me might be difficult for you at the moment.

(Allow volunteer to discuss and reflect on this together).

(If appropriate, and avoiding any insensitivity): I wonder if there might be people that you could speak to who could offer you some support? Can I send you a list of organisations that I think might be useful?

*Obtain postal/email address.*
Appendix 2: Interview schedule, consent form and socio-demographic form
Interview Schedule

Introduction

Spend some time informally introducing myself and the nature and broad aims of the research. Use time to convey rapport.

Remind interviewee of her right to withdraw at any point, including after the interview, and that she does not have to supply a reason. I will of course then destroy her tape.

Reiterate that we will have about 60-90 minutes together. Explain that if at any point the interviewee would like to break or to stop completely, then to please let me know.

Remind ourselves of who we decided (in previous telephone screening procedure) that she might speak with after the interview (e.g. colleague, partner, etc) should the interview raise any issues which she feels deserve more time to talk through afterwards.

Ask her to complete socio-demographic questionnaire: To begin with, I'd like to gather some information about you – you age, qualifications and so on. This is so that I can show the people who read my report something about the range of people that I've been speaking to. The information that you give won't be used to identify you in any way, but if you don't want to answer any of the questions then please don't feel obliged to.

Have interviewee complete consent form.

Her research

Warm up interviewee by discussing contextual information: To get us started, maybe you could give me an idea of the research you were involved in looking at sexual violence. Knowing something about that will help me to put the rest of what you say into context.

(Prompt): For instance, it would help to know how many pieces of research you've done in this area, what your role and responsibilities were, and so on.
Additional prompts if necessary:

- Roughly, what were your research aims?

- What was your role in the research?
  (Prompt): For example, did you also transcribe the data as well as interview, or did someone else carry out that task? What else was your responsibility? (E.g. analysis, writing up).

- How many interviews did you do? Over what space of time were they?
  (If relevant): You mentioned earlier that you have done several pieces of research in this area – do you think you can estimate roughly how many interviews you might have done?

- How did you recruit your participants?
  (Prompt): For example, were you recruiting from a hospital or Rape Crisis centre, or did you recruit from the community?
  How did you go about that recruitment? Then what happened?

- How long were the interviews, usually?
  (Prompt): For example, maybe you were quite keen to keep to a particular time frame, or perhaps you felt it was important to allow the interviewees as much time as they needed?

- Broadly, what areas were covered in the interviews?
  (Prompt): For example, perhaps you asked your interviewees directly about their experiences of rape, or maybe they raised this or other potentially distressing material themselves?

- What sorts of people were you interviewing?
  (Prompt): For instance, perhaps you were interviewing only male or only female victims of rape, or some other specific group?
(Rationale: to note whether there seem any similarities between the interviewee and the group she interviewed that might encourage identification – e.g. an older female researcher interviewing older women).

- How would you describe your relationships with interviewees?
(Prompt): I'm wondering how you would describe the quality of the relationships you had with the interviewees, for instance whether rapport was good or not, and how you felt spending time with you interviewees.

- Over what period of time did you have contact with the interviewees?
(Prompt): For instance, perhaps you had just one meeting with them, or held multiple interviews?

- Were you a member of a research team, or were you the sole researcher?
(Continue probing and summarising until you have a clear idea of their research in some detail)

Therapeutic experience and expertise – if relevant

I noticed from your socio-demographic form that you are also a [e.g. psychologist / counsellor]. Did you have any psychological / counselling training when you did the research?

(If no, go to next section)

(If yes): When you did this research, did you have any experience working therapeutically with victims of rape?
(If yes): Can you say some more about that? (E.g. something about the number of clients, the length of contact).

Were you aware of any personal impacts of doing that sort of work? Can you say some more about that, if you feel comfortable doing so?
(Prompt): By personal impacts, I mean any ways in which you may have had strong feelings about the client or the work you did together.
What makes you say that?

Did you have any experience working with other traumatised clients? Can you say some more about that?

During your research interviews, were you aware of any advantages - to you or your interviewees - of having your therapeutic skills and experience? What makes you say that?

(Prompt): For example, perhaps you drew on your therapeutic skills and experience during difficult points in the interview(s), or at some other time during the research process.

(If relevant): Were there any other advantages? What makes you say that?

Did you feel that there were any disadvantages, to your or your interviewees, of having these therapeutic skills? What makes you say that?

(Prompt): For example, I have heard of some researchers who describe feeling frustrated at not being able to make full use of their therapeutic skills during research interviews. On the other hand, other researchers don’t seem to experience difficulties such as this and report managing the in-depth interview quite straightforwardly. Which, if either, of these experiences most matches yours?

What makes you say that?

(If relevant): At what point(s) did that difficulty occur? How did you handle that? Were there any other disadvantages of having therapeutic skills that come to mind?

The personal impacts of the research

Let’s explore the time period over which you actually conducted your research. Maybe we could think of this in terms of a timeline, from planning the research, carrying it out and submitting it, up to now.

First of all, when you were planning your research, did you have any expectations of how carrying it out might impact on you personally?
(Prompt): By personal impact, I mean ways in which you may have anticipated that the research could affect you, above and beyond making intellectual and practical demands. In other words, how you might have expected that it would affect you emotionally. What makes you say that?

When you think back to carrying out the research – when you were interviewing, transcribing or analysing - were there any ways in which it seemed that the work was having a personal impact?
(Prompt): For example, I am aware of some researchers who say that investigating difficult topics makes no demands on them beyond the academic sphere, whereas others describe feeling very affected by hearing stories of trauma from their interviewees. Where would you place yourself along this pole? What makes you say that?

(If acknowledges personal impact): At what point or points during the research process did you become aware of that? (E.g. during / after a particular interview / during transcription / after research was completed).
Were there any other ways in which the work seemed to have an impact on you personally, that you would feel comfortable sharing? (Prompt): For example, are you aware of any other ways in which doing this research affected you in terms of feelings about yourself, other people or the research itself?

At what point during the timeline did you become aware of that?

Were there any events or moments during the research process that stood out as particularly significant or challenging? What makes you say that? How if at all did that affect you? (Prompt): For example, perhaps you found a particular aspect of the research process difficult? What made that difficult?

In what ways, if at all, did you try to make sense of these impacts? (Prompt): In other words, did you draw on any theories, have ideas of your own, or talk with someone to help make sense of these impacts?
Were there any ways in which you were able to make use of your emotional reactions during the research process? Can you say some more about that?

Are you aware of any ongoing difficulties as a result of your experience/s researching sexual violence? Can you say some more about how that is still affecting you?

(If does not acknowledge any personal impact): I'm quite interested that you feel that doing this research had no personal impact. Can you say some more about what leads you to say that it had no effect on you?

(Prompt): I am aware that some therapists who work with traumatised clients talk about the personal impact that such work can have. I have also heard researchers talk about feeling affected by their research with people who have experienced trauma. However, I am interested to hear that your experience seems rather different to this: can you say some more about that?

What makes you say that?

Impacts on / reactions of others

(If personal difficulties were noted): How, if at all, did your supervisor / institution / team (whichever is relevant) react to these difficulties? What makes you say that?

Were you aware of your chosen research topic having any impact on those around you, such as a partner, friends or family? What makes you say that? When did you become aware of that?

(If yes): How did their reactions affect you, if at all? Can you say some more about that?
Personal issues and selecting the research topic

If at any point it appears that the interview, particularly during the following section, is drawing close to sensitive areas with which the participant appears to have serious emotional difficulties (e.g. indicated by changes in tone, posture, language or behaviour as well as any spoken indications), discreetly and sensitively pull the questioning away. Move smoothly on to the next section ("Plans and coping skills") or close the interview ("This seems to be very difficult for you, which I can understand. This isn’t an easy topic to discuss. You’ve given me a lot of information already and I think I’d like us to leave the interview here") and then move to supporting and affirming her whilst avoiding opening up particular areas of difficulty. If she insists on carrying on, stress that, “In fact, we’ve already covered a great deal of what I hoped to talk about today, and you’ve given me a lot of very interesting material. At the moment, I’m concerned about supporting you”).

Was there anything in particular that drew you to this topic of research?

(Avoid fishing for personal details or trying to “uncover” unconscious / unspoken motives – allow interviewee to answer this question how she wishes and accept her answer at face value).

(If interviewee indicates having been raped / assaulted / sexually abused herself and seems uncomfortable discussing this): There’s no need for you to say any more about this today if you don’t want to. Would you rather we moved on and left this here?

(Move to “Coping skills” section if necessary OR sensitively terminate interview if interviewee appears upset, and support her).

(If interviewee indicates having been raped / assaulted / sexually abused and seems prepared to discuss this): Are you comfortable talking about this today? Whilst I’m not going to ask you to tell me about your personal experience, it’s fine for us to move on if you would rather. (Move to “Coping skills” section if necessary OR carefully terminate interview if interviewee is upset and support her).
(If go-ahead is clearly given AND you feel satisfied that the interviewee seems able to discuss this safely): As I said, I'm not going to ask you to tell me about any personal experience you have of this topic. However, I would be interested to know whether you were aware of any disadvantages to having this shared experience with your participants?

(Try to sensitively steer interviewee away from opening up and discussing any personal experience of rape / assault but rather to focus on her research experiences. Support her in this by avoiding probing for details).

Did you find that this shared experience was in any way advantageous to you as a researcher? Can you say some more about that, if you feel comfortable doing so?

(As above; support interviewee in staying focused on the research experience and avoid fishing for details).

(If this question seems relevant and appropriate): I noticed that when you described your research earlier, there seemed to be certain characteristics that you shared with your interviewees, such as (e.g. being a young female researcher interviewing young females / male researcher interviewing males, etc.). Did having these shared characteristics impact on you in any way? Can you say more about that?

**Plans and coping skills**

When you were planning your research, did you consider how you might protect yourself from any personal impacts, or how you might cope with these as they occurred? (If yes): What methods did you consider in advance? Did they prove to be helpful?

(If no): How did you cope with the personal impacts of this research as they occurred?

(Prompt): In other words, in what ways did you deal with any emotions or stresses raised by doing the research?

Were there any ways in which you endeavoured to cope alone?
Were there any ways in which others helped you?

Can you say some more about that?

Were there any practical ways in which you dealt with these impacts?

(Prompt): For example, perhaps you decided to break up tasks into manageable parts, or used distraction, or some other practical way to deal with these impacts?

What strategies seemed most helpful to enable you to cope? Which seemed least helpful, as you look back?

What sort of support, if any, did you receive from your research supervisor / team / institution (where appropriate: check which apply) to help you cope with the emotional impacts you mentioned earlier?

(Prompt): For example, perhaps you felt that your supervisor provided time and space for you to talk about the personal impacts you mentioned earlier, or maybe you felt that s/he didn’t invite you to use supervision time in this way.

Can you say any more about that?

Looking back, was there any kind of support you would have liked to have received from your supervisor / team / institution?

What makes you say that?

Can you say something about how the support you received differed – if at all – from the support you would have liked to have got from your supervisor / team / institution?

What makes you say that?

In retrospect, what would have been most helpful for you to have known before you started this research?

(Prompt): For instance, if you were talking with a researcher who was new to this topic, would there be anything that you think that s/he should be mindful of before s/he started? What makes you say that?
Drawing to a close

Were there any parts of your research experience that you found valuable or rewarding? What makes you say that? Was there anything else? (Worth spending some time on this before winding up the interview - consolidating meaningful aspects as well as any ways in which she coped)

Reflecting on the interview experience

Before we end, I'd like us to spend some time reflecting on what it's been like for you to take part in this research. Fist of all, was there anything that you expected us to cover today that you were surprised to see left out?

If yes: Can you tell me why you feel that this should have been part of our discussion?

Were there any moments in the interview where it seemed like I didn't understand, or used the wrong language?

(If yes): When did that happen in the interview? What was it that jarred with you? Is there anything else to add? (Welcome this feedback and thank her)

Has there been anything negative or difficult about doing this interview today?

(If yes): Can you tell me something about why it was difficult?

(Acknowledge any difficulties and offer some unhurried time to discuss what issues the interview may have raised: don't expand on these but reflect that I have heard and take them seriously. Explore - at appropriate stage - what interviewee can do to address any ongoing concerns e.g. talking with a trusted person. If necessary, go back to the printed sheet of local supportive services that has been offered and arrange to call interviewee later / following day)

Has there been anything helpful or valuable about doing this interview?

Is there anything that you would like to add, or to ask me, before we end? Thank participant. Arrange to send copy of research later in the year.
Research consent form

The aim of this research is to explore the experience of having researched the topic of sexual violence or rape. The accompanying Information Sheet provides further details. Please take time to read this now if you have not already done so.

You will be asked to take part in an informal interview about your experience of researching sexual violence or rape. This will include questions about your experiences of researching this topic, what drew you to this topic of research, any personal impacts of doing this work that you may have become aware of and ways in which you may have coped with these. The interview will be conducted sensitively and I will encourage you to say no more than you are comfortable with.

The interviews will be recorded on audiotape so that, when I am writing up the research, I can quote your experiences accurately. To protect your confidentiality I will not quote in my report any information that might identify you. When I write up your interviews therefore, your name, the names of anyone you refer to, any locations or other identifiable information will not be recorded. Once transcribed, the audiotape will be erased. The data will be handled in accordance with the Data Protection Act (1988).

At this point, you may have questions or concerns, or feel that you would like some more information: if so, do please ask me before reading on. Take some time at this point if you need to.

Please read the following paragraph, and if you are in agreement, then sign where indicated.

I have read and understood the Information Sheet provided. I agree that the purpose of this research, and what my participation in it will involve, has been made clear to me. I agree that have been given an opportunity to ask questions about the study and have understood the responses given as a result, and that I have been given adequate time to consider my participation.
I understand that I am free to withdraw from this study at any time (including afterwards) without having to offer a reason, and that my data will be destroyed as a result.

I therefore consent to be interviewed about my experience of researching sexual violence, what drew me to this topic of research, the possible personal impacts of doing this work and ways in which I coped with these (if applicable). I also agree that an audiotape of this interview may be made, on the understanding that this recording will be transcribed for research purposes only and then erased and that my data will be handled in accordance with the Data Protection Act (1988).

Interviewee signs: .............................................................................................................

Name (block capitals) .............................................................................................................

Date: .......................................................................................................................................

On behalf of those involved with this research project, I undertake that, in respect of the audiotapes made with the above participant, professional confidentiality will be ensured. Likewise, any use of the audiotapes or transcribed material made from the audiotapes will be for the purposes of research only. The anonymity of the above participant will be protected and all data will be treated in accordance with the Data Protection Act (1988).

Researcher signs: .............................................................................................................

Name (block capitals) .............................................................................................................

Date: .....................................................................................................................................
Please could you respond to the following questions (leave out any that you would prefer not to answer). This information will help me to show the people who read my report something of the range of interviewees that I have been speaking to. Please ask if anything seems unclear.

1. What is your age? [ ] years.

2. Which (if any) of the following terms best describes your ethnic background?

(Please circle the appropriate answer)
- Black
- African
- Caribbean
- Other Black background
- White
- British
- Irish
- Other White background
- Mixed
- White and Black Caribbean
- White and Black African
- White and Asian
- Other mixed background
- Asian
- Indian
- Pakistani
- Bangladeshi
- Other Asian background
- Other ethnic groups
- Prefer not to say
- Chinese
- Other ethnic group (please state)

3. What is your highest educational qualification?

(Please circle the appropriate answer)
- Undergraduate degree
- Postgraduate degree / Diploma
- Masters degree
- Doctorate
- Other (please specify)

_______________________________________________
5. Do you also have a therapeutic training?
(Please circle the appropriate answer)

I do not have any therapeutic training
I'm a Clinical Psychologist
I'm a Counselling Psychologist
I am a Psychotherapist
I am a Counsellor
I'm a Trainee Clinical Psychologist
I'm a Trainee Counselling Psychologist
I'm a Trainee Psychotherapist
I'm a Trainee Counsellor

6. If you have a therapeutic training, how many years experience as a therapist do you have (post-qualifying)? (Write below).

7. What is your current occupation (or, if you are no longer working, what was your last occupation)? (Please write your occupation below):

8. Where did you hear about this research? (Please circle one)
I was contacted directly (by letter/email)
From a leaflet
Ad in The Psychologist / Counselling and Psychotherapy Journal
Word of mouth
Other (please state):
Appendix 3: Table 1: Complete set of categories and subthemes developed from analysis of the data
Emboldened subthemes reflect those excluded from the analysis due to word limitations. Illustrative quotes from the data are provided.

**Category 1: Interpersonal processes involved in “passing” trauma to researchers**

<table>
<thead>
<tr>
<th>Subtheme</th>
<th>Illustrative Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Empathic engagement with traumatised people</td>
<td>You, to some extent, take a bit from all of the interviews away with you, and some more than others, so you carry a load (Kate).</td>
</tr>
<tr>
<td>Identifying with interviewees</td>
<td>She was very similar in age to me. I think probably what I did was just identify with her a lot (Zoe).</td>
</tr>
<tr>
<td>Resonance with personal experiences of sexual violence</td>
<td>At first it did affect me quite badly [ ] because it did bring up issues for me about things that had happened (Olivia).</td>
</tr>
</tbody>
</table>

For discussion, see Corcoran (1989); Figley (1995); Kitson et al. (1996); Pearlman and Mac Ian (1995); Pearlman and Saakvitne (1995a); Wilson and Lindy (1994).
Category 2: The emotional impacts of researching rape

| Feeling unprepared for the intensity of interviewing | I thought, these are probably going to be difficult conversations [but] until I actually did it, I didn’t fully take on board what it would involve (Diane). |
| Anger | I just felt so angry; angry at the men, angry at the police, angry at myself because I couldn’t do anything about it (Carol). |
| Guilt and anxiety | Guilt, guilt at feeling you didn’t believe them. [ ] I felt guilt at the doubt because I was aware that that was the mechanism by which [male survivors] were excluded from [ ] service[s] and that was happening in the interview context as well (Euan). |
| Powerlessness and frustration | You do feel quite helpless. You come away and you feel frustrated. But if you dwell on that, you just couldn’t go on (Natalie). |
| Feeling isolated or unsupported | We pushed for more regular supervision. [ ] I know [clinical psychology] assistants who get more support and aren’t in contact with as disturbing work (Clare). |
| Feeling immersed in horror | Rape isn’t something you usually think about in any real detail or deeply or for a prolonged period of time but you end up spending a lot of time in that zone (Kate). |
| Horror or shock | It’s just the horror [ ], I think, that’s impacted on me (Carol). |
| Sadness and distress: | You listen [back] to the interview and I sound almost like I’m in tears a lot of the time (Zoe). |
| Responsibility | You feel responsible for your respondents and you feel responsible for the outcome of what you produce. [ ] That feeling of responsibility is, I think, very high (Megan). |
| Disturbance | Sometimes they were very composed [ ], they were so kind of fine about it but at the same time they were telling me something really horrific [ ] That was [ ] upsetting (Diane). |
| [She] had been raped by her father [ ] and she was obviously so damaged. [Her eyes were sort of dead (Natalie). |
| Emotional / physical reactions immediately after interviews | I would always have a really bad headaches afterwards; I would feel that my head was really clamped (Diane). |
| | Speaking to women who had had terrible experiences [ ]; you come away and you feel very drained, all the time, emotionally (Zoe). |

(cont....)
Difficulties accepting / recognising emotional impacts

You want to be able to handle anything. [ ] It wasn't until one day when I did get very upset that I realised how much of an impact it was having (Carol).

I wasn't consciously aware that things were going a bit pear-shaped because it's so gradual ... there was no kind of point at which there was a big rupture (Euan).

For discussion, see Campbell (2002); Comas-Diaz and Padilla (1990); Schauben and Frazier (1997); Sexton (1999); Stanko (1997); Wasco and Campbell (2002).

Category 3: The ripple effect of researching rape

Experiencing “haunting” imagery

It sort of haunts you really; you definitely carry those things, I think, afterwards. They pop up later, and I think that's the difficult bit (Megan).

Fears about vulnerability to rape

You do feel concerned for your safety. I did become scared about going out at night (Natalie).

Becoming cynical about relationships

It just makes me despair about human relations, really (Diane).

Displacing anger

I think that [ ] where my relationships with men have been difficult, I think it's because they can feel that I feel angry (Megan).

An awareness of human cruelty

It made me think things like, what are people like? [ ] Why do they do things like this to each other? How can they? And how can people survive it? (Diane)

For discussion, see Etherington (1996; 2000); Pearlman and Saakvitne (1995a); Pearlman and Mac Ian (1995); Schauben and Frazier (1995); Stanko (1997).
### Category 4: Coping strategies

<table>
<thead>
<tr>
<th>Self-care (exercise; socialising; journaling; making music; meditation; time alone; limiting numbers of interviews per day)</th>
<th>I really love music so if I'm upset, if I go and play my drums or my xylophone or my piano, I feel much better (Susan).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obtaining formal support (supervision, group debriefing)</td>
<td>I [] tried not to do more than one interview in a day because [] some of them were really, really draining (Carol).</td>
</tr>
<tr>
<td>Obtaining informal support from peers / family</td>
<td>We had several debriefing days where the whole research team got together and talked [] and shared our feelings (Carol).</td>
</tr>
<tr>
<td>Avoidance / numbing feelings</td>
<td>We maintained a very close-knit group so we were [] keeping an eye on each other (Kate).</td>
</tr>
<tr>
<td>Putting emotional reactions to use</td>
<td>I quite liked boozing. But it escalated; it absolutely escalated and spiralled during this project (Euan).</td>
</tr>
<tr>
<td>Taking action</td>
<td>The emotion of empathy gave me the motivation to continue (Euan).</td>
</tr>
<tr>
<td>Appreciating the intrinsic rewards of researching trauma</td>
<td>I couldn’t do anything for them. So when they said, [] is there any system for me to put in a formal complaint [to police], at least I felt I could do something, you know? (Carol).</td>
</tr>
<tr>
<td></td>
<td>I often felt almost uplifted sometimes because I was [] really proud of these people [] for sharing these experiences with me (Diane).</td>
</tr>
</tbody>
</table>

For discussion, see Comas-Diaz and Padilla (1990); Danieli (1994); Illiffe and Steed (2000); Pearlmann and Saakvitne (1995a, 1995b); Wasco and Campbell (2002); Williams and Sommer (1999).
Appendix 4: Ethical approval letter and details of target journal
12 March 2004

Ms Heidi Ashley  
PsychD Student  
Department of Psychology  
School of Human Sciences

Dear Ms Ashley,

The emotional impact of researching sexual violence: a grounded theory analysis (EC/2003/139/Psych)

I am writing to inform you that the Ethics Committee has considered the above protocol, and the subsequent information supplied, and has approved it on the understanding that the Ethical Guidelines for Teaching and Research are observed. For your information, and future reference, the Guidelines can be downloaded from the Committee's website at http://www.surrey.ac.uk/Surrey/ACE/.

This letter of approval relates only to the study specified in your research protocol (EC/2003/139/Psych). The Committee should be notified of any changes to the proposal, any adverse reactions, and if the study is terminated earlier than expected, with reasons.

Date of approval by the Ethics Committee: 12 March 2004
Date of expiry of approval by the Ethics Committee: 11 March 2009

Please inform me when the research has been completed.

Yours sincerely,

Catherine Ashbee (Mrs)  
Secretary, University Ethics Committee  
Registry

cc: Professor T Desombre, Chairman, EC  
Dr A Coyle, Supervisor, Psychology
Qualitative Research in Psychology

Information for Authors

Aims and Scopes

Qualitative Research in Psychology aims to become the primary forum for qualitative researchers in all areas of psychology—cognitive, social, developmental, educational, clinical, health, forensic—as well as for those conducting psychologically relevant qualitative research in other disciplines.

Qualitative Research in Psychology is dedicated to exploring and expanding the territory of qualitative psychological research, strengthening its identity within the international research community and defining its place within the undergraduate and graduate curriculum. The journal will be broad in scope, presenting the full range of qualitative approaches to psychological research.

The journal aims:

- to firmly establish qualitative inquiry as an integral part of the discipline of psychology;
- to stimulate discussion of the relative merits of different qualitative methods in psychology;
- to provide a showcase for exemplary and innovative qualitative research projects in psychology;
- to establish appropriately high standards for the conduct and reporting of qualitative research;
- to establish a bridge between psychology and the other social and human sciences where qualitative inquiry has a proven track record;
- to place qualitative psychological inquiry appropriately within the scientific, paradigmatic and philosophical issues that it raises.

Qualitative Research in Psychology will publish the following types of paper:

- empirical papers that report psychological research using qualitative methods and techniques; especially those that illustrate qualitative methodology in an exemplary manner, or that use a qualitative approach in unusual or innovative ways.
- theoretical papers that address conceptual issues underlying qualitative research, that integrate findings from qualitative research on a substantive topic in psychology, that explore the novel contribution of qualitative research to a topic of psychological interest, or that contribute to debates concerning qualitative research across the disciplines but have special significance for psychology.

- debate section
- book reviews

Submissions for special issues will normally be announced via an advertisement in the journal, although suggestions for topics are always welcome. Book reviews will normally be suggested by the Book Review Editor, although unsolicited reviews will be considered and the journal will also review other relevant media as well as qualitative research software.

All papers are refereed by, and must be to the satisfaction of, at least three authorities in the topic. All material submitted for publication is assumed to be exclusively for Qualitative Research in Psychology, and not to have been submitted for publication elsewhere. All authors must assign copyright to Arnold (by completing the copyright assignment form). Priority and timing of publication are decided by the editors, who maintain the customary right to edit material accepted for publication if necessary.

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Qualitative Research in Psychology aims to become the primary forum for qualitative researchers in all areas of psychology - cognitive, social, developmental, educational, clinical, health, forensic - as well as for those conducting psychologically relevant qualitative research in other disciplines.

Qualitative Research in Psychology is dedicated to exploring and expanding the territory of qualitative psychological research, strengthening its identity within the international research community and defining its place within the undergraduate and graduate curriculum. The journal will be broad in scope, presenting the full range of qualitative approaches to psychological research.

The journal aims:

- to firmly establish qualitative inquiry as an integral part of the discipline of psychology;
- to stimulate discussion of the relative merits of different qualitative methods in psychology;
- to provide a showcase for exemplary and innovative qualitative research projects in psychology;
- to establish appropriately high standards for the conduct and reporting of qualitative research;
- to establish a bridge between psychology and the other social and human sciences where qualitative inquiry has a proven track record;
- to place qualitative psychological inquiry appropriately within the scientific, paradigmatic and philosophical issues that it raises

Qualitative Research in Psychology will publish the following types of paper:

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- theoretical papers that address conceptual issues underlying qualitative research, that integrate findings from qualitative research on a substantive topic in psychology, that explore the novel contribution of qualitative research to a topic of psychological interest, or that contribute to debates concerning qualitative research across the disciplines but with special significance for psychology
- debate section
- book reviews
Submissions for special issues will normally be announced via an advertisement in the journal, although suggestions for topics are always welcome. Book reviews will normally be suggested by the Book Review Editor, although unsolicited reviews will be considered and the journal will also review other relevant media as well as qualitative research software.

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Appendix 5: Personal reflections
A personal and emotional journey: Reflections on the research process

Immersing myself in the literature on rape for my review and my previous research was a peculiar experience; there seemed a split between the harrowing emotionality of survivors' accounts and the very detached stance taken by many academics. In qualitative research, survivors are given a voice to speak about the emotions involved in experiencing rape, yet the researcher often remains a quite absent, silent figure. I wondered about other people's experiences of the "unspoken" process of how it feels to listen over and over again to accounts of rape in order to create research. I hope too that allowing researchers to speak through my report captures something of the emotionality of researching rape, the methodology being congruent with the topic.

Diane, at the end of her interview, commented that 'after hearing all those voices and trying to do justice to them, it's nice for me to have my voice heard about this issue'. Several others also talked about feeling validated by having their experiences recognised, as they had acknowledged and validated their interviewees'. I was pleased about this, but it was also very healing for me to listen to the researchers, who also validated my own experience of researching rape in the process of sharing theirs. Looking back, perhaps this was one reason why I felt strongly about interviewing this group rather than taking a quantitative approach that wouldn't have allowed this personal contact.

Like many participants, I hadn't expected researching rape to be as painful and debilitating as it was, assuming that my training would equip me. Having these assumptions challenged last time did mean that I came better prepared to research trauma again. This research was much easier to handle emotionally and to compartmentalise appropriately, perhaps because I was another step removed from the survivors' experiences. I did however notice how my mistrustful beliefs about men and my anger from last time were easily revived, even by hearing researchers' "second hand" stories of rape.
It helped however that I have been learning CBT since my last research, and I found that this model had a lot to offer in terms of coping. I tried formulating an alternative belief about men ("not all are abusers and many are trustworthy, good people") and set about noticing what Christine Padesky calls the "teeny-tiny", sometimes almost inconsequential things that over time build up a case for this alternative. I found this really helped, enabling me to develop a more integrated view taking account both of the reality of the awful things I had heard about men and the ordinary, daily, positive associations I also have with men in personal or professional capacities (or, indeed, strangers who turned out to be trustworthy or kind). This also helped me feel as though I was actively building a structure to protect my personal life and my client work from this otherwise "emotionally leaky" topic.

I also felt better able to attend to my self-care, such as finding rituals to mark the boundaries between doing the research and my "other" time and minimising my exposure to, for example, reports of trauma in the media. Having done these two research projects and worked with some traumatised clients, I also feel more aware now of how the trauma I hear about works inside me; it quickly gets "under my skin", but the bits that stay and haunt me are often those having some kind of personal connection or meaning which needs "unpicking" in personal therapy. For me, this usually allows these images or thoughts to be "let go of". Listening "second-hand" to some (quite graphic) stories of rape this year, and realising that they do lose some of their sting as they are passed along the chain from survivor to researcher to me, also encouraged me to use my therapist more regarding the trauma I hear about in my client work. I have in the past felt frightened of "contaminating" other people by doing this, and a developmentally helpful outcome of this research has been feeling more anchored in terms of using the support available more fully and trusting that my helpers can survive this and have their own confidantes further along the chain of support.

It did feel at times odd to interview researchers, particularly when I knew that several had considerably more experience than me. Interestingly, some seemed to move between allowing themselves to be interviewees, then "popped" back into being a researcher by commenting on my interviewing style ("Yes, yes, actually, that's good; you're very good at pushing the right buttons, aren't you? Very good at spotting the things; well done'
(Euan) or the status of the data obtained ('I think it's kind of intriguing epistemologically what's - [laughs]. Let's get it back into academic talk' [Megan]). As Megan hints, I wondered sometimes if this was almost a defence against feeling or discussing the personal or emotional aspects too deeply, and after trying unsuccessfully to explore this with a couple of participants, decided to just respect this. The boundary between researcher and therapist was also easier to manage this year, being mainly confined to feeling guilty and uncomfortable when (as a researcher) I felt delighted when participants supported my hypothesis that researching rape is emotionally difficult by talking about feeling traumatised, then (as a therapist) feeling rather mercenary responding to others' difficulty this way.

I think too, reflecting overall on my research experiences, that what draws researchers to topics and what we hope to get out of our research - and equally, what participants hope to get out of taking part - are interesting and important questions that probably run much deeper than both parties' desire to contribute towards something of applied / academic worth. Like a therapeutic encounter, there seem many layers of meaning, expectation and emotion in the relationships that make qualitative research possible; again, this seems rarely spoken about although applying a qualitative methodology once more to a traumatic topic gave me a welcome opportunity to reflect on this.
Appendix 6: History of category cards (development of theory) and Figure 1., showing the links between revised categories in the boxes. The lines represent the links between categories.
1. Original set of card names after analysis and coding of data

1. Survivors' and my participants' reasons for being interviewed
2. Relationship with own research (feeling proud of it / guilty at its inadequacy)
3. Aiming for personal / human encounter at interview rather than 'distant researcher'
4. Frustrations, limitations and dilemmas associated with researcher role
5. Anger
6. Coping responses
7. Particularly challenging aspects of research
8. Awareness of participants' vulnerability / damage
9. Therapeutic value of interviews on interviewees
10. Ripple effect of researching trauma; impacts on researcher and those around him/her e.g. friends, team members, students given transcripts to type up
11. Impact of seeing participants in their own contexts
12. Distress
13. Reasons for researching rape
14. Learning from research process
15. Immersion in research process
16. Lack of awareness except in retrospect of emotional impacts
17. Formal support or lack of
18. Sadness
19. Feeling responsible for causing harm / for helping participants
20. Resonance with a personal experience of being raped
21. Horror and shock
22. Identifying with interviewees
23. Feeling emotionally disturbed
24. Contributing to interviewees' recovery
25. Feeling haunted by material
26. Feeling isolated going to interviews alone
27. Difficulties acknowledging / accepting own emotional reactions
28. A passion for this work / work as key part of identity
29. Exercise to cope
30. Positive outcomes of research experience
31. Procrastinating because research is upsetting
32. Feeling uplifted by research and own contribution
33. Feeling anxious about doing the interviews
34. Confiding in close people
35. Making use of emotional reactions in research process
36. The perils of empathy
37. Wanting to remember / wanting to forget
38. Guilty and anxious
39. Importance of offering participants something e.g. empathy, validation
40. Physical/emotional reactions immediately after interviews
41. Practical difficulties associated with research
42. Horror at what people are capable of
43. Impacts on personal relationships with men in life
44. Importance of seeing coping / resiliency in survivors

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45. Feeling unprepared for what it feels like to interview survivors
46. Others’ reactions to your work (don’t want to engage)
47. Negotiating boundaries
48. Alcohol to numb feelings about research
49. Feeling cynical and angry
50. Feeling disturbed in situations where interviewees were raped e.g. walking home
51. Participants point to a parallel process between own experience and survivors’
52. Exposure to horrific material
53. Making a difference
54. Losing control of research situation
55. Challenges to boundaries by participants
56. Feeling protective
57. Feeling frightened of being raped oneself
58. Feeling isolated by other researchers
59. Research spills over into personal life – can’t stop thinking about it
60. Comparing participants with yourself
61. Feeling impotent/powerless/helpless to help interviewees
62. Misc. coping e.g. making music or decompression rituals
63. Feeling more frightened early on that you could be raped
64. Impacts on sex life
65. Speaking out angrily against rape myths/ offensive views

2. First cluster developed around category of COPING (obvious initial clumping)

6. Coping responses
9. Therapeutic value of interviews on interviewees
14. Learning from research process
17. Formal support or lack of
24. Contributing to interviewees’ recovery
29. Exercise to cope
30. Positive outcomes of research experience
31. Procrastinating because research is upsetting
32. Feeling uplifted by research and own contribution
34. Confiding in close people
35. Making use of emotional reactions in research process
39. Importance of offering participants something e.g. empathy, validation
44. Importance of seeing coping/resiliency in survivors
48. Alcohol to numb feelings about research
53. Making a difference
56. Feeling protective
62. Misc. coping

Card 6 too vague and diffuse; quotes split and reallocated to 34 and 17 spilt up into;
Card 62 renamed “Self-care” to better fit data
Card 29 added to Card 62 as an example of this
Card 30 split (too vague and diffuse); quotes added to 14 and 24.
Card 14 title changed to “better knowledge of issues involved in rape” to better fit data
Cards 9, 24, 39 and 53 combined and renamed “contributing something to participants’ recovery” (now Card 24).  
Card 44 added to Card 24: set renamed “coping by appreciating rewards of researching trauma”  
Card 14 split up; some quotes added to card 24, remainder dropped; irrelevant to thesis  
Card 31 abandoned as only one quote  
Card 32 reviewed; relevant quotes removed and added to 24. Card 32 now becomes “wanting to make difference with own research contribution” to better fit remaining data.  
Card 56 renamed “losing boundaries by acting on interviewees’ behalf”  
Cards 56 and 32 amalgamated under “taking action” (Card 56).  

Final core category “COPING”;
17. Formal support  
24. Appreciating rewards of researching trauma)  
34. Confiding in close people  
35. Using emotional reactions in research  
48. Using alcohol excessively  
56. Taking action  
66. “Self-care” (exercising, journaling, making music, “decompression rituals” e.g. time alone)

3. Second cluster developed around category title “emotional reactions” (obvious grouping)  

5. Anger  
12. Distress  
15. Lack of awareness of own emotional reactions except in retrospect  
18. Sadness  
19. Feeling responsible towards participants  
21. Horror and shock  
33. Anxiety about doing interviews  
38. Guilt and anxiety  
40. Physical / emotional reactions immediately after interviews  
45. Unprepared for emotional intensity of interviewing  
61. Feeling impotent /powerless/helpless to help interviewees  

12 and 18 collapsed as quotes very similar, category name expanded to slightly better accommodate data  
33 abandoned as only one quote  

27 and 16 collapsed together as very similar; renamed “Difficulties accepting /recognising emotional impacts” to better fit data (Card 27)  

Card 61 renamed “Feeling powerlessness and frustration” since “impotent” considered inappropriate word in context of topic
Final core category named “EMOTIONAL IMPACTS OF RESEARCHING RAPE” for specificity;

5. Anger
16. Sadness and distress
19. Feeling responsible towards participants
21. Horror and shock
23. Feeling disturbed
27. Difficulties acknowledging or accepting own emotional reactions
38. Feeling guilty and anxious
40. Physical/emotional reactions immediately after interviews
45. Feeling unprepared for emotional intensity of interviewing
61. Powerlessness and frustration
Card 58 (Feeling isolated) added to category as seemed better here
Card 15 (Immersion in data) added as seemed better fit here, renamed “Immersion in horror” to better fit data

4. Third category developed under category title “mechanisms by which researchers seemed to become affected by their research” (working title relating to process aspects)

4. Frustrations, limitations and dilemmas associated with researcher role
7. Particularly challenging aspects of research
8. Awareness of participants’ vulnerability / damage
11. Impact of seeing participants in their own contexts
17. Immersion in research process
20. Resonance with a personal experience of being raped
22. Identifying with interviewees
26. Feeling isolated going to interviews alone
36. The perils of empathy
46. Others’ reactions to your work (don’t want to engage)
47. Negotiating boundaries
52. Exposure to horrific material
54. Losing control of research situation
55. Challenges to boundaries
57. Fear of being raped
58. Feeling isolated by other researchers
60. Comparing self to participants

26, 46 and 58 collapsed under “feeling isolated” (becomes Card 58)
Cards 7 split (too diffuse) and relevant quotes redistributed amongst 8, 4 and 55
47 and 54 added to Card 55 as examples of it
Card 4 collapsed with Card 61
Card 8 split up; relevant quotes added to Card 55, others to Card 23
Card 55 added to 22 (remaining quotes about feeling guilty then added to 38)
57 and 60 added to 22 as an examples of it
11 added to 23 as example of it
Remaining cards grouped under working category title “mechanisms by which researchers were disturbed / impacted by their research”
15. Immersion in data
20. Resonance with own experience/s of rape
22. Identifying with participants
36. Perils of empathy
52. Exposure to horrific material
58. Feeling isolated

5. Forth cluster based around category “ripple or spillover effect of researching rape”; category based on use of such words amongst participants to describe the impacts of research seeping / leaking into their personal time / relationships, etc.

10. Ripple effect on people around researcher e.g. partners, friends, student researchers
25. Feeling haunted
37. Wanting to remember / wanting to forget
42. Horror at what people are capable of
43. Impacts on personal relationships with men
49. Feeling cynical and angry at men
50. Disturbed in situations in which participants were raped
51. Parallel process
59. Research spills over into personal life; can’t not think / talk about it
63. Feeling more frightened early on that you could be raped
64. Impacts on sexlife
65. Speaking out angrily against rape myths / offensive views

37 abandoned as insufficient data to support it; two quotes relating to cherishing bond with interviewees added to Card 24 (COPING), four relating to feeling haunted by imagery added to 25.
25 title changed to “feeling haunted by intrusive imagery” to better fit data
64 and 43 combined and card (64) renamed “displacing anger onto men” to better fit data; one remaining quote about ruminating on issues of consent in own sex life dropped - only quote about this issue. 65 added to this card.
49 renamed “becoming cynical about heterosexual relationships in general” to distinguish from 64
59 added to card 15 (EMOTIONAL)
50 and 63 combined and renamed “fears about vulnerability to rape” to better fit data
51 seemed to broad a concept to fit within to any single category; decision made to interweave quotes where possible throughout main body of analysis
10 split up and quotes reallocated to more specific subthemes (64, 49, 42)
42 renamed “awareness of human cruelty” – more specific title

Final core category named “RIPPLE EFFECTS OF RESEARCHING RAPE”;
25. Feeling “haunted” by imagery
63. Fears about vulnerability to rape
49. Becoming cynical about relationships
64. Displacing anger
42. An awareness of human cruelty

Following the development of the theory, on writing up some subthemes had to be left out, although considered important, because of word limitations (see Table 1).

6. Finally, cards grouped under working title “mechanisms by which researchers were disturbed by their research” reviewed again – category not yet satisfactory

20. Resonance with own experience/s of rape
22. Identifying with participants
36. Perils of empathy
52. Exposure to horrific material

Card 3 added to 36.
Category renamed - to better fit remaining cards - “relational / interpersonal methods by which participants inadvertently ‘infect’ researchers with traumatic material and emotions” (working title)

Final core category renamed “INTERPERSONAL PROCESSES INVOLVED IN ‘PASSING’ TRAUMA TO RESEARCHERS” (more precise);
20. Resonance with own experience/s of rape
22. Identifying with participants
36. Perils of empathy
52. Exposure to horrific material

7. Remaining cards

Card 41 abandoned as not relevant to thesis (generic research problems e.g. obtaining participants)
Card 1 added to 51 (parallels between participants and their interviewees’ needs to have their voices heard); plan to interweave in main body of text if word limits allow
2, 28 and 13 collapsed but card abandoned due to word limitations; point made (researchers’ passion and commitment to their work) seemed implied by other quotes included in analysis anyway.

8. Associations between categories identified

→ denotes one-way link in this direction
↔ denotes two-way association or even circular relationship

Empathy → fears about vulnerability to rape
Empathy ↔ emotions
Empathy → imagery
Emotional reactions (e.g. anger) → putting emotional reactions to use
Emotional reactions (helplessness, powerlessness) ↔ action
Emotional reactions (anger) → displacing emotions
Identifications $\rightarrow$ fears about vulnerability to rape
Identification $\rightarrow$ action
Resonance $\rightarrow$ emotional reactions
Cynicism $\rightarrow$ intrinsic rewards
Helplessness $\rightarrow$ intrinsic rewards
Figure 1: Showing the revised categories in boxes. The lines represent links between categories. Numbers (in brackets) refer to card...