“It’s like wading through mud. But pink, glittery, gorgeous smelling mud”: An Exploration of Domestic Abuse Advocates’ Experiences of Vicarious Trauma and Vicarious Resilience

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Thesis presented in fulfilment for the award of Doctor of Philosophy

November 2024

Funded by Economic and Social Research Council

Abstract

This study worked with Domestic Abuse Advocates (DAAs) who provide support to victim-survivors. It explored the impacts of their role through the lenses of vicarious trauma (VT) and vicarious resilience (VR); examining how DAAs cope with and manage these effects, as well as considering the individual and organisational factors which influence their experiences.

The adoption of creative methods and principles of Participatory Action Research enabled participants to lead conversations and share their subjective understandings of VT and VR. A multi-stage design was implemented. The initial interview with the option of creative activities focussed on DAAs experiences. The second interview, six months later, offered participants the opportunity to consider the initial findings and to extend their earlier accounts. 13 DAAs from Welsh Domestic Abuse Services participated. Seven used the creative sandboxing technique while the remainder chose a standard, semi-structured interview. 11 of these participants also engaged with the second stage interview. Data was analysed thematically.

Participants shared negative effects consistent with VT, including disruptions in their schema related to intimacy, safety and trust, and discussed resulting changes to their behaviours and physical and mental wellbeing. However, participants also shared positive effects consistent with VR, with some noting how these positive and negative effects are interlinked. Participants documented their coping strategies for the effects of VT, including fostering relationships with colleagues and friends and family, maintaining separation and boundaries, exercise and keeping perspective. Positive effects were also heightened through exposure to success stories, contributing to VR. Organisational and individual factors influenced participants' accounts, including organisational support and access to external clinical supervision, everyday experiences as a DAA, and their own previous experience(s) of abuse.

The thesis contributes to an understanding of VT and VR for DAAs and makes recommendations for future research and practice, which could potentially improve the wellbeing of DAAs.

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Acknowledgements

First and foremost, I would like to thank the thirteen women who participated in this research. This thesis would not have been possible without your input across both stages. Thank you for being so honest and open with me, even when the conversations got tough. The work you do is incredibly important, and I hope this thesis is a stepping stone to helping as many of you as possible, so that you can continue supporting victim-survivors as the experts that you are.

I would also like to thank the Domestic Abuse Services who consulted with me, facilitated recruitment, and allowed me to come into your offices and take up your workers precious time. I hope the recommendations from this research are useful in supporting your staff, and I look forward to working alongside you going forward.

An important thank you must go to my amazing supervisors, Dr Rachel Swann and Professor Dawn Mannay – the supervisory dream team. I never expected to have supervisors who I would feel so comfortably natural with, without the need for filtering my life and any stresses. You have both sincerely listened to and guided me throughout the past four years and helped me navigate stepping back into academia. You have made me feel accepted being a PhD-Mum to two little ones, and never made me feel guilty for putting them, or myself first (in fact, you actively encouraged it!) An additional thank you also goes to my progress reviewer, Professor Amanda Robinson. Thank you for all of your input and guidance over the years.

To my family and friends – too many of you should be named, as you are all wonderful people who encourage me and celebrate me. But obviously, I cannot leave this section without thanking my Mam and Dad, who not only are always there for me, but do school runs when needed, put the kids to bed when I am late, and even had us live with them for a while, and had me working from their living room. I love you both.

And finally, all my love, as always, to my wonderful children and my husband. You are my driving force, but you pull me back when I am pushing too hard. Nothing remedies a stressful day like your cwtches, and I hope you are all proud of me, as I always am of you. I love you, three - infinity plus one.

Dedication

This thesis is dedicated to the memory of Dr Catherine Thomas, a true warrior-woman who found, and promoted strength in love and compassion. Her guidance and support were instrumental in me applying for and progressing with this PhD. This is for you, Cath.

Abbreviations

CF – Compassion Fatigue

CFST – Compassion Fatigue Self-Test

CS – Compassion Satisfaction

CSDT - Cognitive Self Development Theory

DA - Domestic Abuse

DAA – Domestic Abuse Advocate

DAS – Domestic Abuse Service

DV – Domestic Violence

IDVA – Independent Domestic Violence Advocate

IES – Impact Event Scale

MBI – Maslach Burnout Inventory

PAR – Participatory Action Research

PTSD – Post Traumatic Stress Disorder

SA – Sexual Abuse

SARC – Sexual Assault Referral Centre

STS – Secondary Traumatic Stress

STSS – Secondary Traumatic Stress Scale

SV – Sexual Violence

TSI-BS – Traumatic Stress Institute (Belief Scale)

VAW – Violence Against Women

VPTG – Vicarious Post Traumatic Growth

VR – Vicarious Resilience

VT – Vicarious Trauma

1. Introduction

1.1. Introducing the Thesis

This thesis explores Domestic Abuse Advocates' (DAAs) experiences of Vicarious Trauma (VT) and Vicarious Resilience (VR) which are caused or heightened by supporting victim-survivors. DAAs provide valuable support to victim-survivors, whether they choose remain with their abusive partner, or if they want to leave them. They are employed by third sector Domestic Abuse Services (DAS), working in emergency accommodation (refuge) services, supporting victim-survivors in the community, or working in specialised roles, such as Independent Domestic Violence Advocates (IDVAs), who support victim-survivors who are at high-risk of harm throughout their journeys.

VT (McCann and Pearlman 1990a) occurs when an individual's psychological needs and related cognitive schema are disrupted by second-hand exposure to trauma. The seven schema which are most relevant to VT are intimacy, trust, safety, esteem, power, frame of reference and independence (McCann and Pearlman 1990a; 1990b). All of the schema may not be disrupted for those who experience VT, instead the needs which are most salient to the worker will be the ones that are affected. As well as disruptions to their cognition, workers can also "internalise the memories of their clients and may have their own memory systems altered"(McCann and Pearlman 1990a, p.142), which can be temporary or permanent, and lead to nightmares and flashbacks of events that they did not personally experience, coupled with negative affect.

While VT concentrates on the negative effects on a worker from being exposed to trauma accounts, Vicarious Resilience (VR) is a concept which focuses on positive effects. Frey et al (2017) used the term to combine Compassion Satisfaction (CS) and Vicarious Post Traumatic Growth (VPTG). CS (Stamm 2002) refers to positive feelings that are generated from seeing the growth and resilience of traumatised individuals, while VPTG (Arnold et al 2005) is typified as the personal and psychological growth which workers experience from exposure to the accounts of the individuals that they support.

Due to their connection with being exposed to second-hand trauma, VT and VR can therefore be experienced by workers who support others through their traumatic

experiences. Prior research has been undertaken to examine the existence and experiences of VT and VR in trauma work samples, including counsellors, social workers and sexual violence specialist workers, such as in Sexual Assault Referral Centres (SARCs). However, this research has been dominated by quantitative methods (Baird and Jenkins 2003; Ben-Porat 2015; Bober and Regehr 2006; Cunningham 2003; Jenkins and Baird 2002; Frey et al 2017; Pearlman and MacIan 1995; Van Deusen and Way 2006; Way et al 2004), and a limited number of qualitative studies comprising of standard interview methods (Arnold et al 2005; Beckerman and Wozniack 2018; Goldblatt and Buchbinder 2003; Hernandez et al 2007; Iliffe and Steed 2000; Steed and Downing 1998). Additionally, research into DAAs is also lacking regarding both VT and VR, with only a few studies including these dedicated domestic abuse workers (Frey et al 2017; Gilbert 2020; Slattery and Goodman 2009; Wilson and Goodman 2021; Wood 2017).

Therefore, this thesis contributes to the current knowledge base through an exploration of DAAs experiences of VT and VR. It should be noted that there are overlaps between DAAs and other Violence Against Women (VAW) workers, such as Sexual Violence (SV) workers which have been previously sampled, as they are vicariously experiencing abuses of victim-survivors. However, there are important differences which justify dedicated exploration of DAAs for their insights into VT and VR. For example, SV workers can be exposed to intimate examinations following abuse and rape, and detailed accounts of highly violent attacks on a daily basis, which could lead to VT. While DAAs are not exposed to this level of SV daily, they are nonetheless told about SV which occurs in abusive relationships. Additionally, those supported by DAAs share information about other abuses, such as coercive control, physical abuse, financial abuse and so called 'honour-based' violence occurring in domestic relationships; and they support victim-survivors with many different aspects of their lives.

To contribute to the on-going debate on VT and VR experienced by DAAs, this research aimed to explore DAA experiences of VT and VR, coping mechanisms and different factors which can influence how they experience these effects. The study drew on Participatory Action Research (PAR) principles and creative methods, which enabled participants to lead conversations and share their subjective understandings of VT and VR. PAR principles include collaboration, having a cyclical process, and creating change regarding the topic (Kindon et al 2007). To facilitate these principles, the research consisted of multiple stages,

firstly consulting with DAS managers on research design, before two stages of interviews with participants. The first stage provided DAAs with a creative method option or semi-structured interview to gather initial findings. Six months later, DAAs participated in a second interview to check their own responses, review initial findings, share any changes they had experienced, review proposals for research outputs and provide feedback on the research.

Creative methods have not been previously adopted to study VT and VR in DAAs, marking an innovative use of methods for this study. While three options for creative methods were offered to participants, sandboxing was the only creative method engaged with. Originally created as a therapeutic tool, the sandboxing technique has been adapted for use in research, allowing participants to create scenes in sand using figures which represent their response to a topic or question (Mannay 2020; Watson, Staples and Riches 2021). The meanings of these creations were then discussed in a semi-structured interview. Participants also had the option to forgo using any creative methods.

This section has outlined the background of this thesis, stating that it will provide contributions of knowledge through the exploration of VT and VR in DAAs. It adopted the innovative method of sandboxing, and PAR principles, to include participants during the process, culminating in creation of research outputs which can be applied to improve the wellbeing of DAAs.

1.2. Motivations for the Study

Prior to beginning this PhD, I worked for six years in the VAW field, conducting research and evaluation for a Welsh national domestic abuse umbrella organisation. In this role, I met many victim-survivors, DAAs, DAS managers, and other professionals. Despite working in a 'back-office' organisation, my colleagues and I were emersed in the VAW content. Over time, I became aware of changes to how I viewed the world, specifically becoming fixated on safety, as well as becoming more wary of the intentions of others. Discussions with colleagues suggested that I was not alone in this, and I was introduced to the term Vicarious Trauma. Reflecting on the changes I experienced in a back-office role, I wondered how DAAs working on the front-line were affected. There was growing awareness of VT in DAS, but on reviewing academic literature, I found minimal information for DAAs and decided to return

to academia to study the topic further. Initially, I was unaware of VR, but as I began my literature review, I determined that when studying the negative effects of being a DAA, it would be amiss to ignore the positive effects, and how these are experienced by workers.

1.3. Structure and Outline of the Thesis

This section outlines the content of the thesis and provides an overview of the following eight chapters.

Chapter Two, *Context and Concepts*, maps the context and theoretical concepts of this research. The first half of the chapter lays out the context behind the DAA role, addressing key terms used throughout the thesis before providing a brief overview of domestic abuse legislation in England and Wales and presenting evidence on the prevalence of domestic abuse. The difficulties faced by victim-survivors in leaving an abusive perpetrator are then discussed before the role of DAAs and DAS are presented. The second half of this chapter provides information on key theoretical concepts, outlining different ways in which workers are affected, including burnout, countertransference and secondary traumatic stress, before explaining VT and why this concept is the most appropriate for examining the effects on DAAs. The chapter then turns attention to the different positive responses, and why it was important to recognise VR concepts in this study.

Chapter Three, *Review of Empirical Evidence*, critically evaluates the existing empirical literature. Research concerning VT in professionals who work in various fields are considered, before an appraisal of studies on VAW workers. The chapter then turns to assessing empirical evidence on risk factors for VT, including length of time in post and the field, caseload, education and training, sex/gender and workers' own experiences of abuse. Prior research on VR in various trauma professions is then assessed, before evidence on causes of VR is examined, including its relationship with VT, "bearing witness" to the healing of others and again, the workers' own lived experience of abuse. Strategies for coping with VT are then explored, focusing on personal, professional and organisational strategies. This chapter concludes by highlighting the gap in current research before introducing the research questions addressed in this study.

Chapter Four, *Methodology*, takes the reader through the justifications and processes which were utilised throughout the research. Firstly, the case study research design which was

guided by a constructivist ontology and feminist lens is justified. Participatory Action Research (PAR) principles and the methods used are outlined, before attention turns to defining the case. My positionality is then explored, followed by an overview of the design consultation process and findings. The methods of data production are then introduced and evaluated. The pilot study conducted prior to data production is discussed, including changes which were made because of feedback, before a consideration of the ethics of the study. Participants are then introduced, and the stages of data production and data analysis are outlined.

Research question one is addressed over two chapters, with each focusing on findings relating to different concepts. Chapter Five, *Vicarious Trauma Effects*, presents participants' experiences of their role as DAAs through the lens of VT. VT effects are discussed in turn, first exploring participants' experiences regarding disruptions to their intimacy schema. Disruptions to trust, safety, frame of reference and power then follow, including changing behaviour where relevant. Participants' thoughts on their memory systems being altered are then examined, before the chapter concludes with evidence relating to VT being cumulative in nature.

Chapter Six, *Exploring the Link Between Vicarious Trauma and Vicarious Resilience*, examines the second half of research question one, presenting findings related to participants' experiences through the lens of VR. The chapter begins with consideration of VT and VR co-existing before attention turns to positive effects of VR. Firstly, the satisfaction element of VR and participants' experiences of this are explored, including their pride and sense of purpose, and the enjoyment they get from their roles. Participants' thoughts relating to the VPTG element are then examined, including empowerment and changes in how they view their lives, relationships and past events.

Research question two on how DAAs manage the negative effects and build on positive effects is the focus of Chapter Seven, *Management and Coping Strategies*. This chapter presents participants' experiences beginning with the effects of relationships on coping and management, including with their colleagues, family and friends, pets and their relationship with their work. Consideration of self-help strategies follow, which include the benefits of focusing on future plans, exercising, spending in nature, and keeping perspective of their impact and power to change victim-survivors' lives. There is an exploration of participants'

use of substances to cope with being a DAA, and the importance of different forms of relaxation. The chapter discusses how exposure to victim-survivors' success stories can help them cope with effects of the job.

Chapter Eight, *Organisational and Individual Factors*, addresses research question three: are there any individual and organisational factors which affect how DAAs experience and manage effects from their work? The chapter begins with discussion of experiences concerning organisational factors, including whether the DAS and management are perceived as supportive, training on VT, and supervision sessions, both with line managers and with external, clinical supervisors. Attention then focuses on individual factors, exploring the effects of DAAs length of time in the role, the specific role within the DAA classification, and experiences they have had in their role as DAA. The chapter also examines how DAAs own history can affect their experiences of VT, VR and their coping strategies, considering the effects of their own experiences of VAW as well as previous employment and health diagnoses.

Chapter Nine, *Conclusion*, outlines the key contributions of this study, and to what extent all three research questions were addressed, followed by reflections on the research processes. The importance of the research design is also considered, before stating some limitations of the study. Finally, recommendations for researchers conducting research in sensitive areas and recommendations for future research and practice are provided.

2. Context and Concepts

2.1. Introduction

This chapter will discuss key terms, definitional issues, context and relevant theories for examining the effects of being a Domestic Abuse Advocate (DAA) on the individual. It begins by examining definitions of Domestic Abuse (DA), before documenting the prevalence of abuse in England and Wales, and how Wales and the United Kingdom (UK) are responding to this issue. It then describes the support provided to victim-survivors of abuse by Domestic Abuse Services (DAS) and DAAs. The chapter discusses theories which are relevant to understanding the focus of this thesis, namely, the negative effects of work including burnout, countertransference, secondary traumatic stress/compassion fatigue and vicarious trauma, as well as positive effects of trauma work, including vicarious post traumatic growth, compassion satisfaction and vicarious resilience.

2.2. Context

2.2.1. Domestic Abuse Definitions and Key Terms

Discussions on the prevalence of abuses and the support provided to victim-survivors cannot be engaged with until the abuses have been defined. Terminology relating to the Violence Against Women (VAW) field can vary. Relevant terms have been included in the abbreviations section at the beginning of the thesis and each term and acronym will be used where applicable.

Historically, Domestic Abuse (DA) has been defined as physical violence, mainly from husband to wife (Erez 2002). However, these violence-based definitions missed inclusion of key behaviours of abuse and control within different familial and intimate relationships (Stark 2013). Coercive control was conceptualised in recognition that violence is used as a method of control along with other, non-violent tactics to ensure the victim-survivor is in a metaphorical “cage” of fear and control and is unable to leave the relationship (Stark 2007, p.198). These non-violent abuses can include financial abuse and control of resources, gaslighting, and isolation from social and familial networks. Victim-survivors have also reported that while physical harm can result in visible and permanent damage, the impact of emotional abuse is “harder to endure”’ as it can be more difficult to explain to others as it does not leave a physical mark (Abrahams 2007, p.28).

Recognising the multifaceted aspects of DA, the current UK Government Definition (2013) goes beyond physical violence to cover different abuse tactics, and includes alternative relationships to intimate, heterosexual relationships, as well as repetition of abuses:

> Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: psychological, physical, sexual, financial and/or emotional.
>
> Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour. Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim. (UK Government 2013, p.2)

Alongside physical and emotional abuse this definition includes sexual violence (SV) within families, or with current or previous partners. It also covers so-called 'honour' based violence, where families abuse members to protect perceived[1] cultural and religious beliefs, or to punish those who have brought shame on the family. This thesis follows the UK definition of DA.

Following definitions, and varieties of abuses, the terminology used throughout this thesis will be set out. Terminology in DA can vary based on location, local policies, organisational views, and preferences. When describing someone who has experienced DA first hand, some organisations and individuals use the term 'lived experience of abuse', others use the term 'victim', some use 'survivor' and others combine them to 'victim-survivor'. While one term may be occasionally more appropriate, for example, using the term 'victim' when the person has been murdered, instead of the unapplicable 'survivor', terms can often be interchangeable based on preference. Some people may prefer being called 'victim' as it

[1] The word perceived is important as it is the abuser's perception of their faith or culture rather than the faith or culture itself that motivates the abuse. This is why 'so called' is also included in the title of the abuse.

acknowledges the harm they have been caused, whereas others (and organisations aiming for empowerment) can prefer 'survivor', as it avoids connotations of helplessness. To acknowledge the validity of both these viewpoints, this thesis will use the term 'victim-survivor' for those with lived experience of abuse.

The term Domestic Abuse Advocate (DAA) will be used to refer to front line workers in Domestic Abuse Services (DAS) who advocate for the rights and safety of the victim-survivor. The term recognises that unlike counsellors, or mental health practitioners, emotional support is only one aspect of DAA work, which will be explored in section 2.2.5. This term has been used in previous research (Frey et al 2017).

2.2.2. Domestic Abuse Legislation in England and Wales

Since the late 1800s, where spousal abuse was accepted, UK law has been amended to prohibit specific acts within DA and improve protection for victim-survivors. Some examples include the Domestic Violence and Matrimonial Proceedings Act (1976) which allowed victim-survivors to obtain court orders against abusive husbands, making rape within marriage illegal in 1991 (Law Commission 1991), the addition of common assault as an offense in the Domestic Violence, Crime and Victims Act (2004) and the implementation of coercive control as an offense within the Serious Crime Act (2015).

In 2015, the Welsh Government was the first of the UK home nations to pass legislation related to VAW which relates to the support of victim-survivors and how VAW is approached. The Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act (VAWDASV) 2015 was created to combat these abuses and strengthen services for victim-survivors. VAWDASV encompasses gender-based abuses within the VAW term, as well as naming DA and SV in an attempt to acknowledge other victim-survivors of these abuses. Objective Five of the VAWDASV Act 2015 is that "relevant professionals are trained to provide effective, timely and appropriate responses to victims and survivors" (Welsh Government 2022). This objective applies to the staff who provide support on domestic abuse, as well as other professions. While it does not reference vicarious trauma (VT) or staff wellbeing, it cites workers needing to give "appropriate responses" to victim-survivors, which may be hindered by VT (Welsh Government 2022).

In England, the Domestic Abuse Act (2021) was passed to raise awareness and improve systems of support; however, this Act does not refer to workers who assist victim-survivors,

beyond improving responses from statutory agencies. Therefore, this project focuses on staff in Wales in response to legislative interest in the services they provide, while acknowledging that any findings may be applicable to those in England and beyond due to similarity of service provision.

2.2.3. Prevalence of Domestic Abuse

To understand the scale of the issue, and thus the extent of the work encountered by DAAs, it is important to examine the prevalence of DA. The Crime Survey for England and Wales (CSEW) estimated that between April 2022 and March 2023, 2.1 million adults in England and Wales experienced DA (Office for National Statistics 2023a). The CSEW contains a self-completion module, in which respondents can anonymously enter their answers regarding abuse directly into a computer, so that they do not have to disclose abuse directly to the researcher. The 2023 data from the self-completion module found that an estimated 1.4 million women in England and Wales experienced DA that year, compared with 751,000 men (Office for National Statistics 2023a). Since the age of 16, 27% of women reported experiencing DA compared to 13.9% of men (Office for National Statistics 2023a).

Due to DA predominantly affecting women rather than men, DA can be positioned as a gendered issue (Office for National Statistics 2023a). However, whilst the self-completion module of the CSEW attempts to combat the disclosure struggles for male victim-survivors of abuse (see section 2.2.4), as well as attempting to combat the disclosure barriers for all victim-survivors, male victim-survivors underreport their experiences of domestic abuse, meaning the true figure of victimisation is unknown (Machado et al 2016). This contributes to the dark figure of crime- the number of crimes which are never disclosed or reported (Biderman and Reiss 1967).

While some data can be misleading due to non-disclosure rates and the dark figure of crime, murder statistics show the extent of the most drastic outcome of DA. While generally men are the most frequent victims of homicide overall, data compiled by the Office for National Statistics (ONS) on relationships from homicides shows that more women than men are fatal victims of a partner or ex-partner, with 80 women killed over the year compared to 16 men (Office for National Statistics 2019). DA accounts for 38% of all homicides of women, but only 4% of homicides of men.

As will be discussed in the next section, there is scarce data on Lesbian, Gay, Bisexual and Transgender (LGBT) experiences of DA due to low levels of research; however, existing studies acknowledge that rates of prevalence can be higher than in cis-gendered, heterosexual relationships. Research conducted by Stonewall (2012) found that lesbian or bisexual women in the UK experience a similar frequency of abuse to heterosexual women, with 1 in 4 being subject to abuse. However, this report found that gay or bisexual men are more likely to experience DA than straight men, with almost half experiencing abuse in their lives from family or partners. The Scottish Transgender Alliance commissioned research into transgender experiences of DA (Roch et al 2010) and found that 80% of respondents had experienced abusive behaviour from a current or ex-partner, which is higher than in cis-gender relationships, regardless of whether they are heterosexual, homosexual or bisexual.

Figure 1 depicts the percentage of victim-survivors from the general population who were aged 16-59, gathered from CSEW results between 2005 and 2023 (Office for National Statistics 2023b). While this data suggests that DA has reduced since 2005, from 8.9%, the rate still stands at 5.1% of the population (aged 16-59) experiencing DA each year. For abuse perpetrated by partners, the rate is 3.4% of the population. The DA percentage may seem low; however, it only accounts for those who experienced DA in the previous 12 months, not in their lifetime, alongside the caution which must be taken using statistics due to reporting rates. Additionally, these rates still equate to over 2 million people experiencing DA each year. While not all victim-survivors will seek support from DAS, and may not leave the abuser, this could represent a large number of service users being supported by DAAs.

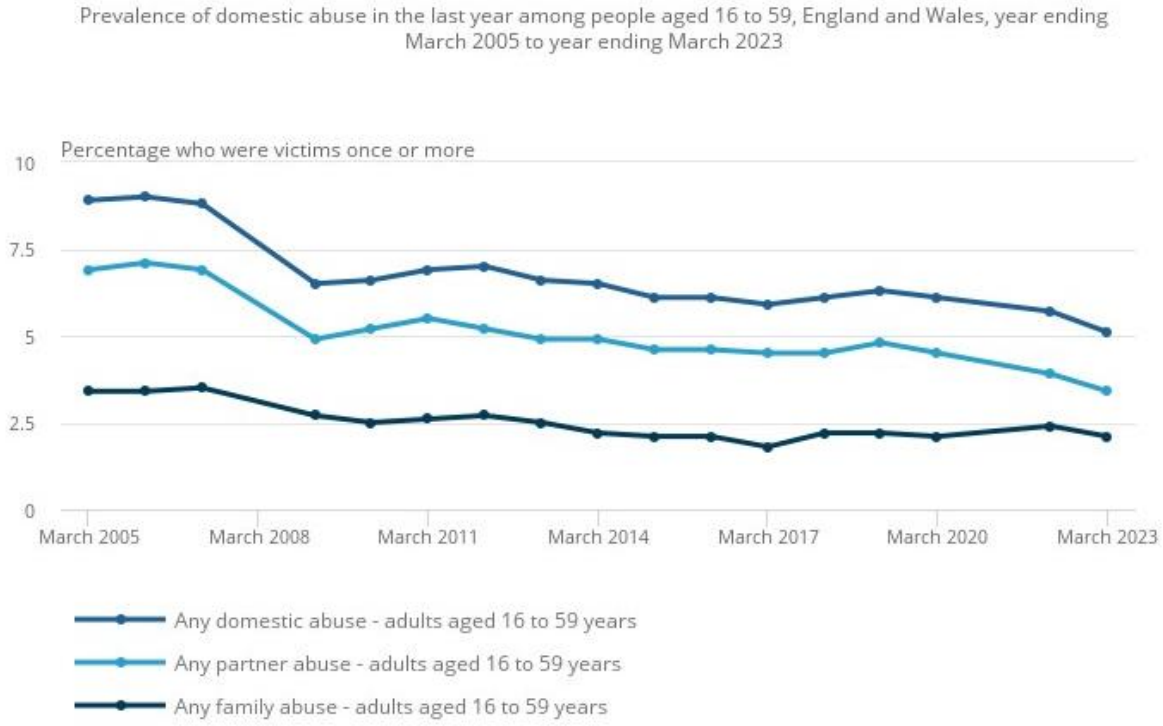

Figure 1 - CSEW Prevalence of DA Since 2005 (Office for National Statistics 2023b)

2.2.4. Leaving an Abusive Partner

Once a victim-survivor has identified that they are in a relationship with an abusive partner, there are still obstacles to leaving. Leaving any relationship poses emotional as well as practical challenges, including financial issues, property or housing and distribution of childcare (Clarke-Stewart and Brentano 2002). For victim-survivors, these issues are often heightened because of reduced resources related to the perpetrator, for example, having no access to money, or personal documents (Postmus et al 2012). Additionally, while navigating these practical issues, victim-survivors can be isolated and in fear of the perpetrator, as well as worries about not being believed, and negotiating the stigma surrounding DA (Abrahams 2007). Each victim-survivor's experience of abuse will vary and can be exacerbated by their intersectionalities and possible multiple disadvantages. Sex, gender, sexuality, disability, culture and religion can all influence how abuse is experienced and whether victim-survivors are able to disclose abuse and leave the perpetrator.

For example, if a male is being abused by an intimate partner, they risk being perceived as "emasculated" as they cannot protect themselves (Huntley et al 2019), which can be a

barrier to male victim-survivors disclosing abuse. Huntley et al (2019) also found that males are less likely to disclose DA due to being unaware of support available to them, and the reactions they receive from support services once they are accessed.

LGBT survivors also need to navigate societal homophobia and transphobia in addition to the standard difficulties leaving the relationship (Calton et al 2016; Woulfe and Goodman 2021). These societal opinions can manifest in systemic inequalities for LGBT victim-survivors (Calton et al 2016), which is exacerbated by low levels of research into LGBT experiences and theories of DA which would highlight needed support, compared to cis-gendered, heterosexual abuse.

Disabled victim-survivors may depend on partners more than non-disabled victim-survivors for assistance and day-to-day living, meaning not only may they not want to lose their carer, but that they have less opportunities to disclose without them present (Radford et al 2006; Plummer and Findley 2012). Because of this "help" observers can be reluctant to believe disclosures of abuse as the perpetrators are understood to be carers (Thiara et al 2011, p.764). Another issue for disabled victim-survivors in disclosing abuse, asking for help and leaving the abuser, is that there is often a lack of appropriate resources for them (Plummer and Findley 2012), including accessible accommodation (Radford et al 2006).

Culture and religion can also add additional barriers to leaving for victim-survivors. For example, victim-survivors who are in strict religious communities may be encouraged to remain with the perpetrator due to the duty they have to their spouse, while cultural practices and values may also pressure victim-survivors to stay due to honour and loyalty (Saunders 2021).

Considering each of these difficulties in leaving an abusive partner, whether general, or exacerbated by intersectionalities, victim-survivors often benefit from support and guidance from professionals, whose roles will be explored in the next section.

2.2.5. Services Provided to Victim-Survivors by Domestic Abuse Services

During their journeys in processing and leaving abusive relationships, victim-survivors can access and be in contact with an array of services, including statutory services such as the police, social services, health, and education. However, non-statutory, third sector organisations provide sector specific support for victim-survivors, which often span from

when they first identify the abuse, through leaving the relationship (or creating safety plans if they decide to stay with the perpetrator) and providing support in rebuilding their lives. Many of these services work under the title of Women's Aid, or Domestic Abuse Services; throughout this thesis they will be referred to as Domestic Abuse Services (DAS).

While the workers at these organisations provide emotional support to victim-survivors, as therapists or counsellors would, they also provide a range of practical services (Hester and Westmarland 2005; Welsh Women's Aid 2021b). These services can be provided in the community or emergency accommodation by specialist workers, termed Domestic Abuse Advocates (DAA) throughout this thesis. This term has previously been used to encapsulate the advocation DAAs do on behalf of victim-survivors, described as having a:

> Focus on crisis intervention and working for the rights of victim-survivors, including providing advice, support, and assistance in obtaining safety and legal protections, medical assessment and care, housing and other needed services. (Frey et al 2017, p.45)

However, it is important to note that DAAs typically have less training than counsellors or clinicians, as the training they receive for the role is short-term, specialised training (Frey et al 2017, p.45). In DAS, DAAs are not commonly referred to by this collective term, and instead are referred to in relation to the service they work in, for example, community support worker, or refuge worker.

In 2020/21, Welsh Women's Aid (WWA) member services supported 17,344 victim-survivors in the community in Wales, making it the service which is accessed by the majority of supported victim-survivors (Welsh Women's Aid 2021b, p.7). Each DAS has an office where victim-survivors[2] can access support on a one-to-one basis. Many services hold "drop in" sessions and appointment services for those in need. These appointments are accessible to all, regardless of whether they wish to leave the perpetrator or whether they need referral to refuge services.

If victim-survivors are leaving an abusive partner and have nowhere safe to live, they can access emergency accommodation services through DAS. This accommodation can be in a shared house (also known as a refuge), or in a dispersed location such as an apartment,

[2] As with emergency accommodation, some services are women only due to the gender-based aspect of VAW.

which can be more suitable for some victim-survivors for whom shared living is not appropriate. These places are safe houses with undisclosed locations, where DAAs provide often intensive support regarding practical matters, such as housing and finances while also working to empower victim-survivors to become independent (Abrahams 2007). 1,226 victim-survivors accessed refuge-based support provided by WWA member services in 2020/21 (Welsh Women's Aid 2021b, p.7). While some refuge services are women only, some DAS have mixed shared houses, or dispersed locations available to male victim-survivors. Victim-survivors have reported that being housed in emergency accommodation gives them a feeling of safety, while shared houses can encourage friendships following periods of isolation (Abrahams 2007).

DAAs also run programmes for victim-survivors to attend which help them address a range of issues. These groups can be held in refuges if there is a need, or in the community. The most popular of these programmes in the UK is the Freedom Programme which helps victim-survivors to identify and name abusive behaviour. An evaluation of the Freedom Programme conducted by Bristol University (Williamson and Abrahams 2010) found that victim-survivors who completed the Freedom Programme were more confident, happier, had improved self-esteem and relationships with their children. In an earlier study, Hester and Westmarland (2005) found that attending groupwork sessions (including the Freedom Programme) empowered victim-survivors and helped them move on from abusive relationships.

Some DAS also have dedicated services to support children and young people (CYP) in the community and in emergency accommodation, depending on funding grants. However, even if there is no dedicated service or specially trained CYP worker, DAAs inevitably support CYP to some extent as they support parents, especially in the case of refuges, where children are housed regardless of there being a CYP worker. Buckley et al (2006, p. 305) found that children exposed to DA find it helpful to share their feelings and experiences to "let it out" and that activities run by workers in refuge help to distract them from the situation.

It should also be noted that DAS can also provide dedicated SV services for those who have been assaulted or exploited outside of an abusive relationship, and some DAS run programmes aimed at perpetrators of abuse. However, dedicated workers in these services

are not the focus of this thesis (see section 4.9.1). Nevertheless, where DAAs support SV victims alongside other abuses, they will be included in this research.

In Wales (and the UK more widely) there are also helpline services providing support regarding VAW. These helplines are free to call and confidential. They provide emotional support and referrals to services if needed and wanted by the victim-survivor. They are available to concerned others, and some provide services to perpetrators. Opening times vary for helplines, however the national helpline in Wales is accessible 24/7. In 2020/21, there were 30,063 contacts to the Welsh Live Fear Free Helpline (Welsh Women's Aid 2021b, pp.44-48) with 89% of victim-survivors reporting an improvement in their emotional wellbeing as a result from their contact with the service. Helpline workers will not be included in this research, as their experiences have been explored in previous research (Taylor et al 2018), which will be discussed in Chapter Three.

2.2.6. Domestic Abuse Service Staffing

The prevalence rates and attendance figures presented have demonstrated that there are many victim-survivors needing different forms of support. In Wales, there are 26 services which provide VAW services. 2020 data from the Routes to Support database (managed by the four UK Women's Aid Sister Federations) show that on average, each DAS in Wales has 22 staff members, with a range of between three and 47 (Welsh Women's Aid 2021a).

While prospective applicants to counselling services or therapists need a high degree of training or education to enter the profession, this is not the case to enter employment as DAAs (Frey et al 2017). While recognising that the DAA role is not that of a therapist, emotional support is part of the job description. Education requirements for DAAs are often below degree level, and whilst experience working with people is needed, it can be from voluntary work, or work in other caring fields. Aspects for selection can include practical elements of support, including knowledge of benefits structures or housing associations, to having a clean driving license and access to a vehicle. Successful applicants are provided with on-the-job training and shadowing of other employees, and they can also access external training from wider organisations to broaden their skillset and knowledge to assist survivors.

By providing emotional and practical support to victim-survivors, DAAs are exposed to detailed and graphic stories of abuse (Beckerman and Wozniack 2018; Cunningham 2003;

Iliffe and Steed 2002). Organisational support for the workers varies, depending on finances, staff levels and leadership (Ashley-Binge and Cousins 2020; Slattery and Goodman 2009). While some organisations have sufficient funds to hire external clinical supervisors, and enough staff for DAAs to have the availability to attend sessions, or split caseloads, this is not always the case in third-sector organisations, where funding can be strained. The effects of the job on DAAs can lead to high sickness rates and high turnover in these organisations (Bell et al 2003). DAAs typically spend two to three years in a position before leaving (Merchant and Whiting 2015) which poses losses for DAS through repeated recruitment.

This study examined the effects that providing these essential services to victim-survivors has on DAAs, how these effects can be managed, and the role of individual and organisational factors. Accordingly, the chapter now outlines theories and models that relate to the effects of working with victim-survivors on DAAs.

2.3. Theories and Concepts

This section examines key theories regarding the negative and positive impacts on those who work with traumatised individuals. To begin, however, a summary of general wellbeing and resilience is offered as a background and base emotional level from which these positive or negative effects would deviate.

2.3.1. Wellbeing and Resilience

There is not a universal definition of wellbeing. This makes measuring wellbeing, and exploring issues related to wellbeing, difficult. Definitions of wellbeing are often only a description of effects of wellbeing, such as being happy, or having a positive mental health, for example, Bradburn (1969) researched psychological wellbeing, which he also referred to as happiness. However, many modern definitions and writers agree that there are multiple dimensions to wellbeing (Jardan and Roache 2023). These dimensions refer to different areas of life which, when maintained, can lead to people maximising their potential and having a good quality of life.

In 1976, Hettler proposed a model of six dimensions which contribute to wellness, or wellbeing, which are: social, occupational, spiritual, physical, intellectual and emotional wellness (Lauzon 2001). For example, if someone feels they are expanding their knowledge they may be achieving the intellectual dimension of wellness.

In 2009, Swarbrick proposed eight dimensions of wellness (Swarbrick 2010). As well as the six dimensions outlined by Hettler, Swarbrick also included environmental and financial dimensions, explaining that the quality of where people live, and their financial situation, can also contribute to their overall wellbeing (Swarbrick 2010; Swarbrick 2023). While these dimensions cover many areas of modern life in Westernised societies, an issue with using dimensions to define wellness and wellbeing is that these dimensions can vary by culture (Jardan and Roache 2023).

More recently, Seligman (2011) explained the elements of wellbeing to create the PERMA model, where wellbeing includes the following – Positive Emotion, Engagement, Relationships, Meaning and Accomplishment (PERMA). For example, if a person feels that they are contributing to society, they could be experiencing meaning in the PERMA model, and therefore have an element of wellbeing. However, while this theory has multi-elements, it does not include the variety of dimensions that are listed in Swarbrick's model (Swarbrick 2010; Swarbrick 2023), which can greatly affect wellbeing.

Following a review of definitions for wellbeing, Dodge et al (2012) proposed an alternative definition, that unlike the others discussed in this section, does not focus on specified dimensions or elements. They proposed that instead, wellbeing can be defined as a state of equilibrium, or having a balance between challenges and resources. They imagined this state of equilibrium as a seesaw. They state that when a person has adequate resources to meet a challenge, and enough challenge to enrich themselves, they have "stable wellbeing" (Dodge et al 2012, p.230). Therefore, if a person was experiencing a plethora of challenges, but had no resources with which to address them, they would not have good wellbeing as they cannot cope with the problems with which they are faced. However, if a person had plenty of resources, but were not being challenged in any area of life, then they would also not have stable wellbeing, as they are not achieving anything or enriching themselves. This definition is more flexible than others which provide descriptions of dimensions, as it allows for individual and cultural differences in relation to the challenges and resources (Dodge et al 2012, p.231).

Due to the positivity of experiencing good wellbeing, continuing in this state is desirable for all. However, there are many things which can negatively impact a person's sense of wellbeing, such as life events, lifestyle and stress, or in the case of DAAs, being exposed to

second hand accounts of trauma. However, if people are resilient, they can cope with these negative experiences. Resilience is a dynamic concept, with most definitions including the overcoming of stress and adversity, to recover to a state of wellbeing. Therefore, these definitions couple risk and adversity with “positive outcomes”(Vella and Pai 2019, p.234). Additionally, some definitions view resilience as a process, rather than a state or trait (Vella and Pai 2019). Hornor (2017) explained some varying definitions of resilience. In keeping with other definitions, one definition stated that resilience is the capacity to recover from challenges. But additionally, for Horner, resilience is also a protective factor from stresses. Therefore, Hornor’s (2017) position suggests that workers who are resilient can effectively recover from stresses, from which they are already protected more efficiently, allowing them to resume the balance of wellbeing. This chapter will now explore different potential challenges to DAAs wellbeing and resilience.

2.3.2. Burnout

Burnout is a psychological syndrome which stems from prolonged exposure to occupational stress (Maslach et al 1997). The Maslachian multidimensional theory of burnout is predominant in the field (Maslach et al 2001), and comprises of three main components; emotional exhaustion, depersonalisation and having reduced personal accomplishments (Maslach and Jackson 1981). Emotional exhaustion is the central aspect of burnout, where people are emotionally drained by their work (Bakker and Costa 2014, p.113). Accordingly, when their “emotional resources are depleted, workers feel they are no longer able to give of themselves at a psychological level” (Maslach and Jackson 1981, p.99).

Maslach et al (2001, p.403) state that while the second and third aspects are not the predominant characteristics of burnout, they are needed for a full picture of the phenomena. Depersonalisation (or cynicism in Maslach and Leiter 2017) is when workers are unable to empathise with colleagues, customers or clients, and become emotionally hardened or callous to people (Maslach et al 1997; Maslach and Leiter 2017). Reduced personal accomplishments, or dissatisfaction with accomplishments (also called inefficiency in Maslach and Leiter 2017) is where a worker loses satisfaction and belief in their employment which can reduce productivity, capability and result in low morale (Maslach et al 1997; Maslach and Leiter 2017).

Maslach devised the Maslach Burnout Inventory (MBI) to measure burnout in working populations (Maslach and Jackson 1981). To address each of the components, 22 statements are measured quantitatively with a seven-point likert scale, with results determined using a directional key (scoring positive statements in reverse) and then the total score is coded as low, medium or high levels of burnout. The MBI is a widespread measure for assessing the existence and prevalence of burnout and has been used to measure burnout in work populations since its creation.

However, while burnout is an established syndrome in the workplace (Shaufeli et al 2009), it can be experienced in any employment setting by people who have little or no contact with those in crisis. Workers who provide emotional support, such as counselling, assist people in crisis with any trauma, which as discussed in section 2.3.3, can affect them in different ways. A key aim of this study is to explore the experiences of those who support victim-survivors of DA, and the concept of burnout does not adequately support this aim.

2.3.3. Countertransference

Emotional support, provided through therapy, counselling or sessions with specialist workers (for example DAAs or substance misuse workers) can have beneficial effects on people who need assistance, or who are struggling with personal or mental health issues (Blackburn et al 1981; Restick et al 2003). These sessions can explore all periods in the client's life, and their associated emotions in relation to abuse, crime, or trauma, which can be potentially disturbing. While the effects of attending therapeutic sessions on the client are well known (for example, see Green and Latchford 2012; Herr 1978), the effects of facilitating sessions on the worker are less openly acknowledged.

Originally conceptualised by Sigmund Freud, countertransference is one such effect on workers facilitating emotional support sessions. Freud is known as the father of psychoanalysis, and his work emphasised the importance of unconscious thoughts, dreams, and the psyche (Lear 2005). During psychoanalytical, and other forms of therapy, clients can transfer their feelings and experiences onto their therapist (Walkerdine et al 2001). Countertransference is the therapist's emotional reactions towards the client, their emotions and story, or their transference (Gemignani 2011; Walkerdine et al 2001). These reactions could be based on cultural norms or be led by personal experiences (Dalenburg 2000). Countertransference has been deemed the "enemy of neutrality" (Dalenburg 2000,

p.4) when being objective is the aim of the therapist. Countertransference has also been recognised in conducting research, specifically qualitative methodology where subjectivity is centralised (Gemignani 2011). While not a common term to those outside therapy or research fields, countertransference is widely acknowledged within them, featuring in teaching resources and academic journals (Hayes et al 2011) where techniques to identify reactions and avoid "problematic" countertransference are explained.

Since the initial work of Freud, the concept of countertransference has been debated, and different versions have been proposed by various authors. For example, totalistic countertransference emerged in the 1950s and encompasses all reactions that the therapist has towards the client (Hayes et al 2018), whilst particularist countertransference focusses only on reactions that are a hinderance to the session, or which would not be echoed by other professionals (Dalenburg 2000).

Irrespective of whether countertransference describes all reactions, or only those considered to be troublesome, these effects can impact any emotional support worker, therapist, or counsellor, faced with any client, regardless of whether they have experienced trauma and need to describe or discuss disturbing events. Those who conduct work with trauma survivors, or those in crisis, such as DAAs, have additional pressures in terms of providing support to victim-survivors who have disclosed accounts of trauma to them. Trauma workers are also exposed to the details of dangerous people and events, and they are made aware of their own risk of trauma, which can affect them more than non-trauma therapists (Pearlman and Saakvitne 1995). Therefore, countertransference, although useful to consider as it acknowledges helpers' thoughts and feelings, is not a dominant theory in exploring the enduring effects of supporting victim-survivors on DAAs. Consequently, the next section explores concepts related to the long-term effects of trauma work, beginning with Secondary Traumatic Stress.

2.3.4. Secondary Traumatic Stress/Compassion Fatigue

For those who have experienced trauma first-hand, the appearance and diagnosis of Post-Traumatic Stress Disorder (PTSD) can occur. PTSD can be caused by experiencing any traumatic event, including car accidents, natural disasters or being a witness or victim of crime. The criteria for diagnoses under the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSMV) include: exposure to actual or threatened death, injury

or sexual violence (criterion A); presenting with intrusion symptoms such as flashbacks (criterion B); avoidance of stimuli which remind you of the event (criterion C); negative change in mood and cognitions (criterion D); problems with arousal such as hypervigilance (criterion E); occurring more than a month after the event (criterion F); effects disturbing functioning (criterion G); and the disturbance is not due to substances (criterion F) (American Psychiatric Association 2013).

To assist their recovery, clients discuss these events with trauma therapists, which exposes workers to the details and emotions which occurred during and following the event. Therefore, while assisting clients with their suffering, therapists themselves can be "absorbing that suffering itself as well" (Figley 1995, p.18). Figley identified that trauma workers can present with the criteria for PTSD described above, without ever being directly exposed to the trauma themselves. For example, a therapist may develop PTSD surrounding rape despite never experiencing SV, only hearing about it from clients. At the time of Figley's writing, criterion A of the DSM-IV included close associates as being able to develop PTSD, such as family members, but not workers (American Psychiatric Association 2000). From this, Figley proposed the concept of Secondary Traumatic Stress (STS), the:

> "Natural consequent behaviours and emotions resulting from knowing about a traumatising event" which presents in "symptoms nearly identical to PTSD". (Figley 1995, p.21)

Therefore, those who work with traumatised clients, such as DAAs, can develop each of the criterion listed above, suffering from intrusion symptoms (such as nightmares about assaults), avoidance of stimuli (such as avoiding watching certain television programmes), change in mood or cognition (such as persistent anger, or not feeling safe), effects on arousal (for example, not being able to sleep), and these effects may be long lasting, disrupt their lives and not be related to substance use. As with PTSD, Figley proposed that STS can occur from exposure to one event, and emerges suddenly, without having a cumulative or gradual onset (Figley 1995, p.25).

It should be noted that since the publication of the DSM-V, however, under criterion A4, workers who have "repeated or extreme" exposure to trauma can now be diagnosed with PTSD (American Psychiatric Association 2013). However, for this diagnosis, workers would need to be assessed by an appropriate professional who deemed their exposure and

reactions adequate, which workers may not pursue unless the disruption on their lives is significant and above clinical diagnosis levels.

Although Figley first named the concept STS, he then replaced the title of the condition with Compassion Fatigue (CF). In his 1995 book, Figley explains that the term Compassion Fatigue was proposed for those who may find the term Secondary Traumatic Stress to be derogatory or who would find identifying with the term uncomfortable, while they identify with effects from "compassion in the line of duty" (1995, p.26). He stated that these two terms could be used interchangeably to refer to the same concept, leading to studies using either or both terms.

STS/CF propose that the reasons why some workers are affected more than others surround empathy of the worker and exposure to the trauma of others; principally that those who are more exposed to trauma are more likely to develop STS/CF, and those who are more empathetic are more likely to develop the syndrome (Figley 1995). Like countertransference, Figley also suggested that those who have prior personal history of trauma will be more likely to experience STS/CF. Studies exploring these factors and their relation to STS/CF will be explored in the Chapter Three.

In order to measure STS/CF, Figley devised a quantitative tool, named the Compassion Fatigue Self-Test (CFST). The test consists of a 40-statement questionnaire which is measured on a five-point scale and includes statements such as "I am losing sleep over a client's traumatic experience" (Figley 1995). More recently, Figley and others devised an updated tool, the Secondary Traumatic Stress Scale (STSS), with which to measure STS (Bride et al 2004). While STS/CF focusses on the mirrored effects of PTSD on the trauma worker, a different theory regarding the effects of indirect trauma on a worker focuses on cognitive schemas and their disruption. This concept is Vicarious Trauma.

2.3.5. Vicarious Trauma

Vicarious Trauma (VT) was introduced as an effect of working with traumatised individuals by McCann and Pearlman (1990a). The concept was built from their proposal of Constructivist Self Development Theory (CSDT), which provides an explanation of how trauma is experienced by victim-survivors (McCann and Pearlman 1990b). Before explaining VT, an explanation of CSDT will first be provided.

CSDT is an interactive theory between the person and their environment. Accordingly, CSDT is based in the constructivist premise, where people actively create and construe their personal realities, which become a framework for understanding their world (McCann and Pearlman 1990b; Mahoney and Lyddon 1988). CSDT is a synthesis of other theories, including developmental, social learning and cognitive theories, which is used to explain experiences of trauma, where trauma is defined as an event being unexpected and exceeding the individuals perceived ability to meet its demands. CSDT has a direct effect on:

> Disrupting the individuals frame of reference and other central psychological needs and schemas. (McCann and Pearlman 1990b, p.10)

In CSDT, the self is comprised of four elements which interact and impact each other; basic capacities, which regulate the individual's self-esteem; ego resources, which regulate interactions with others; psychological needs, which are the motivations of the individual; and cognitive schemas, which organise the individuals experience of the self and the world (McCann and Pearlman 1990b).

Through their definition of trauma, two central aspects of the self are challenged by traumatic events, psychological needs and cognitive schemas, which they propose can influence the individual's personal reality and how they find meaning in the world. While people can have many needs, the psychological needs which are the focus of CSDT and trauma experiences are: Frame of Reference (a framework for understanding their experience); Safety; Trust/Dependency; Esteem (feeling valued by others and to value others); Independence; Power; and Intimacy (connections with others including community). Cognitive schema, or assumptions and beliefs about the world and oneself, are linked to these needs, for example, believing that you have control over your life, and that other people can be trusted to treat you with respect.

CSDT states that if a person experiences a traumatic event, such as rape, this can challenge their psychological needs which would disrupt their cognitive schemas for how to view the world and themselves (for example, the world is not safe, I cannot trust anyone, I have no control over my life). The needs which would be disrupted would be those which are most salient to the individual (McCann and Pearlman 1990b). For example, if the victim-survivor values control highly, but not independence, then control would be most affected. These disrupted aspects would then influence their self-capacities (identity and self-esteem) and

their ego resources (how they interact with others) to damage all aspects of the individual's self following trauma.

CSDT also explains that memory can play a vital role in experiences of trauma, through both verbal (factual retelling of the event) and image (sense-based, emotive aspects of the event) memory (McCann and Pearlman 1990b, p.28). While whole memories can be worked through in therapy sessions, fragmented memories can hide the true extent of trauma and prevent it from being addressed. This can occur through holding the verbal memory, without the emotive image aspect, or through recalling images (including other sensory information), such as flashbacks, hallucinations, or nightmares, without being able to explain what happened. In the book which proposed CSDT, McCann and Pearlman followed these premises for CSDT to explain how to provide effective trauma therapy to clients (1990b).

The original proposal of CSDT related to those who had experienced trauma first-hand, and CSDT was used as a base from which to propose effective therapeutic methods. However, McCann and Pearlman (1990a) then used this foundation to build a theory regarding indirect traumatisation, or VT. The authors proposed that the psychological needs which are most important to the trauma worker (from the relevant trauma needs listed) and the cognitive schemas related to them can be disrupted and altered from listening to accounts of traumatic events and supporting victim-survivors through their recovery. They defined VT as:

> Pervasive, that is, potentially affecting all realms of the therapist's life; cumulative, in that each client's story can reinforce the therapist's gradually changing schemas, and likely permanent, even if worked through completely. (McCann and Pearlman 1990a, p.136)

This suggests that VT does not occur following one disturbing account in a support session, rather it develops through being exposed to continual stories and traumatic events, meaning that VT builds and slowly changes how a trauma worker thinks and feels about the world and themselves. This can then affect aspects of their life away from work, and it cannot be reversed, meaning that schemas may be changed forever.

VT also considers the memory aspect of CSDT, stating that as well as schemas being disrupted, trauma workers can:

> Internalise the memories of their clients and may have their own memory systems altered temporarily or permanently. (McCann and Pearlman 1990a, p.142)

This can lead to trauma workers having vivid recollections of events which they did not experience, flashbacks, nightmares or intrusive thoughts, which can lead to negative affective states such as sadness or guilt. As with STS/CF, VT is linked to empathy with the client, and a factor that has been proposed to contribute to VT is the therapists own personal history or abuse, along with their own ideals or aims (Pearlman and Saakvitne 1995). Poor supervision and lack of training are also cited as contributory factors for VT, and this will be discussed in Chapter Three.

Despite outlining the existence of VT and explaining its dangers, it is described not as an issue to avoid, or to demonise, but as "an occupational hazard that must be acknowledged and addressed" (Pearlman and Saakvitne 1995, p.123). Therapists and trauma workers enter and continue employment for many reported positive reasons, including the rewards and enrichment to their lives from undertaking work which helps others (McCann and Pearlman 1990a; Pearlman and Saakvitne 1995) and propose that VT needs to be viewed and approached as a "normal reaction to the stressful and sometimes traumatizing work with victims" just as PTSD is viewed as an understandable reaction to a trauma event (McCann and Pearlman 1990a, p.145).

However, research has also suggested that through being affected by VT, trauma workers can become less effective team members, can lead to high turnover of staff, and can breed cynicism which permeates an organisation (Pearlman and Saakvitne 1995, p.126). Therefore, alongside the effects on the individual of VT, it can also affect the service, which can further affect the continuity and quality of service provided to victim-survivors.

VT is measured through the Traumatic Stress Institutes Belief Scale (TSI-BS) (Jenkins and Baird 2002), now also referred to as Trauma and Attitudes Belief Scale or TABS, which measures the extent to which cognitive schemas have been disrupted in "self" and "other" subscales that relate to the trauma psychological needs (for example, safety, trust, intimacy). While it was originally created to assess direct traumatisation, it can also be used to measure vicarious schema disruptions.

Because their work involves supporting victim-survivors who have experienced traumatic events, and the continuation of this over time, VT is an appropriate concept through which to explore the effects of being a DAA on the individual.

2.3.6. Differences Between Concepts

While Figley, Pearlman and McCann deemed STS/CF and VT as different concepts, and separated them from burnout, there are clear overlaps between these concepts, regarding affect and change in outlook.

Jenkins and Baird (2002) examined the measures of the three concepts to determine if they assess separate phenomena, looking at the CFST (STS/CF measure), the TSI-BS (VT) and the MBI (burnout) along with measures for general distress and a traumatic event experience checklist. Their first three hypotheses sought to test the concurrent validity of the measures (whether the measures were examining the same effect), the next three hypotheses aimed to test the discriminant validity (the extent to which the measures were assessing different phenomena) and the final hypothesis aimed to examine whether the measures responded to prior personal trauma, opposed to only indirect. Five of their seven hypotheses regarding the measures and constructs were supported, with two partly supported, which indicates that the three constructs are distinct, and not simply different aspects of the same phenomenon. Studying both discriminance and concurrence between the tests is a strength of this research, as it acknowledges and measures both similarities and differences between the constructs. Additionally, this study sampled VAW workers, specifically DA and SV counsellors, to examine the concepts. This is a benefit for this study as it has a VAW trauma sample, rather than a sample of generic therapeutic sample.

Alongside these benefits, Jenkins and Baird (2002) also included a discussion of the comparison of STS/CF and VT, which has been summarised in Table 1 to detail the differences. The focus on general workplaces for burnout separates it from the other concepts, but according to Jenkins and Baird (2002), while both concepts have similarities in symptoms, qualitatively, their focuses differ, with STS/CF focussing on the observable symptoms, with an acknowledgment that there can be cognitive changes, while VT focusses on the more theoretical cognitive changes, while acknowledging that there can be observable symptoms. They also both differ in onset, with STS/CF being caused by a one-off discussion, while VT is caused by being exposed to stories over time.

Table 1 - STS/CF and VT Differences Summarised from Jenkins and Baird (2002, p.425)

Secondary Traumatic Stress/Compassion Fatigue	**Vicarious Trauma**
Focus on observed PTSD Symptomology	Focus on self-perceived cognitive schema change (theoretical)
Acknowledge cognitive shifts, but focus on rapid onset PTSD symptoms	Acknowledge PTSD symptoms (affect, memory based) but focus on content of belief change
Caused by 1 severe exposure to another's symptoms	Caused by prolonged exposure over time

In critique of VT and STS, it could be argued that the three concepts are too similar to be separated, rather that they show different aspects of one phenomenon. Devilly et al (2009) contended that VT and STS are actually just different aspects of the more established phenomenon of burnout. They justified their exploration due to "little empirical validity testing" (Devilly et al 2009, p.374) of the TSI-BS (despite Jenkins and Baird's previous exploration of the concepts), and compared three measurements for VT, STS and burnout to discover if they are measuring different phenomena. These comparisons found that all three concepts are "highly convergent" and that the concepts for VT and STS "do not display construct validity" (Devilly et al 2009, p.381), which could support that the three constructs measure the same phenomena.

However, unlike Jenkins and Baird's (2002) study which addressed the focusses of the concepts, this study only examined the quantitative measurements for the three concepts. Due to the similarities of the concept descriptions and content, it is expected that there would be similarities in the measurements and constructs. For example, it would be expected that Devilly et al (2009) would find a strong convergence between VT and STS due to the similarities of what is included in the concepts. However, this quantitative data ignores the differing focuses discussed in the concept descriptions and illustrated in Table 1. Additionally, despite utilising the Maslachian definition of burnout, the researchers did not use the MBI to measure burnout, instead using a different tool[3], which may affect the

[3] The Copenhagen Burnout Inventory

similarities between concepts during the comparison. Additionally, although burnout may overlap with both concepts, it does not have the same focus on trauma work. Accordingly, this study will present VT and STS/CF as different concepts, which have overlaps in measurement and disruptions, but which have different focuses, so can be studied separately.

Despite these differences between the concepts, a key flaw in the literature is term confusion, with many researchers switching between terms, or confusing the focus of the separate concepts (Branson 2019). Branson stated that confusion of terminology can affect the validity of research (for example, in confusion over variables) and that researchers in this field should make sure their definitions are clear. Therefore, due to the exposure to traumatic material, and cumulative nature over time, this thesis will draw on VT as a concept to explore negative effects on DAAs, and will maintain clear terminology and application to avoid term confusion.

2.3.7. Vicarious Post Traumatic Growth and Compassion Satisfaction

This chapter has examined the negative effects which could befall a trauma worker; however, not all effects on the worker are negative. The following sections will examine concepts which state that supporting trauma survivors can not only benefit the victim-survivor, but also the worker.

As stated earlier in the chapter, PTSD can occur in those who have been traumatised. However, following a traumatic experience, survivors of trauma often report improvements in their lives, including being more resilient, striving to achieve goals, improved affect, and general positive changes (Tedeschi and Calhoun 1995). There are different terms which describe positive effects on a victim-survivor, which can be grouped under the term Adversarial Growth, including Post Traumatic Growth, Stress-related growth, blessings and positive adjustment (Linley and Joseph 2004). From their review into studies regarding Adversarial Growth, Linley and Joseph (2004) found that over time, those participants who reported some level of growth were less distressed in the future, suggesting that those who experience positive effects following trauma may benefit from long-term improvements in their lives.

As this growth and betterment can occur following direct experience of trauma, or PTSD, it can be argued that following indirect experience to trauma, workers can also experience

growth and benefits. Vicarious Post Traumatic Growth (VPTG) was a term introduced following research into positive effects on trauma psychotherapists, which found that while 100% of participants reported negative outcomes, such as intrusive thoughts and exhaustion, 100% also reported positive outcomes, such as increased compassion. 90% noted the benefit of being able to be part of a survivor's journey and to witness them heal and grow (Arnold et al 2005). Arnold et al. (2005, p.257) proposed that the positive effects participants shared are "remarkably similar" to growth following direct exposure to trauma, and that being negatively affected presents workers with a chance to grow from the experience, saying the "tears they shed on behalf of their clients represent an extraordinary opportunity for personal growth" (Arnold et al 2005, p.260). Research evidence for VPTG will be discussed in more detail in Chapter Three.

Additionally, the notion of trauma workers being positively affected by their work was discussed following research into STS/CF that looked for a positive factor termed Compassion Satisfaction (CS, Stamm 2002). While STS/CF have been referred to as a "cost of caring" (Figley 2002), Stamm proposes that there can also be "payments" to caring for and supporting traumatised people (2002, p.109), which come from practitioners feeling good about the work they are doing. While VPTG focusses on the growth that can occur from supporting a traumatised person, CS focusses only on the satisfaction and pleasure the worker derives from the job, and not further growth in their lives.

2.3.8. Vicarious Resilience

A third concept which proposes positive effects from providing trauma support on workers is Vicarious Resilience (VR). This concept in its original form is caused by witnessing the resilience of clients, through their healing and reassessment of their problems and lives, which leads workers to become more hopeful and resourceful in their own lives (Hernandez et al 2007). The effects of VR are generalisable beyond the therapeutic session to the workers personal life, with specific focus being on the hope and optimism that seeing survivors achieve can provide. Hernandez et al (2007) are clear however, that VR is not simply "the sum of all positive experiences that therapists remember" from their interactions with clients, nor does it cover generic motivations in the workers lives, but that it is caused by more complex elements (2007, p.238). Whilst examining the theory, the authors also unexpectedly were presented with experiences of VT, despite not asking about

negative effects, which suggest that the two concepts are linked and may co-occur (Hernandez et al 2007, p.238).

While the original proposals of these concepts differ in focus, Frey et al (2017) proposed adopting VR over CS and VPTG for practical usage, as it has a broader scope which can encompass both positive feelings from CS and the personal growth of VPTG. They supported the argument for this through significant shared variance between tests for CS and VPTG. Various factors were presented which could improve the presence of VR, VPTG and CS in the theory introductions, including social support, spirituality and being able to acknowledge the positive effect of the work on their lives (Arnold et al 2005; Hernandez et al 2007; Stamm 2002). Studies which explore these factors will also be introduced in Chapter Three.

Following discussions of these concepts, this study will explore the effects on DAAs through the lenses of VT and Frey et al's (2017) proposal of VR. VT has been chosen to explore these experiences as it focuses on the cumulative effects of being exposed to trauma which has been experienced by others. Burnout is not appropriate due to the possibility of it being experienced by people in any workplace, while countertransference can also be experienced by all therapists and researchers, whether or not they work with trauma. While STS could be applied to these experiences as it focuses on second hand trauma, it has been excluded from use in this study as it could be caused by a one-off event, whereas DAAs are exposed to these accounts every day. Regarding the positive effects, as Frey et al's (2017) concept of VR incorporates both VPTG and CS, this will be the concept used for this research, to ensure all positive effects are gathered within one term.

2.4. Conclusion

This chapter has presented the contextual background and conceptual frameworks that will be drawn on throughout this thesis. It began by exploring DA definitions and terminology, before discussing relevant legislation in Wales and England. The prevalence of DA and practicalities of leaving an abusive partner were then discussed. Services which can be accessed by victim-survivors were explained, stating that DAS are a key aspect of this support, before turning attention to the workers. DAAs are exposed to traumatic stories and situations on a daily basis, and these may have a detrimental, or positive, effect on their wellbeing.

The chapter then explained the different concepts regarding effects of working with trauma survivors, first setting out information on resilience and wellbeing, before explaining the negative effects of burnout, countertransference, Secondary Traumatic Stress (also known as Compassion Fatigue) and Vicarious Trauma (including a presentation of its base theory Constructivist Self Development Theory). Some arguments regarding these concepts were presented, including the position that STS/CF and VT are aspects of burnout, and the position that they are separate entities focussing on different issues. This section also raised that a key criticism of literature in this field comes from term confusion, where these concepts are used interchangeably despite their differences.

The chapter acknowledged that not all effects from trauma work are negative, presenting the positive effects of Vicarious Post Traumatic Growth, Compassion Satisfaction and Vicarious Resilience. These discussions of concepts justified decisions on using the concepts of VT, as it is applicable to the sample population, and VR, as it encompasses the different positive terms, for this research.

This chapter provided a foundational base for Chapter Three, which will explore the empirical evidence regarding these concepts by examining VT, VR and related concepts in trauma work samples, before highlighting the gap in the existing literature and proposing the key research questions in this study.

3. Review of Empirical Evidence

3.1. Introduction

Following the contextual background and conceptual theories discussed in Chapter Two, this chapter will critically engage with existing empirical evidence surrounding Vicarious Trauma (VT) and Vicarious Resilience (VR). There is a wealth of research related to burnout and countertransference, however this is not included as the focus of this thesis is on effects of specifically providing support to traumatised individuals, not all workplace or therapeutic stresses[4]. While ideally this section would separate out research studies on VT, Secondary Traumatic Stress (STS) and Compassion Fatigue (CF), as discussed in section 2.3.6, in practice this is difficult due to many studies having confused terminology (Branson 2019) or not specifying the type of trauma beyond "indirect" (for example, in Knight 2013) or "secondary" trauma (for example, in Baker et al 2020). For this reason, studies that specify which concept they are using will be identified as such and those who use broader, less specific terms, will be referred to as VT. To explore existing empirical studies and highlight the need for this study, the chapter will examine different facets of VT and VR and how they could be experienced by Domestic Abuse Advocates (DAAs). As this chapter will evidence, there are few examples of empirical research into the experiences of DAAs; therefore, this chapter will explore effects on workers in the wider Violence Against Women (VAW) field.

Accordingly, empirical evidence for experiences of VT in professions other than VAW will be discussed. This will then be followed by support for the existence of VT in VAW workers, and its effects. Section 3.4 examines the empirical evidence for risk factors for developing VT, including length of time of working with traumatised individuals, caseload and direct contact hours with trauma victim-survivors, education levels, sex/gender of the worker and their own lived experience of VAW. Section 3.5 discusses the existence of VR in a range of trauma workers, before focussing on evidence of VR in VAW workers. Section 3.6 then explores known causes of VR, including its interplay with VT, "bearing witness" and being a victim-survivor. The empirical literature documenting how experiences of VT are managed, and the associated coping mechanisms, will be discussed in section 3.7. The knowledge generated in

[4] For overviews of workplace burnout and countertransference see Edú-Valsania et al 2022, Jacobs 2019, Machado et al 2014 and Shoman et al 2021.

these studies and the areas that need further exploration are drawn together in section 3.8, introducing the aims of this study and research questions.

3.2. Vicarious Trauma Experiences in Different Professions

There are studies of secondary trauma in many different roles, including social workers, nurses, firefighters, police and police/crime support workers. Armes et al (2020, p.2) summarised that STS research with social workers places prevalence between 15-35%. However, while levels which meet the clinical diagnosis for PTSD were lower, in his study of social workers (n=294), Bride (2007, p.67) found that using the Secondary Traumatic Stress Scale (STSS), 70.2% of the sample reported at least one symptom of STS in the previous week. These studies demonstrate that STS is prevalent in social workers, and that while they may not experience all aspects, it is likely that they experience some vicarious effects from their work.

Additionally, Ashley-Binge and Cousins (2020) conducted a systematic review of 12 quantitative studies into VT in social workers and how their experiences are addressed, identifying individual and organisational strategies. They summarised that individual aspects which mitigate VT in social workers included maintaining a work-life balance, having supportive colleagues and strong social networks and engaging in exercise, while organisational aspects included having a positive workplace culture, adequate resources and debriefing meetings (Ashley-Binge and Cousins 2020, p.197).

Emergency department nurses have also been studied using the STSS to establish prevalence for STS. In 2015, Duffy et al surveyed Irish emergency department nurses (n=105) finding that 64% met the criteria for experiencing STSS. A statistically significant variable in this study was of the nurses considering changing career (p=0.017).

Unlike social workers and nurses, some professions require workers to place themselves in direct risk while supporting others, notably, the police and firefighters. This can lead to workers developing their own PTSD as well as being exposed to VT (Salleh et al 2020; Wagner et al 2020). When researching VT in these samples, empirical research is less clearly defined as solely VT, and instead focuses on PTSD, and includes VT, or secondary trauma, in their descriptions. For example, Bastug et al (2019) identified secondary traumatisation in firefighters (n=100), with 40% scoring as having results consistent with experiencing PTSD using the Post Traumatic Stress Symptoms Scale. Similarly, Violanti and Gehrke (2004)

considered Compassion Fatigue (CF) in police officers (n=115); however, the measure used was designed for PTSD (the Impact Events Scale- IES), and results showed that 43% of police officers were at high risk of PTSD[5].

However, there are some studies of police officers which study STS using defined measures, such as Velasco et al (2023). This research used the STSS to study STS in 112 Spanish police officers (alongside the IES to measure direct trauma), and found that all participants experienced both indirect, and direct trauma. In their article on policing, Foley and Massey (2021) summarise that some roles have a more significant impact on police officers' wellbeing, specifically those focused on sexual violence (SV), domestic abuse (DA) and cases involving children. Exploring this, Parkes et al (2019) conducted qualitative research with 11 police staff (10 detectives and one civilian investigator) who work with SV, framing their findings through PTSD[6] and VT. Eight participants had become more suspicious and cynical, and viewed interactions through the lens of SV, with one saying that "you don't see the world through the same eyes any more" (Parkes et al 2019, p.326). Additionally, six participants reported feeling isolated because they could not share their thoughts and feelings with friends and family in case they "contaminate" them (Parkes et al 2019, p.327), while others discussed how their relationships had been negatively affected including becoming overprotective of their children. Nine participants also reported experiencing intrusive thoughts, with one saying she can still see the images she has witnessed, including having flashbacks, and one participant explained her feelings of powerlessness to help all victim-survivors. The authors stated that these findings mapped to five of the seven VT schema, therefore suggesting VT in SV police staff.

Similarly, Bozga et al (2020) conducted semi-structured interviews with 15 female police officers who worked with sexual offenses in England to determine how they experienced the influence of their work on their lives. They found that all participants "reported experiences associated with VT" (Bozga et al 2020, p.42). These included changes to their relationships, with their sex lives being affected and becoming overprotective of their children, feeling weary, and having an overwhelming sense of responsibility for victim-

[5] Other studies within this chapter also use the IES, which measures PTSD symptomology in their VT studies, therefore this measurement confusion is not restricted to police and firefighters.
[6] In their article, they justify use of PTSD over STS as the latest DSM includes secondary exposure to trauma, however they keep VT separate as the disruption to schema and cumulation of effects is different (see section 2.3.4 and 2.3.5)

survivors. Most participants also reported anxiety attacks, and all participants reported effects on their sleep, with some having nightmares. One participant explained how the details of a case, of a victim-survivor's "little red sandals" featuring in their dreams, evidencing how their cases permeate their lives (Bozga et al 2020, p.39).

Additionally, Huey et al (2023) sampled police support workers (n=49) in Canada, using semi-structured interviews to explore their experiences of VT. These police support workers did not attend crimes, with their roles being primarily administrative, however they were exposed to accounts of crime, with one participant saying "we see the photos. We see the statements" (Huey et al 2023, p.553). Participants positioned transcribing police interviews as the most frequent exposure, with one participant reporting flashbacks from one case she transcribed. Participants also reported having nightmares and being able to recall pictures of victims. Additionally, one participant explained how she developed a different view of death, which while not conceptualised through VT in this study, aligns with a change in frame of reference.

Similarly, Open Source Investigators who examine videos and pictures for human rights breaches can experience secondary trauma (Dubberley et al 2015). Baker et al (2020) surveyed these workers (n=33) using mixed methods to identify mitigation techniques, finding that strategies such as limiting exposure (especially at home), accessing community support and self-care strategies can help.

This research evidences the existence of VT in social workers and emergency service workers, with the final two studies illustrating how it is not only those who attend to the traumatic events who can be affected, but also those who are indirectly exposed to abuse after its occurrence.

3.3. Evidence for Existence of Vicarious Trauma in VAW Workers

This section will assess key studies which support the existence of VT in roles within the VAW field. Early explorations into the existence of VT within the VAW sector were undertaken by Steed and Downing (1998). They conducted 12 semi-structured interviews with Sexual Abuse (SA) Therapists in Australia to gain an understanding of the impact of working with SA victim-survivors. Aligning with the concept of VT, participants described negative changes to their worldview, variations in their feelings of security and identity, and

also documented negative physiological symptoms, such as low energy and disturbed sleep patterns. Eight interviewees stated that they were more vigilant regarding theirs and others safety, seven experienced intrusive thoughts and dreams, six described being wary of men and struggling to trust their partner, and seven reported changes to their friendship group due to their work.

In a later study, Iliffe and Steed (2000) interviewed 18 Australian therapists and counsellors who worked with victim-survivors and perpetrators of DV. This sample (13 women and 5 men) reported experiencing changes in their cognitive schema (for example, feeling less secure in the world and having less trust regarding relationships) and personal impacts (including physical responses such as nausea and feelings or anger and horror) from hearing traumatic material, which map directly onto the concept of VT. However, whilst this study does explore VT experiences in workers with victim-survivors, the inclusion of support for perpetrators may skew results if there are variations in effects from supporting different groups. Support for this can be found within the study, as therapists who worked with perpetrators reported feeling energised when they run group sessions, with the authors concluding that perpetrator work can be "stimulating" for the worker (Iliffe and Steed 2000, p.402).

In the United States of America (USA), focus groups conducted with Mental Health Counsellors (n=11) who worked in DV organisations reported shifts in worldview, including difficulties remaining positive, and an emotional impact on their personal lives, such as struggling to enjoy activities, feeling numb and having nightmares (Beckerman and Wozniak 2018). Another theme which emerged from these focus groups was hypervigilance and fear of harm, which stemmed from being in close proximity to victim-survivors, and therefore perceiving risk of harm from the client's perpetrator.

Phenomenological interviews with 20 Israeli social work students, who were doing fieldwork in the VAW sector, provided evidence that effects from working with VAW can be focused on specific schema alongside general changes in schema (Goldblatt and Buchbinder 2003). These students not only reported blurring of boundaries and general VT effects, but also highlighted effects on specific schemas. For example, these students reflected on how they view their familial and intimate relationships changing because of their experiences at work, with them constantly being on guard and alert to their safety. Further research by Goldblatt

et al (2009) explored 14 senior VAW social workers to examine effects on their private lives, finding further disruptions to intimate relationships. Participants in this study shared that their relationships are impacted by their awareness of inequality and abuse, with one explaining that her "home has become a battlefield" (Goldblatt et al 2009, p.373). These findings support the suggestion that working in the VAW sector may have disproportionate effects on different schema groups, specifically safety and intimacy, in line with the focus of the role.

In South Africa, Sui and Padmanabhanunni (2016) conducted qualitative interviews with trauma psychologists (n=6), three of whom supported SV victim-survivors, and two who support DA victim-survivors (among other traumas). All participants experienced VT effects, including disruptions to safety, changes in dreams and feeling anger, and also discussed how they try to instil safety precautions in their loved ones.

Turning to the UK, Taylor et al (2018) conducted research on the impacts on VAW helpline workers (n=10). While this study did not categorise findings under VT, many of the findings are consistent with the concept. Participants discussed the emotional impact of their work, saying it leads to burnout, as well as highlighting the affects their role had on their relationships, with some describing struggling to form and maintain intimate relationships due to being wary of men. One participant also stated that the role "massively" affects her sex life because of the abuses she hears about (Taylor et al 2018, p.859). This research also explored coping mechanisms which will be covered in section 3.7.

Another UK study on VAW workers researched the impacts on staff working in an English Sexual Assault Referral Centre (SARC), with the sample of doctors, crisis workers and Independent Sexual Violence Advocates (n=16, Massey et al 2019). 12 interviews and four focus groups revealed negative experiences of sadness, frustration and anger, absorbing the emotion of victim-survivors, de-sensitising and feeling hopeless at the "never-ending" nature of the job (Massey et al 2019, p.693). Participants also discussed the accumulation of effects due to the volume of their cases. Positive effects and coping mechanisms were also explored in this study, which will be discussed in sections 3.5, 3.6 and 3.7 respectively.

In 2021, Crivatu et al conducted a Rapid Evidence Assessment[7] (REA) of research which focused on impacts on SV workers. This REA summarised findings of the negative impacts of working with SV, positive effects (discussed in 3.5), as well as self-care mechanisms and organisational support (discussed in section 3.7). They reported that in the quantitative studies sampled, "significant signs of traumatization" were found in more studies than those who did not find significant signs (Crivatu et al 2021, p.60). Participants across the studies also experienced loss of trust and safety for both themselves and loved ones, specifically surrounding males, which led to changes in their behaviours. A range of negative emotions were also found to be experienced by participants, including anxiety, anger, sadness and emotional fatigue.

However, whilst the majority these studies effectively use qualitative methods to evidence the existence of VT and experiences of indirect effects, they examine the experiences of VAW therapists, SV or helpline workers or VAW specialised social workers, and not of DAAs. One study which does examine the desired sample of advocates (termed Domestic Violence Advocates or DVAs in this USA study) was conducted by Slattery and Goodman (2009). This research was quantitative, aiming to measure risk and protective factors for STS in 148 Advocates, and did not focus on experiences of VT. Similarly, Wood (2017) in the USA, and Gilbert (2020) in the UK, conducted research on DAAs to determine the effects of being a victim-survivor conducting this work. These three studies will be examined in the following section.

This lack of research into experiences of VT in DAAs demonstrates a gap in the literature, as DAAs roles comprise of different tasks and support than that of counsellors or therapists (see section 2.2.5) or social workers. Therefore, while there may be parallels in experiences, this cannot be established without an evidence base for DAAs VT experiences.

3.4. Vicarious Trauma Risk Factors

This section will examine different risk factors for VT, including length of time in the field, caseload, education or training, sex/gender and the worker's own lived experience of abuse.

[7] A Rapid Evidence Assessment is similar to a systematic review, but focuses on a smaller period of time to provide an overview of recent research (Crivatu et al 2021)

3.4.1. Length of Time in Post and Field

In their article which introduced VT as a concept, McCann and Pearlman (1990a) suggested that the length of time working with traumatised individuals affects VT levels, with those who have worked for longer having lower levels of VT compared to newer staff members. While they acknowledge that VT is cumulative in nature, they stressed how those who have worked in the field longer may have learnt how to cope with VT effects, meaning that newer staff members are more at risk due to inexperience. In a later study employing the Traumatic Stress Institute-Belief Scale (TSI-BS) with 188 non-specialist trauma therapists (who support those affected by various types of trauma), Pearlman and MacIan (1995) found that trauma therapists who were newer to the role had higher VT levels, shown through high results for disrupted cognitive schema, specifically the schemas of self-trust, intimacy and esteem (Pearlman and MacIan 1995).

Similarly, clinicians who treat survivors of SA with shorter service than their peers have been found to have higher levels of VT. Way et al (2004) sampled clinicians registered with two American membership bodies[8] (n=347) with a range of service years. However, this quantitative study used the IES as its measurement for VT, often used to measure direct PTSD symptoms in participants, which may mean that results using the TSI-BS for VT would vary.

Being newer to the field is also a risk factor for VAW perpetrator workers as well as victim-survivor supporters. Van Deusen and Way (2006) conducted a quantitative study in USA, examining differences between clinicians who support victim-survivors (n=111) or the perpetrators of sexual abuse (n=272), using the TSI-BS found no difference between the groups. However, they found that for both groups, being newer to the field was associated with greater disrupted cognitive schemas, specifically around trust and intimacy with others.

However, while there is evidence supporting shorter tenure being a risk factor, there is also evidence to the contrary. In a USA based quantitative study of SA workers (n=35), DA workers (n=17) and those who work with both SA and DA (n=49), Baird and Jenkins (2003) found that less experienced staff with lower time in the field do not have higher VT scores, instead only finding higher burnout levels through the MBI in workers who have been in the

[8] The Association for the Treatment of Sexual Abusers and the American Professional Society on the Abuse of Children.

field longer. Similarly, in a study with therapists who work with victim-survivors of violence in Canada (total sample n=259, subsample who completed TSI-BS n=53), Bober and Regehr (2006) found that older and more experienced counsellors have more disrupted beliefs surrounding intimacy with others[9]. This suggests that research into the impact of the accumulation of VT over time is inconsistent, highlighting the need for more exploration into why some workers who have been in the field for longer are less affected than others.

Additionally, Bromley et al (2024) found mixed results in whether length of time in the field impacts DV and SV workers[10]. They conducted a systematic review of 30 articles (16 quantitative, 13 qualitative and one mixed methods) examining risk and protective factors in DV and SV workers regarding their professional quality of life[11]. They found only one quantitative study, conducted by Horvath et al (2021) studying ISVAs, where more experienced workers were at higher risk of experiencing negative impacts. However, when looking at qualitative studies sampled, two found that length of time in the field were protective for staff members, with them experiencing fewer negative impacts (Bromley et al 2024, p.8).

Due to these contradictory findings, further research is needed regarding the effect of length of service in the VAW field on levels of VT. As each of the above studies was quantitative in nature, and focusing on non-DAA roles, this further supports the need for qualitative research into risk factors for DAAs experiencing VT, and how they experience change over time.

3.4.2. Caseload and Direct Hours with Victim-Survivors

Length of time spent with trauma victim-survivors, due to high direct contact hours or high caseloads, has also been argued as a risk factor for VT. This section will examine the evidence for this.

In the quantitative aspect of a mixed methods study of counsellors (n=118) and SV counsellors (n=30), Schauben and Frazier (1995) found that workers with a higher percentage of SV clients on their caseload reported more disruptions in their cognitive

[9] Age correlated with results of the TSI-BS other-intimacy subscale at p<.001, and years of experience correlated with TSI-BS other-intimacy subscale at p<.01 (Bober and Reger 2006, p.5).
[10] The systematic review uses the term advocates, though this is not necessarily used in the articles sampled.
[11] A term used by the authors to include CF, STS, VT, Compassion Satisfaction and VR.

schemas through the researchers' own VT scale, particularly in the area of other-esteem[12]. This suggests that the more exposure workers have to traumatic accounts from SV victim-survivors, the more likely they are to develop VT.

However, the association between caseload or direct contact hours with victim-survivors, and workers experiencing VT is contested. During a study on VT and spiritual wellbeing (concerning meaning, purpose and core beliefs), it was found that while specialist SA psychotherapists with higher caseload exposure had higher PTSD and distress scores (via the IES), they did not have higher VT levels on the TSI-BS (Brady et al 1999). This finding was replicated by Bober and Regehr (2006) (sampling therapists who work with survivors of DA, SV or child abuse) where therapists who have high contact hours scored highly on the IES for distress, but there was no association between their hours working and TSI-BS scores for VT. These findings imply that while higher caseloads or contact with victim-survivors may negatively affect workers through making them distressed, it does not necessarily lead to the disruption of cognitive schema and the development of VT. These contradictory findings were also found in the quantitative studies in Bromley et al's systematic review (2024), where workers perceived workload could be both a protective and risk factor for their professional quality of life. However, the qualitative studies placed high workloads as a risk factor for DV and SV workers.

Slattery and Goodman's (2009) quantitative study on risks and protectors of STS in DV Advocates also found that the number of direct service hours were not predictive of higher STS levels. However, this study used a PTSD symptoms scale as an indicator, and not an STS or VT measure; therefore, these findings may not be reproduced with VT measures, as although there are similarities between PTSD and STS and VT, the concepts are distinct (see section 2.3.6).

Additionally, there is also evidence that higher workload and exposure to SA and Domestic Violence (DV) victim-survivors has the opposite effect on VT. A quantitative study of SA and DV agency staff (n=101) in USA by Baird and Jenkins (2003) measured self-reported scores on effects using the TSI-BS (for VT), Maslach Burnout Inventory (MBI), Compassion Fatigue Self-Test (CFST for STS) and a symptom checklist for distress. It was found that workers with

[12] Other-esteem relates to seeing the values in others (see section 2.3.5 for more information on cognitive schemas within VT).

higher workloads scored lower on the TSI-BS than others, reflecting higher workloads being associated with lower VT risk. This could be due to higher caseloads meaning less focus on each traumatic recount. Unlike Brady et al (1999) and Bober and Regehr's (2006) research, this study found that there was no relation between workload and general distress levels.

As with length of time in the field, there are conflicting research findings regarding the effects of caseload and direct service hours on risks of developing VT. There is also a lack of qualitative research examining this risk factor, and how caseloads interplay with experiences of VT, which would need to be explored to understand how to protect against VT.

3.4.3. Education, Training and Role

The majority of studies examined in this chapter sampled professions requiring high levels of education and training, such as therapists and mental health counsellors. For example, in Schauben and Frazier's study of SV counsellors (1995, p.52), 96% of the sample were reported as having a bachelor's degree, or higher, with 28% having a doctorate. Dalton (2001) found that social workers with master's level education had significantly lower STS levels (using the CFST) than those with bachelor's degrees, which suggests that those with lower levels of education may be more at risk of VT and related effects.

Whilst undertaking education, therapists and counsellors can be introduced to the effects which can be experienced by trauma workers and taught how to recognise and navigate these effects. While these topics are introduced in specialised VAW training, such as Independent Domestic Violence Advocate (IDVA) training, DAAs are not necessarily made aware of VT on entry to the role, which may impact on how they can recognise and mitigate its effects. Being trained in the impacts of the role was cited as helpful by VAW helpline workers, as they received "little training focusing on the emotional impact of the role" (Taylor et al 2018, p.859).

Additionally, it is possible that it is not the level of education which affects the risk of VT, it may be the role which a person is able to occupy, which can be linked to their level of education. In their study on DA and SV workers, Baird and Jenkins (2003) used a sample comprising of different roles within an agency, including counsellors, therapists and psychologists, but also caseworkers, crisis workers, interns and hotline workers. Within this sample, 13.9% had a high school education, while 84.1% had a college degree or higher

(Baird and Jenkins 2003, pp.76-77). They noted that those with lower levels of education were more likely to be in a role such as crisis worker. The crisis worker role is similar to the role of DAAs, which as discussed in section 2.2.6, does not require high levels of education to enter the position. Baird and Jenkins (2003) also found that VT levels were lower in the staff with higher education (but they had higher burnout levels). As with Dalton's (2001) study, this could suggest that those with lower education levels are more at risk of VT, but alternatively, it could suggest that those in more hands-on roles, such as crisis worker, opposed to more skilled and technical roles, such as therapist, are more at risk of VT.

This supports the need for research into experiences of DAAs, whose roles are distinct from those of therapists. It also exposes the need to find out whether DAAs, who do not necessarily have prior training, have undertaken training on VT and how it can be managed, and whether this has an impact on their experiences.

3.4.4. Gender

Within the VAW sector, workers are predominantly women; therefore, samples for studies on VT in this sector are overwhelmingly women. For example, in Slattery and Goodman's (2009) and Beckerman and Wozniack's (2018) studies, 100% of the sample were women, while in Schauben and Frazier's research (1995, p.52), 4 men participated alongside 144 women, and were subsequently removed from the data set due to low response numbers. As discussed in section 2.2.3, women are primarily the victims of VAW, meaning that overall, women are involved in supporting other women. This could elevate the VT risk for VAW workers as they may identify more with their clients, or they could see themselves as being at risk of the same trauma.

Morran (2008) conducted research into the impacts of the role on those who work with DV perpetrators. While his sample was mainly women, 10 out of 30 participants were men, allowing for limited comparisons to be made. Participants completed a qualitative questionnaire, and whilst some evidence of VT was found for male workers, specifically around "heightened awareness to others" (p.147), there was strong evidence that women workers experience VT. The effects which were reported by women align with disruptions to cognitive schemas of: safety ("I have felt very powerfully just how I am seen by men and that has really shaken me", p.145); power ("feeling exposed and vulnerable", p.146); trust ("I am more wary" p.145); esteem ("constantly watchful for abusive or disrespectful

attitudes to women", p.144); and intimacy ("I felt negatively about men in general" p.145). This suggests that while men may experience some VT effects, women working within the VAW sector can have additional schemas disrupted by their work, as well as experience physical effects ("anger, rage and even loathing for the men they worked with" p.146).

Iliffe and Steed (2000, p.400) (see section 3.2 for more details on this study) also found some differences between men and women DV counsellors, with them both describing VT impacts, but women experiencing "these feelings more intensely and more frequently".

Considering gender differences in VT in police officers (n=115), Violanti and Gehrke (2004) examined the association between types of incidents to which police officers are exposed (including frequencies of these events) and trauma levels (using the IES for distress). They found that women officers' distress scores were significantly influenced by attending child abuse cases (33.2 odds ratio), while male officers distress scores were most associated with being exposed to victims of homicide (15.5 odds ratio, p.78). However, the authors acknowledge that women officers are more likely to be assigned child abuse cases, which may account for increases in distress for women workers surrounding VAW, as they experience them more than their male counterparts. It should also be noted that this study used a distress scale rather than a VT scale, so symptoms of VT may not be as pronounced as distress in relation to certain crime incidents.

3.4.5. VAW Workers Own Lived Experience of Abuse

In their paper introducing VT, McCann and Pearlman state that the therapists own "unresolved issues" do not always underlie disruptions in cognitive schema (1990a, p.146) and that working with others may assist in therapists addressing their own needs. However, similar concepts such as STS/CF proposed by Figley state that "unresolved trauma of the worker will be activated" by trauma work, placing those with lived experience at more risk (1995, p.27). Subsequently, other studies introduced in this section have examined whether there is a link between a workers own lived experiences of trauma and abuse and their development of VT.

In previous VT studies with VAW professionals, there have been questions to ascertain the prevalence of prior traumatisation. Schauben and Frazier (1995, p.56) found that 83% of SV therapists surveyed had experienced SV themselves, while Jenkins and Baird found that 55% of DV counsellors had experienced sexual or domestic abuse (2002, p.428). In a sample of

perpetrator and victim-survivor workers, it was reported that 76% of workers had experienced childhood maltreatment (Van Deusen and Way 2006, p.76). In their study with DV Advocates, Slattery and Goodman (2009, p.1367) asked participants about their lived experiences of abuse, and 55% of their samples reported prior abuse. In Wood's (2017, p.315) study with Intimate Partner Abuse Advocates in the USA, 18 of 22 participants reported being victim-survivors. These prevalence rates indicate that many workers in the VAW field have personal, lived experience of abuse, and there is a higher prevalence of victim-survivors in the VAW field than in the general population, where the statistic is 27% of women (see section 2.2.3). Therefore, if being a victim-survivor does increase the risk of workers experiencing VT, the VAW workforce may be at higher risk than other professions, especially where their experiences resonate with those of their clients.

In Pearlman and MacIan's study (1995, see section 3.4.1 for details) it was found that there was a significant difference on results of TSI-BS subscales specifically for safety (self and other), trust (self and other), self-esteem and other-intimacy for those therapists who have experienced (undefined) personal trauma, compared to those without lived experience. This evidences how therapists who have experienced trauma themselves can have higher VT levels. However, in this study, the therapists were not specialist VAW workers, and the personal trauma was undefined. Accordingly, therapists may be reflecting on trauma such as car crashes, and hearing similar trauma accounts from clients, which may vary to reflecting between personal and vicarious accounts of VAW.

Cunningham's (2023) quantitative findings support the theory of being a SA victim-survivor having a negative effect on those who work with SA victim-survivors. Cunningham found that there was a "positive and significant correlation" between these workers reporting experiencing SA, and disrupted schemas of self-safety and other-esteem subscales (Cunningham 2003, p.455). This supports the position that lived experience can be a risk factor for VT when supporting those with similar experiences.

However, in a study into the interplay between the motivation to enter trauma work and the effects of providing support on the worker, Jenkins et al (2011) found that being a victim-survivor only had a marginal effect on the TSI-BS for DA and SV counsellors' VT scores ($p<.10$). Nevertheless, they were more likely to report symptoms of STS on the CFST ($p<.001$; Jenkins et al 2011, p.2405).

Conversely, quantitative studies have shown there is no link between counsellors being victim-survivors and experiencing VT. Despite hypothesising that SV counsellors who have lived experience of SV would have higher VT scores on the TSI-BS, Schauber and Frazier (1995) did not find evidence to support this, with scores between cohorts having no significant difference. Similarly, quantitative findings using the Childhood Trauma Questionnaire and IES found that there was no association between experiencing maltreatment in childhood and VT in sexual abuse workers (Way et al 2004). However, this study only examined the association between maltreatment in childhood with PTSD symptoms measured with the IES. A later study by Van Deusen and Way (2006) observed the association between childhood maltreatment and VT levels in sexual abuse clinicians, this time using the TSI-BS to measure VT and found a link, with those experiencing childhood maltreatment having higher disruption of schemas. However, both of these studies only concern experiences of abuse in childhood, and not VAW experiences throughout their whole life and the interplay with VT. This may affect results as more recent trauma may be unresolved, or clearer in the worker's memories. It is also possible that SA clients will not have been abused in childhood, so workers may be less reminded of their own experiences in supporting them. These findings suggest that there is contention over whether having lived experience of personal trauma is associated with higher VT levels than those without lived experience in quantitative research.

Qualitative research has studied the impact of being a victim-survivor on providing VAW support, and both studies discussed here sampled VAW advocates. In the USA, Wood (2017) conducted qualitative interviews on how their own experience influenced service provision with 22 Intimate Partner Violence (IPV) Advocates, 18 of whom were victim-survivors. While these findings were not framed in VT, instead focusing on the impact on their support, and most findings could be seen as positive effects (which are included in section 3.6.3) participants raised negative effects surrounding being triggered by the content they hear, which can bring their own struggles to the forefront of their minds.

Similarly, in a qualitative study of English DAAs of different levels of seniority (n=12), including volunteers, case workers and managers who identify as being victim-survivors of abuse, Gilbert (2020) found that victim-survivor-professionals report specific negative effects of working with survivors of DA. As with Wood, these centred around being

"triggered", with one participant saying their experience is "not buried, it never will be buried, it will never be forgotten" (Gilbert 2020, p.81). However, as with Wood (2017), many of the findings also related to positive effects of being a victim-survivor as a DAA (see section 3.6.3).

While the quantitative studies discussed in this section measure the association of lived experience with VT, in many cases the trauma they were asked about is not defined or is confined to sexual or childhood violence and not VAW. Also, while levels of VT were compared to non-victim-survivors, their experiences were not explored as the studies were overwhelmingly quantitative based. The exceptions to this were Wood (2017) and Gilbert's (2020) qualitative studies which examined the experiences of survivor-professionals. However, these studies did not focus effects on VT, instead Gilbert only touched on the concept, and Wood focussed on impacts on service provision. Therefore, there is a need to examine how being a victim-survivor of VAW, including but beyond childhood or sexual abuse, interplay with experiences of VT.

In summary, many of the risk factors within section 3.4 are contested, and underexplored in relation to DAAs and their experiences of VT. This is especially the case regarding effects of length of time in the field, caseload, education and training, and victim-survivor status which this thesis will build upon.

3.5. Existence of Vicarious Resilience

As explored in section 2.3.7, not all effects of trauma work are negative. This section will examine the evidence which supports the existence of Vicarious Resilience (VR). As outlined in section 2.3.8, VR is a term which encompasses the psychological growth of Vicarious Post-Traumatic Growth (VPTG) and the positive feelings of Compassion Satisfaction (CS).

In studies which explored VT, VR effects have been discussed by participants, even if the aim of the research was not to explore positive effects of trauma work. For example, in Steed and Downing's (1998, p.5) research (see section 3.3), participants reported positive and negative changes. Positive changes included developing an appreciation of the resilience of clients and seeing themselves as more "adjustable and flexible". In relation to these expressions of positive change, Steed and Downing (1998, p.6) proposed that VT is "inadequate as a conceptual framework for understanding the full range of effects" of

trauma work. Therefore, to fully understand the effects of working with traumatised individuals, additional frameworks need to be included.

Vicarious Post Traumatic Growth (VPTG, see section 2.3.7) was introduced from a qualitative study of psychotherapists working with a wide range of trauma (Arnold et al 2005). The study drew on naturalistic interviews with 21 psychotherapists to examine positive effects from working with trauma victim-survivors. All participants reported negative effects from their work (including intrusive thoughts, sadness and exhaustion). However, they all also reported positive effects from their work. These positive effects included: experiencing client growth (n=19) and having positive "trait oriented changes in the self" (n=18, p.250) including increased compassion, tolerance and empathy. Some said that the work affected their levels of spirituality and religious beliefs, for example, feeling that their "faith had deepened" (n=16, p.251); and participants also said their work gave them a heightened awareness of their own good fortune (n=11, p.251). The researchers observed that when asked "how have you been affected by your work with clients who have experienced traumatic events?" 16 out of the 21 participants reported positive effects first. While this may signal that the positive effects being reported first are the most important to participants, it is also possible that they were the first answers given as they are the most acceptable for psychotherapists to share, as they do not want to begin an interview sharing the difficult aspects of their role, or the negative effects on them.

Evidence for the existence of VR has been found in trauma specialists in different fields. For example, Hernandez et al (2007) conducted interviews with 12 Colombian Mental Health workers, who support survivors of torture and political violence. They found that workers learn from their clients about how to cope with adversity and that these positive effects can be strengthened if they are brought to the workers attention. For example, participants reported that witnessing clients overcome adversity affected their own attitudes and emotions; they felt empowered, hopeful and "more resourceful, less fearful, more dynamic, more resolute" (p.237).

As well as the Steed and Downing study (1998) explored at the beginning of the section, there have been other studies in the VAW field which have found support for the existence of VR. Bell (2003) conducted semi-structured interviews with 30 DV counsellors (USA based) to determine how they experience work. While 10% of participants reported negative

effects from their role, 40% reported positive experiences (with many also reporting mixed effects). Positive effects which were found included becoming more compassionate and grateful.

In their mixed methods study exploring counsellors' motivation for entering the VAW field, Jenkins et al (2011) found that 40 of 106 counsellors (38%) responded to an open ended survey question[13] on the changes they have experienced from the work with positive answers. For example, participants reported having a better understanding themselves, being more aware of their own feelings, feeling more empowered, having higher self-esteem, dealing with their own problems more openly, trusting their instincts more, and stating they are a better person. 37 of the counsellors (35%) reported on effects directly related to clients, which focussed on learning from the clients' resilience and learning how to better handle situations with clients (Jenkins et al 2011, p.2403).

Massey et al (2019) also found that SARC workers reported positive effects from their roles. These included them finding the job rewarding and feeling pride in their work. Participants also discussed seeing the importance of their work and how it is meaningful. Additionally, participants raised feeling a sense of camaraderie with their colleagues, and they linked this to coping mechanisms (see section 3.7).

In their REA, Crivatu et al (2021, p.61) summarised positive effects experienced by SV workers, which can fit with the concept of VR. In line with the compassion satisfaction element of VR, participants across studies reported being fulfilled and feeling satisfaction from their work. Regarding the psychological growth aspect, the authors found participants in the studies reported feeling more empowered and confident and positive changes in their perspective, specifically in how they view their own lives and feeling more pleasure in familial and spousal relationships.

Following these studies providing evidence to the existence of VR in trauma workers, and VAW workers, the next section will introduce factors which can contribute to workers experiencing VR.

[13] Open ended questions were as follows – "Please explain why you decided to volunteer or work at a sexual assault and/or domestic violence centre/shelter. What motivated you to pursue this type of volunteership/work?" and "Also, please describe any personal changes you have experienced as a result of your work/volunteership at this or any other SA and/or DV centre/shelter?" (Jenkins et al 2011, pp.2399-2400)

3.6. Causes of Vicarious Resilience

Research has suggested various factors which can contribute to the occurrence of VR. This section will specifically examine the interplay between VR and VT, "bearing witness" to the resilience of their clients, and the interplay of lived experience as factors which can cause VR.

3.6.1. Relationship with VT

McCann and Pearlman (1990a, p.146) proposed that growth and resilience in trauma workers may assist in coping with VT effects, through "activities that provide hope and optimism". As hope and optimism are key aspects of VR, this suggests that VT and VR are closely interwoven concepts. This section will examine how the two concepts are linked.

In Goldblatt and Buchbinder's (2003) research with VAW social worker students (see section 3.3) alongside the negative schema changes found, participants also discussed the positive effects of working with trauma victims. For example, one participant realised through her work how positive her partnership with her husband is, which made her appreciate their relationship more (Goldblatt and Buchbinder 2003, p.267). It was also suggested that if the social work students were encouraged to address the potential negative narratives from work (for example, being constantly aware of the potential for being in an abusive relationship), that they can lead to growth such as empowerment. For example, one participant struggled with identifying issues in her family, but then found the courage to confront her parents over their situation and the effect it has on her young brother (Goldblatt and Buchbinder 2003, p.264). This supports the need for VAW workers to have training on VT and VR, so that they can acknowledge the changes which they are experiencing, and work to turn them into positive effects.

Additionally, semi-structured interviews with 13 mental health workers with torture survivors found that VR and VT coexist (Hernandez-Wolfe et al 2015). Hernandez-Wolfe et al (2017, p.163) stated that VT and VR do not negate each other, but that workers can experience both positive and negative effects at the same time, that trauma work is a "source of both stress and joy". Similarly, case studies with workers who support children victim-survivors of DA (n=4) have shown that workers are more aware of the chances of experiencing negative events in their own lives. However, while they report these VT

effects, they also report VR responses, in trusting "that they had enough strength to face what life might present" (Silveira and Boyer 2015, p.523).

As well as qualitative studies implying a link between VR and VT, this association has been suggested in quantitative research. During a study examining VPTG in different groups of therapists (n=214), using the STSS and the Post-Traumatic Growth Inventory, a significant correlation between STS scores and growth was found ($p<0.1$), specifically that growth declines when STS is high (Ben-Porat 2015). Conversely, in a mixed methods study exploring counsellors' motivation to entering the VAW field (n=106), participants who had higher quantitative scores on the TSI-BS scale for VT also qualitatively reported more positive changes (Jenkins et al 2011).

Following debates on how a higher caseload can lead to higher VT (section 3.4.2), Brady et al (1999) found psychotherapists (n=446) with more exposure to sexual assault cases had higher scores on the Spiritual Well-Being scale. They stated that while "exposure to disturbing material" may have negative effects, that these can "eventually result in a stronger, healthier sense of spiritual wellbeing" (Brady et al 1999, p.392).

These studies all support a link between VT and VR; however, how they are linked, whether they exist separately, but in tandem, or whether VT strengthens or weakens VR responses, are contested, and need further exploration.

3.6.2. "Bearing Witness" to Victim-Survivors' Resilience

A factor that may contribute to experiences of VR in trauma workers is "bearing witness to their clients resilience" (Silveira and Boyer 2015, p.521). Silveira and Boyer (2015) conducted case study research with four child support workers in the DA field, where participants reported being inspired by the strength of their clients and feeling hope and optimism from the work. This implies that by seeing the growth of their clients and how they overcome challenges, positive effects in the worker can occur. The participants also reported how seeing their clients' issues put their own struggles into perspective, which can make them more resilient. This change of view maps directly to the psychological growth aspect of VR.

Similarly, in interviews with psychotherapists who work with trauma survivors (n=21), 90% of participants reported a positive experience in observing and encouraging client growth

and how it is exciting to be involved in their journeys (Arnold et al 2005, p.250). This was also found by Hernandez-Wolfe et al (2015, p.163) (see section 3.5), where “almost all” participants stated that seeing client progression affected their “perception of self” and “general outcome in life” in a positive manner.

These studies suggest that seeing positive outcomes for those they are supporting can facilitate VR and lead to positive effects in trauma workers. Nonetheless, the sample for each study is different to that of this thesis, being conducted with child workers, psychotherapists who work with all trauma, those who work with torture survivors, and child victim-survivors of DA. It is possible that there are differences in experiences of VR for DAAs and how they can be caused, which will be explored in this thesis.

3.6.3. Lived Experience of Abuse and VR

While having lived experience of abuse can influence experiencing VT, it is also possible that being a victim-survivor can interplay with VR. In their exploration of DV and SV counsellor motivation for entering the role, Jenkins et al (2011, n=106) found that professionals who start the work because of their own trauma were more likely to report positive changes due to the role, such as personal growth and understanding themselves better. This finding contrasted their hypothesis that their own lived experience increased negative effects, further illustrating that the interplay between personal experience and VT and VR are not fully understood.

As stated in section 3.4.5, while not focused on VT or VR, Wood’s (2017) qualitative research with victim-survivor IPV advocates found positive effects from their role, alongside the negative effect of being triggered. Participants discussed how their views of the past had changed, with one being able to identify herself as a survivor, whilst others began to “name” their experiences through “new terms and concepts”, which they had learnt (Wood 2017, p.318). One participant stated that she sees a change in herself, saying “that’s not who I am anymore” when thinking about when she was with the abuser, but that she understands “what she went through” (Wood 2017, p.322). While these experiences were not applied to VR, they would fit with the psychological growth aspect of the term, due to growth in how they understand their past. Additionally, participants shared how they can connect with victim-survivors better than non-victim-survivor-professionals, as they can empathise and relate to them.

Similarly, victim-survivor DAAs in Gilbert's research (2020) reported having a sense of purpose from their work, and that they can use their experience to help others, evidencing VR. The victim-survivor DAAs in this study also explained how because of their experiences that they have a natural empathy and have a better understanding of the victim-survivors they work with.

Wilson and Goodman (2021) conducted a grounded theory approach to examine the experiences of 12 DV survivor-advocates in the USA regarding their organisational culture. They found that when survivor-advocates felt their needs and "staff survivorship" were acknowledged by their organisation, they felt better able to cope with "work stress" (Wilson and Goodman 2021, p.2673). Participants also shared that when organisations are more open about DV advocates having their own experiences of abuse that there is an increased sense of belonging and shared values. These positive feelings can link with VR for victim-survivor-advocates.

Further support for increased VR being due to personal experience of trauma can be found in Frey et al's (2017) research into domestic abuse and SV advocates in the USA. This quantitative study with 222 advocates found that experience of personal trauma predicts increased VR through using the Vicarious Post Traumatic Growth Inventory and Compassion Satisfaction subscale of the Professional Quality of Life Scale. However, the researchers suggest that while workers may reflect on their own experiences through their work, which leads to VR, it is possible that those who have experienced personal trauma are drawn to advocacy work due to being resilient people, and therefore the resilience existed prior to their engagement in advocacy work.

While there are more studies including DAAs regarding VR than in VT exploration, there is still a need to further examine DAAs experiences of this concept. As highlighted in section 3.6.1, VR components will inevitably be raised by participants, regardless of whether they are directly questioned on VR. Additionally, the studies highlighted here either do not solely focus on DAAs (as SV advocates are included in Frey et al 2017), or are consigned to research other aspects, such as the effect of victim-survivors on service provision (Wood 2017) or focus on the general impacts of being a victim-survivor being a DAA, without focusing them through the lenses of VT or VR (Gilbert 2020). Consequently, this supports

the need for research to further examine VR with DAAs, including questions about their own survivor status, but also exploring their general experiences of VR.

Following discussion on the existence of VT, how VT is experienced by VAW workers, risk factors for experiencing VT, as well as the existence of VR and what can cause it, this chapter will now explore research regarding how trauma workers can cope with VT and mitigate its effects.

3.7. Strategies for Coping with VT

Pearlman and Saakvitne (1995; and Saakvitne and Pearlman 1996) proposed three types of interventions which can mitigate the effects of VT. The first are personal strategies, which include: identifying which schemas are most important to the worker and addressing how they are disrupted; maintaining a personal life; using psychotherapy themselves; identifying healing, self-care activities, such as pursuing hobbies; and tending to their spiritual needs, whether they are rooted in organised religion, in other humans, or in nature (Pearlman and Saakvitne 1995).

The second type of intervention were professional strategies, including supervision, which can also include external clinical supervision where cases are discussed, as well as support and supervision sessions with managers. They also noted the benefits of developing a professional connection with others, for example through attending workshops; and maintaining a balanced work life by limiting contact hours, or limiting exposure to traumatic stories outside of work, such as violent movies. The final strategy within the professional interventions echoes a cause of VR, in workers remaining aware of the value of supporting others, and the positive effects that their role has on clients (Pearlman and Saakvitne 1995).

The third type of interventions, organisational strategies, include having an appropriate physical setting in which to work, that is safe, private and comfortable, with the option to have items which are meaningful to them on display; having access to adequate resources, such as to supervision, continuing education and being able to take time off; having a work atmosphere which encourages respect; and developing or accessing additional services and resources for clients, which can be utilised by trauma workers so that the worker does not have to “do it all alone” (Pearlman and Saakvitne 1995, p.134). While the final two strategy types could be considered together due to organisational control over professional strategies, to allow sufficient consideration for each point, this section will now assess

research supporting each of these three categories in turn, and whether they assist in reducing workers experiences of VT.

3.7.1. Personal Strategies

Schauben and Frazier (1995) studied female counsellors who worked with SV victim-survivors (n=148). They measured the effects of the work, using questionnaires designed with both quantitative measures and open-ended questions, and asked participants to list which coping strategies they used to deal with "workplace stress". They found that the techniques which were associated with the lowest scores on the researchers own VT scale were active coping (actively doing something to alleviate distress when you identify a personal issue), seeking emotional support from others, planning (making a plan of action for dealing with worries), seeking instrumental support (such as getting advice) and humour. Conversely, behavioural disengagement (acknowledging that they are struggling, but refusing to deal with issues) had an association with higher VT symptoms, while denial of any problems and use of alcohol and drugs had no effect on symptoms (Schauben and Frazier 1995, p.60). Supporting the position put forward by Pearlman and Saakvitne (1995), this study suggests that personal strategies that address issues are useful for reducing symptoms of VT, while attempts to disengage from worries can increase VT symptoms. However, it should be noted that the VT scale used was designed by the authors, and it was not one which has been validated for measuring VT, unlike the TSI-BS. Additionally, the participants were asked to explain how they deal with "work-place stresses" which may have been interpreted by respondents to include problems that do not relate to VT, but to other organisational matters, influencing the results of the study.

Support for negative coping strategies being associated with higher trauma scores can be found in earlier research. For example, in Way et al's (2004, p.66) study, results of the PTSD measuring IES[14] were compared to reports of using certain types of coping strategy, revealing that higher "trauma effects were positively associated with greater use of negative personal strategies". These findings imply that use of negative strategies (defined in this study as reliance on pornography or substances) are not effective in reducing symptoms and possibly worsen effects. However, the findings for this research do not support positive

[14] Limitations for the Impact Event Scale measure used in this study can be found in section 3.2

coping strategies being associated with lower VT scores; in this case, those who reported the greatest use of positive coping strategies reported greater trauma effects. Importantly, the direction of this association is unknown – are participants who used the most positive personal strategies (such as exercise or seeking support from friends) then experiencing greater VT symptomology. Or were these participants experiencing high VT symptomology, so began engaging in more positive personal coping strategies to assist themselves. This line of reasoning to determine the effects of personal coping strategies needs further exploration with trauma workers though qualitative means, to gain a richer understanding of their experiences, acts of coping and which came first.

The importance of physical exercise in coping with trauma work featured in Iliffe and Steed's (2000) interviews with DV counsellors (n=18) with participants reporting routine activities such as going for a walk or gardening. These activities provided counsellors opportunities to "process what they had heard" and were also proposed as an "important way of reminding themselves that the world was not all negative" (Iliffe and Steed 2000, p.408). In these interviews, DV counsellors also reported other acts of self-care as being important, such as eating a balanced diet, getting enough rest, reading or watching films which are non-violent and spending time with loved ones. However, they also stated this needed to be balanced so that they did not overcommit to social engagements when they needed to rest and recuperate.

Additionally, in her study of DV counsellors, Bell (2003, p.520) found that having positive role models both within and outside work can help with coping with the job, as well as faith and spirituality of the workers can providing a buffer against negative effects, for example, that things "happen for a reason".

More recently, SARC workers have expressed the benefit of spending time with family and friends as a means of coping with the effects of their work[15] (Massey et al 2019). Pets were also cited as important, linked with exercise from walking dogs, alongside general exercise and the benefits with coping with their work effects. SARC workers also explained how general self-care through relaxing assisted in managing effects to help them "switch off", including jigsaws and watching television, though participants shared how they "avoid

[15] While focusing on VR and not VT, Frey et al (2017) also concluded the importance of peer relationships in improving VR from their quantitative study with DA and SV advocates.

serious or distressing topics" (Massey et al 2019, p. 699). In this study, alcohol was not used to "maladaptive" levels, but participants did discuss "social or light" drinking as a coping mechanism (p.700). Additionally, self-care and "switching off" was also cited by VAW helpline workers as methods of dealing with the impacts of the role (Taylor et al 2018, p.860). These included tasks such as exercise, socialising and engaging with personal hobbies. Taking time off from work was also raised in both Crivatu et al (2021) and in Greenburg's autoethnographic chapter which provides guidance for coping with VT (2020).

In a review of 27 VT intervention studies, Kim et al (2022) found that interventions included psychoeducation (training on VT and selfcare strategies), mindfulness, art and recreational programmes, and alternative medicine programmes to determine their effectiveness in addressing VT symptoms. Their assessment showed "promising" results (Kim et al 2022, p.1454) for these interventions reducing VT symptoms, however there were some conflicting findings, which need further exploration. One study included in their review sampled 55 DV counsellors (Boone and Castillo 2008) which included the art programme of participants, finding that using poetry therapy, participants can reduce their STS symptoms according to IES scores.

Knight (2013) also explored self-care strategies with practitioners supporting adult victim-survivors of childhood SA. She contended that trauma workers need to acknowledge their thoughts and feelings regarding their work, as emotions are validated only once they are acknowledged. Knight also suggested that workers need to engage in activities which bring them joy in order to counteract negative effects of the work, but emphasised that this will vary for each person, so they need to find "what works for them" (Knight 2013, p.232).

However, there is an issue in suggesting self-care for trauma workers, especially those in the VAW field, for managing negative effects of their role. Even if organisations are promoting and providing resources for workers to access self-care (which is suggested in Bell et al 2003), it still implies that it is the practitioner's fault for developing VT as they do not adequately care for themselves. Within the VAW field, it is frowned upon to take a victim blaming attitude to victim-survivors, for example, in saying they should have protected themselves or left the perpetrator earlier. In line with this practice and following their research on VT in counsellors, Bober and Regehr (2006, p.8) questioned the appropriateness

of victim blaming practitioners, when research and organisations say that professionals should have protected themselves more adequately.

3.7.2. Professional Strategies

This section explores research focussing on professional strategies (Pearlman and Saakvitne 1995), and discusses varying workload, debriefing, accessing supervision, remaining aware of their role limits and the benefits of their work.

Alongside the personal strategies which were reported in their study of DV counsellors, Iliffe and Steed (2000) found that professional strategies are also important. Participants discussed monitoring the levels of their caseload as there are risks involved in having a high caseload of trauma clients (see section 3.5.2). Additionally, having team support and debriefing with peers was cited by all participants and reported by the authors as:

> The most important strategy for dealing with the aftereffects of a difficult counselling session. (Iliffe and Steed 2000, p.407).

However, whilst debriefing was reported as being the most useful strategy for these participants, the need for client confidentiality must be maintained, so this debriefing needs to be managed in a way that helps the worker, while protecting the client, for example, with private details not being discussed in a public environment. Similarly, SARC workers in Massey et al (2019, p.698) cited that support from colleagues was “essential” to being able to do the role. One reason provided for this was that workers have few opportunities to offload due to the confidentiality of their role, therefore they find it helpful to talk to colleagues about the effects of the role when they cannot confide in family and friends.

Linked to debriefing with colleagues, Schauben and Frazier (2018, pp.479-480) reported that DV counsellors rely on peers for “blowing off steam”, and one participant discussed how workers engage in gallows humour as this helps them “let off a little steam”. Craun and Bourke (2014, pp.841-843) state that gallows humour is “placed within the gray area between positive humor and negative humor”, noting that it is “not uncommon” for SV workers to use it to cope with the job. Craun and Bourke sampled Internet Crimes Against Children task force workers (n=508) to study the relationship between STS and gallows humour, finding that gallows humour was occasionally used by participants, but that it corresponded with higher STS levels. They concluded that this could indicate that those who

use gallows humour are struggling with their wellbeing. However, it should be noted that in this study, gallows humour was not defined, which could have affected results due to varying interpretations of the term.

Turning away from informal, colleague support, following a literature review of relevant studies in 1999[16], Sexton stated that trauma work is:

> Too demanding to do without supervision, and this should be understood as an ethical responsibility. (Sexton 1999, p.400).

There are two different types of supervision within trauma work, supervision which links to support and evaluation within the role, usually conducted by a line manager, and clinical supervision, where cases are discussed with an external professional.

In their review of literature[17], Bell et al (2003) examined steps that organisations can take to reduce VT in their staff. Supervision was an essential component for the prevention of VT, with Bell's PhD participants saying that a weight is lifted when they share details of a difficult cases, "you can… give them a couple of your rocks and your sack gets lighter" (Bell et al 2003, p.468). This review, however, stresses the importance of keeping these supervision sessions separate to the evaluative functions of supervision, for example, through recruiting an external clinical supervisor, as workers may be disinclined to share any worries with their managers if they fear it may affect their job security. Regarding workload, the authors summarise the importance of trauma workers having a diverse caseload, with trauma clients being distributed amongst staff so that workers have caseloads which vary in intensity.

Knight (2013) also discussed the importance of supervision in dealing with indirect trauma, stressing that sharing reflections on their responses to their work can validate and normalise workers feelings. However, where this supervision is with line managers, as opposed to clinical supervisors, it is a challenge for the manager to:

> Maintain appropriate boundaries, and not transform the supervisory session into a therapeutic one. (Knight 2013, p.232).

[16] Findings from this literature review have not been included in this thesis in favour of more recent literature reviews which cover more contemporary studies.
[17] This report included a literature review and drew quotations from the lead author's doctoral study exploring the impact of domestic violence on those who work with 'battered women'

With a clinical supervisor, however, this could be less troublesome, as they are trained therapists whose aim is to explore the effect of workloads so that workers can process information and continue with their work. This suggests that there is a role for both line manager supervision (to validate and normalise VT in the workforce, and have more frequent check-ins with staff) and also more structured clinical supervision (to explore VT reactions) in addressing VT.

Formal supervision was also cited as a coping strategy by SARC workers by Massey et al (2019, p.698), yet some participants in this study raised concerns around group supervision sessions, citing difficulties with "bothering" or "offending" others, as well as being concerned about confidentiality. These concerns for group clinical supervision were also raised by VAW helpline workers (Taylor et al 2018) who explained that one-to-one supervision from an external supervisor could help them cope with the role (though they reported a lack of these sessions), and that while group supervision with peers can be beneficial, it should be offered alongside individual sessions because of group dynamics and confidentiality.

Additionally, Sommer and Cox (2006) conducted research with nine SV counsellors. They found that using stories helped with processing their experiences, which they proposed would be helpful to conduct in supervisions. They argued that stories created by SV workers could create "an entry point" for supervisors to explore experiences with workers, which could help recognise and address VT (Sommer and Cox 2006, p.12).

As bearing witness to client's resilience can enhance VR, identifying and witnessing client resilience may also be a helpful strategy in dealing with VT. The final coping strategy reported by DV counsellors (Iliffe and Steed 2000, p.408) was through "identifying clients' resilience and strength". For the researchers, appreciating that clients have survived thus far without the counsellors help means that workers do not feel overburdened with the responsibility for their clients' futures. Moreover, while they are there to guide clients, they are not responsible for the choices they make, and their life is their own to lead. This implies that by workers acknowledging that their role is to assist and empower those with lived experience, but that they are not ultimately responsible for their choices, that they can better manage the effects of the role. This recognition of responsibility and that the victim-survivors' lives are their own sets up boundaries between the worker and client.

Furthermore, Beckerman and Wozniak (2018) (see section 3.3 for more details) contend that showing successful endings to workers could assist in reducing VT as they can then identify the benefits that they have had on another person (which as in section 3.6.2 can also enhance VR). They suggested that for refuge workers who only see clients when they are most in need (due to clients leaving to rebuild their lives):

> The story has no ending, and each new client is an overlay of previous clients who also arrived in dire trauma. (Beckerman and Wozniak 2018, p.484).

While this was not a focus within their study, the authors suggest that future studies should examine the effect of being exposed to success stories on VT levels in trauma workers, especially DAAs, which this thesis will explore.

However, the existence of these strategies, even if workers are satisfied with their implementation, are not necessarily effective in reducing VT. Research conducted with Israeli DV therapists (n=143) examined the effects of supervision on STS, burnout and role competence (Ben-Porat and Itzhaky 2011). Comparing results from quantitative questionnaires including the STSS, it was found that while being satisfied with supervision was associated with higher role competence, satisfaction with supervision was found not to significantly correlate to STS scores (Ben-Porat and Itzhaky 2011, pp.102-103). However, this study did not examine the quality of supervision, only whether participants felt satisfied with supervision. Therefore, while workers may feel satisfied with supervision, they may not be receiving guidance or support, which could lower their VT responses.

Supporting this position, in a study on predictors of STS in DV advocates, it was found that "quality" supervision, where workers report an "engaging, authentic and empowering" relationship with their supervisor was a protective factor in experiencing STS ($p<.01$, Slattery and Goodman, 2009, p.1369). Nonetheless, as previously stated, this study used a PTSD scale to measure STS; therefore, this finding may imply that quality supervision is effective in reducing effects from their own trauma, while further research needs to be conducted regarding VT.

To ensure that workers are accessing supervision which makes a positive difference to them, Tarshis and Baird (2019) devised a four-level framework[18] which could create

[18] This framework was devised following findings from a systematic literature review of 20 complete articles.

adequate supervision for supporting workers who may experience VT. These first three levels are intrapersonal (recognising vulnerability to VT), relational (setting boundaries with clients) and community/organisational (trauma training and structured/clinical supervision). These points further highlight the need for workers to have VT training (section 3.5.3 and Kim et al 2022) so that they can recognise their vulnerability, recognise VT and know how to mitigate it. The need for setting boundaries at the relational was also raised by Iliffe and Steed (2000) and Greenburg (2020).

3.7.3. Organisational Strategies

Tarshis and Baird's (2019) last level for good supervision concerns the organisation focussing on structural and environmental steps, for example in banishing the stigma of VT. This section will explore the different strategies which are deemed as Organisational Strategies by Pearlman and Saakvitne (1995).

Bell et al's (2003) article on organisational strategies to prevent VT in their staff raise numerous actions, but also highlight the importance of the organisational culture. They argue that organisations which include trauma work should acknowledge and normalise VT, which would provide an environment in which workers would feel more comfortable in communicating that they need support. Organisations can also assist in reducing VT by ensuring that staff use allocated annual leave and accrued time, and by providing opportunities for staff to vary their workload and access continuing education. In organisations where trauma workers may be at risk of violence, which can exacerbate disrupted schemas of safety and trust in line with VT (such as working in refuges where there is a risk of perpetrators finding their victim, or offices with openly advertised locations), organisations can also reduce the fear of being exposed to violence by ensuring the environment is safe. For example, security measures could be introduced or through implementing a buddy system for lone-working staff. Organisations can also reduce the development of VT by allowing workstations to be comfortable, and to have personal items, so that trauma workers can have items available to uplift them if they are experiencing negative feelings (Bell et al 2003).

Crivatu et al (2021, pp.62-23) highlighted that workers' perceiving the organisation as "organizationally and operationally supportive" can reduce VT, while organisations which provide negative or conflicting messaging can hinder wellbeing. Supporting the suggestion

that organisations can aid workers by giving them control over their workstations, workload and education, during their quantitative study on DVAs, Slattery and Goodman (2009) found that when using a regression analysis, the only significant workplace factor which associates with lower STS results ($p<.01$, using the PTSD scale) was when participants reported working in an empowering environment. This was where they felt respected in their role and by their organisation and had "access to power", such as having the opportunity to initiate or lead projects (Slattery and Goodman 2009, p.1365).

Alternatively, half of the DV counsellors interviewed by Iliffe and Steed (2000) reported that socio-political involvement was important to deal with the effects of their work as it gives them a constructive path to channel their emotions. This suggests that it is helpful for workers to able to direct their negative feelings into changing the socio-political landscape, for example, protesting gender inequalities, which aims to reduce the need for VAW workers.

This section has explored different personal, professional and organisational strategies which can help in coping with VT. However, these studies only sampled wider VAW workers, and while there may be similarities between these and DAAs, this cannot be established without an empirical evidence base.

3.8. Highlighting the Gap

This chapter has assessed the research surrounding Vicarious Trauma (VT) and Vicarious Resilience (VR), examining the effects on workers in different fields and how those in the VAW field may experience heightened VT responses, especially surrounding feelings of trust, safety and intimacy. It explored the risk factors for experiencing VT, before evidencing the existence of VR, causes of VR and strategies that have been adopted to mitigate VT. Throughout this discussion, areas have been highlighted which would benefit from further research and the review informed the central research questions for this doctoral study.

While there is existing research regarding VT and VR in the VAW field, few studies focus directly on Domestic Abuse Advocate (DAAs), or those in equivalent roles (Frey et al 2017; Gilbert 2020; Slattery and Goodman 2009; Wood 2017). The majority of studies are concerned with the experiences of social workers, mental health counsellors and therapists. Yet, alongside providing emotional support, DAAs also give practical support, such as providing emergency housing in refuge, parenting support and legal support. Therefore,

arguably DAAs are more involved in victim-survivors' everyday lives than counsellors and other practitioners delivering therapy sessions. Accordingly, research needs to build on existing literature to determine the effects of VT and VR on DAAs. Within this chapter, there has been exploration of personal, professional and organisational coping strategies for VT, as well as the causes of VR. However, much of the research on these strategies have conflicting results and it will be useful to explore these tensions with DAAs.

Aside from some qualitative studies regarding the exploration of the existence of VT and VR (Arnold et al 2005; Beckerman and Wozniack 2018; Goldblatt and Buchbinder 2003; Hernandez et al 2007; Iliffe and Steed 2000; Steed and Downing 1998), the evidence surrounding VT and VR are mainly based on quantitative research studies (Baird and Jenkins 2003; Ben-Porat 2015; Bober and Regehr 2006; Cunningham 2003; Jenkins and Baird 2002; Frey et al 2017; Pearlman and MacIan 1995; Way et al 2004; Van Deusen and Way 2006; Violanti and Gehrke 2004). Where qualitative studies have explored these topics, these have been through standard interviews and focus groups. Considering the methodology used in the field, a more participant led, creative approach could potentially generate different insights, which has been considered in relation to the current study.

Following the review of the literature, this research will be conducted with Domestic Abuse Advocates (DAAs) in an exploratory, qualitative study, utilising creative methods to give choice and freedom to participants in how they communicate the effects of their work. This exploration will be guided by the following research questions -

1. Through the lenses of Vicarious Trauma and Vicarious Resilience, what are the effects of being a Domestic Abuse Advocate on the individual?
2. How do Domestic Abuse Advocates manage the negative effects of their work, and how do they build on positive effects?
3. Are there any individual and organisational factors which affect how Domestic Abuse Advocates experience and manage effects from their work?

The VT aspect of research question one derived from the lack of academic research into DAAs experiences of VT, which I was driven to explore due to my own personal experience and interest in the topic. The VR aspect of the question stemmed from the discovery in literature that even when VR is not asked about, positive aspects of trauma work are raised by research participants. Therefore, to explore VT and not VR in DAAs would not produce a

full picture of experiences of effects. Research question two was proposed to find practical ways which can assist DAAs in managing the effects of their work, which was guided by the strategies cited by other samples in existing literature. Before beginning this thesis, research question three originally focused on the influence of DAA's own lived experience. However, on reviewing the literature, contradictions in other factors, both individual and organisational became apparent. Therefore, research question three was expanded to explore what organisational and individual factors are reported by DAAs in influencing the effects they experience from their job.

The next chapter will present and justify the methodological choices and practice in this study.

4. Methodology

4.1. Introduction

The previous chapters offered a review of the literature and demonstrated why this study is needed, as well as setting out the key areas of focus. This chapter documents how the project was designed and conducted. The chapter initially explains the constructivist and feminist perspectives which informed the case study research design. Participatory Action Research (PAR) is then outlined and the chapter details how principles from this approach were drawn on in designing the research. This leads to a justification of why individual interviews involving creative methods were chosen to explore the nuanced experiences of Domestic Abuse Advocates (DAAs).

Section 4.3 introduces the research site, presenting an overview of the organisations which were involved in the study. Section 4.4 reflects on my positionality as a researcher, examining how my own background and identification as a partial 'insider' influenced the research. Section 4.5 outlines the design consultation and the changes stemming from this consultation process. The methods of data production will then be evaluated in section 4.6, setting out the rationale for the modes of engagement offered to participants in the study. A pilot study was also conducted for this research and consideration of this is the focus of section 4.7. Ethical considerations will then be explored in section 4.8, including issues around informed consent, protecting participants, and protecting myself. Section 4.9 explains the inclusion criteria and recruitment process and introduces the research participants. Section 4.10 discusses how data was produced with participants, outlining the actions taken before interviews, during stage one of the project and in stage two. The framework of thematic analysis is provided and justified in section 4.11.

4.2. Research Design, Approach and Methods

The design, approach and methodology for this study was informed by the topic and research questions, as well as the positionality of the researcher. This section outlines and justifies how the design, approach and methods were appropriate to attend to the research questions, which are as follows:

1. Through the lenses of Vicarious Trauma and Vicarious Resilience, what are the effects of being a Domestic Abuse Advocate on the individual?

2. How do Domestic Abuse Advocates manage the negative effects of their work, and how do they build on positive effects?
3. Are there individual and organisational factors which affect how Domestic Abuse Advocates experience and manage effects from their work?

4.2.1. Research Design

My epistemology aligns with constructivist thinking, that knowledge and social realities are actively constructed by agents (Baert et al 2014). More specifically, my view of constructivism aligns with that of the sociologist Karl Mannheim and his position that knowledge is:

> Always produced from a specific social and historical standpoint, reflecting the interest and culture of the groups in question. (Delanty 1997, p.113).

As discussed in section 2.3.5, the concept of Vicarious Trauma (VT) was built from Constructivist Self Development Theory (CSDT, McCann and Pearlman 1990b) which takes a constructivist view of people actively building their realities through engagement with their environment. Therefore, taking a constructivist position aligns with this research into VT and Vicarious Resilience (VR), which recognises the importance of exploring the subjectivity of individuals experiences and meaning making (Jonassen 1991). This counters the positivistic trend of previous research into VT where quantitative approaches have dominated (see section 3.3). In these positivist, quantitative studies, focus has been on assessing prevalence and measurement of experiences, over understanding interactions and the nuances within experiences. Therefore, in this study, a qualitative design was adopted so that subjective experiences of DAAs regarding VT and VR could be explored.

Feminist research was conceptualised to counter male dominated, androcentric studies which have been central in the social sciences (Renzetti 2018). The core principles which guide feminist research are a recognition that gender is socially constructed into femininity and masculinity; that these are organising principles for social life; that most societies are characterised by sexism; and that female experiences should be included in research (Renzetti 2018, pp.74-75). Research by, and the focus of, radical feminists also frequently centres on Violence Against Women (VAW) (Mackay 2015).

Feminist theory can be used as a framework which informs the whole research process, including deciding on methodology and data analysis (Campbell and Wasco 2000; Kaur and Nagaich 2019). However, in this research, the feminist lens was only used to guide the conduct of the study, and contact with participants, and not as a conceptual lens with which to analyse findings. Drawing on principles of feminism and a feminist lens enabled me to conduct this research in a sensitive and ethical manner, specifically in applying a feminist ethics of care, which consists of having consideration for all people involved in the process (Fisher et al 1990; Keller and Kittay 2017).

In line with the ethics of care, a central justification for why a feminist lens was adopted for this research lies around the awareness of power imbalances between myself as the researcher, and the DAAs participating. Feminist researchers have argued against participants being "treated as objects to be worked on" (Abbott and Wallace 1997, p.287) with researchers taking what they want from populations and then leaving "satisfied", regardless of the effects on the participant. Feminist researchers therefore strive for constant awareness of power imbalances throughout the whole process[19], and suggest that qualitative co-research, conducted with the affected population can address these issues and maintain agency for participants (Harding 2020). Therefore, I applied a feminist lens in order to stay aware of these imbalances, and acted to minimise them through my research approach (see section 4.2.2).

This feminist lens and application of the feminist ethics of care also induced consideration of the wellbeing of research participants. Applying this feminist lens prompts researchers to be empathetic in their conduct (Renzetti 2018), addressing how their research is affecting stakeholders at each level and stage of the process. "Maximizing harm reduction" is another key aspect of the using the feminist ethics of care when working with participants, and researchers also need to be aware of vulnerabilities of their participants (Drenton and Gurrieri 2025, pp.7-8). This was especially important for this research due to the sensitive nature of the topic, and discussions around trauma and personal experiences.

Additionally, the use a feminist-lens for conducting this research is appropriate as it centres the experiences of those who support victim-survivors, who are predominantly women (see

[19] This is not to say that non-feminist research does not address power imbalances, nor that all feminist research achieves this aim, but that is a prescriptive aim of this approach.

section 2.2). The very job of a DAA has also been created by VAW which characterises patriarchal oppression in the lives of victim-survivors, and there was the possibility that many participants would also have lived experience of abuse.

However, while applying a feminist lens to research can help researchers act ethically and assist in being aware of these power imbalances, the notion of a truly equal relationship between researcher and researched has previously been called “an illusion” (Grenz 2014, p.72). This is because it is the researcher who ultimately decides what to include in the study and subsequent reports. Throughout this study, I endeavoured to check my initial decisions and themes with participants (see section 4.11.2), however, this inherent power imbalance will be reflected on in the conclusion.

This research adopts a case study design. Yin defines case studies as:

> Investigating a contemporary phenomenon (the “case”) in depth and within its real-world context. (Yin 2018, p.15)

This is apt for addressing the three research questions for this project in exploring the effects of being a DAA and how these are mitigated. A key component for case study design is “bounding the case” (Yin 2018, p.31) where boundaries of the case which will be researched are defined. For this project the boundaries could be formulated in various ways: with individual cases per participant to form a multiple-case study; each organisation as a case; or Wales’ Domestic Abuse Services (DAS) as a case, within which the effects and mitigations are explored. Considering research question three on individual and organisational influences, and as a case study focuses on exploration of a phenomena, this research considers the case boundary as DAAs working in any Welsh DAS. This makes the study a type two case study, of a singular case with multiple units (Yin 2018). Within this case, experiences and tactics of individuals and the impacts of organisational measures relating to VT and VR are considered. The case as a whole is further defined in section 4.3.

4.2.2. Research Approach

Collaboration consistent with feminist-thinking aligns with Participatory Action Research (PAR). For Kindon et al:

> PAR involves researchers and participants working together to examine a problematic situation or action to change it for the better. (Kindon et al 2007, p.1)

While PAR may be most affiliated with qualitative methods, it can be used across different designs, if it includes collaboration, a cyclical process and striving for change. This research used principles from the PAR approach, drawing on aspects of collaboration, reflection, and striving to create change for DAAs.

Levels of collaboration within different PAR projects vary, with some involving participants in all decisions and aspects of the research, and others only involving participants at certain points along a scale of involvement (Brown 2021). These approaches recognise that participants are experts of their experience and should be included in research which concerns them to gain valuable insights, while simultaneously challenging researcher led paradigms. To acknowledge participant expertise and to improve their control over research which concerns their wellbeing, this research involved participants in repeated stages during the process for data generation and analysis, which will be outlined in section 4.6. Design consultation and a pilot were also conducted with DAS managers and a VAW worker, which are discussed in sections 4.5 and 4.7 respectively.

PAR designs also have a primary purpose of generating change and providing practical outcomes and actions (Kindon et al 2007; Selener 1992). This relates to this research as VT is a practical issue for those who support victim-survivors, and this study aimed to produce outputs that could assist DAAs in identifying and managing VT and VR. The resulting research outputs will be presented in the final chapter of this thesis.

Another principle of PAR is that it is a cyclical process, between action (including planning and observation) and reflection (Walker 1993). Contrasting with a process for non-PAR research, the cyclical PAR process includes more reflection and questioning of researchers' choices and practices, and there is an expectation that researchers will document them, inquire and discuss their reflections with others (Wadsworth 1998). To counter my identification as an insider (section 4.4), reflection throughout the process on choices made and action taken aligns to this aspect of PAR.

It is important to acknowledge that this study did not adopt a fully PAR approach. While the study did adopt PAR principles that informed the design and conduct of the study, including participants being involved in reviewing findings, creating action and though reflecting on my own influence, it did not actively involve participants in all processes of research to the

extent that PAR has been adopted in some earlier studies (Brown 2021). This will be reflected on in section 9.4.2.

4.2.3. Research Methods

Within the qualitative approach from constructivist and feminist principles, this study drew on individual interviews with a small sample of participants (n=13). Focus groups can be appropriate in exploring experiences which are shared in a demographic (Smithson 2008). However, participants may be hesitant to share personal insights into VT and VR if they are in a group with colleagues, or potential competitors due to the challenging nature of domestic abuse (DA) funding[20]. Individual interviews enable participants to share their views in confidence, without fear of reprisal. This is important as if participants felt that their ability to conduct support work had been compromised by VT, they may feel unable to share this in a focus groups setting where they could be identified, and any information shared could potentially be used against them in employment reviews or during competitive funding bids.

Creative methods have not previously been used to explore VT and VR in DAAs (section 3.9), but this study adopted a creative approach to qualitative interviews. Banks (2018, pp.7-8) highlights two strands of visual methods: the first involves images collected by the researcher which are then shown to participants to document or analyse experiences, while the second involves images which participants have either produced or consumed. Creative methods align with this second strand of visual methods, where participants create aspects which assist in explorations into desired topics (Mannay 2016).

While creative methods can be associated with researching children to encourage participation and agency (Johnson 2008; Lemon 2019; Watson et al 2021) they have also been employed in research with adults (Mannay et al 2017; Rainford 2020; Staples et al 2024). Creative methods practitioners highlight how these methods can aid in gaining more nuanced insights about the experiences of participants' social lives (Banks 2018; Mannay 2010; Mannay 2016; Rainford 2020). For example, in Rainford's research with educational practitioners, creative methods served to stimulate discussion of everyday practice so that it

[20] Some services in DAS and the roles within them (specifically refuge services and floating support community services) are fixed term contracts, which are put to tender at the end of the contract. When services are put to tender, organisations compete over gaining the contract, while workers may have to compete for job vacancies.

could be reflected on and allowed a “deeper consideration than a question-answer format” (Rainford 2020, p.110).

Another benefit from using creative methods is that introducing a third object into the interview process to form elicitation interviews can reduce the awkwardness which can be experienced by participants when taking part in interviews. This is because both participant and researchers’ attention can be focussed on the object, which reduces eye contact and awkward silences while participants think about and answer the question (Banks 2018, p.76). This can also help in discussions of sensitive topics, as the creations can act as a physical barrier between the participant and topic (Kara 2015), which can protect them from traumatic accounts, which is also the case with this research.

Creative methods also complement following principles of PAR through providing agency to participants throughout data production, enabling them (rather than the researcher) to lead the discussions with their creations (Mannay 2010; Watson et al 2021); and creative methods also encourage action (Brown 2021). These complementary features reinforce the choice of creative methods being introduced alongside PAR within this project. Furthermore, creative approaches were also selected because they can be of benefit when the researcher is an insider to the field or research topic, as in this study (see section 4.4).

Therefore, creative methods were provided as an option to participants during the first stage of this research, during initial interviews. In keeping with facilitating agency, participants were not obliged to partake in creative methods, and had the option to engage in standard, semi-structured interviews instead if preferred. Participation in semi-structured interviews, as opposed to creative methods, is not a negative for the research or participants, as it was important that participants felt comfortable during the interviews so they could share their experiences and did not do anything they found uncomfortable. Additionally, questions were planned so that required information could be gathered regardless of participants choice of method. The creative options available to participants, and further exploration of standard semi-structured interviews will be discussed in section 4.6.

4.3. Research Site – Defining the Case

This research concerns Domestic Abuse Advocates (DAAs) who work within Domestic Abuse Services (DAS), and the effects on them as they are exposed to traumatic material while

they provide emotional and practical support to victim-survivors. This section will explore the research site to define the case, providing information about the services which took part.

As stated in section 2.2.2, the Welsh Government were the first of the home nations to introduce an Act focussing on Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) aiming to improve the lives of victim-survivors, prevent abuses and support DAS. While the UK Government has since passed the Domestic Abuse Act 2021, since the VAWDASV Act was passed in 2015, there has potentially been more time for focus on quality of services and therefore been more focus on staff training and wellbeing in Wales. Additionally, the geography of Wales is varied, comprising of dense urban areas through to remote rural areas, each of which is covered by a locally focused DAS, providing access to support for a variety of abuses. For these reasons, along with my own existing networks within the Welsh sector, DAAs in services in Wales were the case of this study.

There were 26 organisations which provide support to victim-survivors in Wales (Welsh Women's Aid 2021a) from which participants could be recruited. To form the case, six DAS from across Wales were approached for recruitment and involvement in the research, making them gatekeepers for the process[21]. Of these six organisations, five engaged with the project[22].

These organisations assisted by sharing information about the research with their staff members (see section 4.9.2), provided confidential spaces in their offices for the research to take place if participants chose to have interviews there, and also consulted on organisational aspects which could have an impact on their staff members experiences of VT and VR. Managers from all five services shared organisational aspects, a summary of which are included in Table 2. To protect participants who were recruited from their organisations and business sensitive information, the DAS which were represented have been given a pseudonym, and identifiable information has been removed.

[21] On commencing this PhD, I contacted all DAS in Wales to establish interest in the project. The five DAS which engaged (plus the additional DAS I contacted but did who did not engage) were sampled from the interested parties to cover a variety of geographical sites.

[22] An additional DAS was not approached to replace the sixth as recruitment numbers from the existing five DAS were sufficient.

Table 2 - Summary of Domestic Abuse Services Involved in the Case

Pseudonym	Staff Levels	External Clinical Supervision
Empower DAS	70+	Group - quarterly for all frontline staff. Option for 1-2-1 if preferred.
Guidance DAS	100+	Group - every 2 months for DAAs 1-2-1 if needed, but employee counselling offered first due to Clinical Supervisor capacity
Liberty DAS	30+	One team has clinical supervision monthly due to staff changes. In other teams, a need for clinical supervision needs to be raised with a line manager and it will be provided. This is due to funding constraints and staff not wanting it.
Autonomy DAS	40+	Individual - 2 monthly – can opt out if they want but this is not encouraged (SV Service get monthly)
Encourage DAS	100+	Individual every 6 weeks. Staff encouraged to attend. IDVA individual every month.

Across the five organisations, staff levels ranged from over 100 to in the thirties, including some services which had merged neighbouring services together (leading to higher total staff numbers), and others which had retained a local service only. All organisations provided refuge services, community support, various programmes (such as the Freedom Programme[23]), drop-in services and some level of Children and Young People (CYP) service or programmes. Additionally, three organisations included sexual violence (SV) services and two employed trained counsellors; however, these staff were not the focus of this project (see section 4.9.1 for inclusion criteria).

All five services stated that ideally, they require DAA recruits to have prior experience in a support work role (with most setting this as a minimum of two years) with no needed formal qualifications. However, at the time of these discussions, some managers shared that recruitment was difficult, and they were receiving minimal applications, leading to them becoming more flexible in prior experience, in favour of value-based recruitment.

[23] See section 2.2.6 for information on the Freedom Programme and other services.

Additionally, some DAS have introduced junior roles where staff can learn on-the-job. However, the smaller organisations (Autonomy DAS and Liberty DAS) said that this was not possible as new staff needed to "hit the ground running" due to the demands of the role and capacity levels. Despite this, all five services provide inductions, which include all necessary training for the job, and staff can attend further training if a need is identified.

Support and supervision sessions with line managers were conducted across services. While all organisations had some capacity to provide external clinical supervision (ECS), this varied, from needing to be requested for most teams in Liberty DAS, to group clinical supervision every three months (Empower DAS), group clinical supervision every two months (Guidance DAS), individual clinical supervision every two months (Autonomy DAS) and individual supervision every six weeks (Encourage DAS). For the organisations who provide group clinical supervision, managers stated that staff can access individual supervision if they prefer, or if a need is identified by individuals or managers for more tailored support.

Although some organisations stated they had high levels of turnover, the managers said that leavers rarely cite VT or wellbeing as reasons for terminating employment[24]. Managers were also asked about their sickness rates which were reported as being normal, with only two staff members across the five DAS reported as being off sick due to VT[25].

While none of the organisations had specific policies on VT at the time of the consultation, three had wider wellbeing policies which referred to VT, and another was developing a wellbeing policy. Two DAS reported that they have a dedicated wellbeing officer or staff wellbeing representatives to assess and share concerns around staff wellbeing.

Managers were also asked to explain any additional measures they take to benefit staff wellbeing, reduce VT and encourage VR. All organisations stated they are flexible for emergencies, and three of the organisations stated they have staff away-days to build staff rapport and to reward their hard work, while one provides specific funding for staff led events.

[24] However, one manager suggested that leavers were not always honest about their reasons for leaving in exit interviews, so VT may have been a more justification than cited. Instead, high turnover was cited as being due to contracts ending, staff not passing probation, or staff moving to higher paid roles.

[25] Both of these staff members were dedicated SV workers, and ineligible for this project, see section 4.9.1.

4.4. Researcher Positionality

I undertook study surrounding DA as I have both professional and personal experience in the field. As stated in section 1.2, I worked for six years in a Welsh national umbrella organisation for DAS conducting research and evaluation, and I frequently had contact with managers and workers in DAS and victim-survivors of all abuse types. Subsequently, I built professional relationships with managers and workers in DAS. This immersion in the sector exposed me to both the negative and positive effects on workers of providing support to victim-survivors, which sparked interest in exploring the concept. I also became aware of my own VT from the sector, especially changes in my own schemas around self-safety and other-trust (see section 2.3.5). As well as having professional experience in the field, I also identify as a survivor-professional, as I have my own lived experience of VAW. Consequently, I am acutely aware of the complexities in the interplay between personal experience and views, and professional roles and requirements.

All researchers should be aware of their positionality, and how this can affect projects (Lumsden 2019), and because of my own experiences and familiarity with the sector and participants, I needed to be aware of the impacts of this 'insider' positionality. Identifying as an insider to the sample can have benefits for conducting research, such as my existing knowledge of the field and the current context surrounding the target sample (Greene 2014). This meant that I was already aware of the overall requirements for DAA roles, acronyms for abuse types and related services, understanding of risk assessments, and tensions in the field. Therefore, I did not have to ask for explanations, for example of acronyms such as MARAC (Multi Agency Risk Assessment Conference), during interviews, which could have reduced the available time for discussions, and disrupted the flow of narratives. Another benefit of my insider status was that participants may have put more trust in me and this research (Ellard-Gray et al 2015), and also trusted my ability to engage with them "without passing judgement" (Rowlands 2022, p.18). Thirdly, being an insider aided recruitment and access to participants (Greene 2014), for example, through having existing knowledge of processes such as correct emails for contacts.

While being an insider can provide these benefits, there can also be limitations to being closely aligned with the field or participants. For example, sharing some of my background to gain trust, such as identifying my own VT from the field, could result in participants not

fully explaining the effects or changes to their schema, instead only alluding to effects; for example, saying “You know what it’s like” instead of explaining the exact effect on them (Aburn et al 2021; Chaplin et al 2018). Another concern with identifying with participants’ experiences, may be unknowingly looking favourably on participants or their actions (Henderson 1998), or the opposite, of (unknowingly) discounting any findings which do not align with the researchers own experience (Chammas 2020). To mitigate these negative effects of being an insider I was reflexive throughout the entire process (Greene 2014; Lumsden 2019; Rowlands 2022). This included using a reflective journal (see section 4.8) and the inclusion of second stage interviews, where my categorisations of findings and themes could be explored with participants, ensuring they matched their experiences and had not been dominated by my own interpretations. Reflections on the effect of my positionality, and reflections on the process of the research will be presented in the conclusion.

Additionally, as a previous colleague to managers and potential participants in this study, I also needed to navigate the transition from “friend to researcher” (van den Scott 2018, p.2). This familiarity needed to be addressed throughout the project to ensure that participation and recruitment were ethical, with participants not feeling obliged to take part. To counter this I set boundaries through conversations and paperwork with participants. This clarified that participation was voluntary, and information they shared during interviews was data to be gathered and recorded for analysis, in contrast to “water cooler conversations” that we would have had while I was a colleague, or friendship discussions outside of work. More discussion of the ethical implications of participation due to my previous role in the field will be discussed in section 4.8.

While identifying as an insider can have these benefits and limitations, being categorised as simply an insider or an outsider does not reflect the complexities of social and personal identification (Roberts 2018). A researcher will never be a complete insider with their participants (Henderson 1998). This is because while a researcher may have some similarities with participants, all intersectionalities cannot be matched (Maniatt and Coates 2022). For example, while I am a survivor-professional, I may be a different age or ethnicity to my participants, which could influence our views and experiences. Another factor which distances me from being an insider is that I have moved from the position of being a colleague in the sector, to a researcher in the field.

Despite debates surrounding insider-outsider influence, the potential of personal influence still needs to be acknowledged and limited to ensure participants' insights are not affected by my prior knowledge. Visual methods are useful for making the familiar strange when the researcher identifies as an insider (Mannay 2010) as they give participants freedom to lead data production, which can produce unexpected discussions. During Mannay's creative research with mothers and daughters, where she identified as an insider, being led by participant's creations revealed information which she would not have otherwise discussed (Mannay 2010). This suggests that enabling participants to lead data production can distance researcher influence and ensure that participants are free to create and discuss what is important to them. This benefit reinforces my use of creative methods within this project, not only as a tool to provide an in-depth view of subjective experiences of DAAs, but also to limit my influence on participants and findings as an insider.

4.5. Design Consultation

As noted in section 4.2, in line with PAR approaches, three service managers provided feedback on my initial design[26]. These discussions informed aspects of the design and process for the research. While the managers agreed with most points of the research design, there were two key aspects on which they independently proposed amendments.

Consulted DAS felt that all participants should be given a variety of choices for the creative method, as well as the option of standard, semi structured interviews, which did not have a creative aspect. While they thought that some participants would happily engage with my initial chosen creative method of sandboxing (see section 4.6), they advised that not offering a choice of creative methods or a standard interview would ostracise some potential participants. Following these discussions, I provided all participants four options, three including creative methods (see section 4.6) and the option of a standard, semi-structured interview.

Secondly, managers fed back on the proposed timings of the study, involving participants at two points, initially to produce data, and then nine-months later to assess any changes and to discuss initial findings. Discussions in the consultations suggested that this may be too long as many DAAs are on fixed term contracts. They advised that the second meeting

[26] An additional service was also approached, however whilst being interested in supporting the project, the manager was unable to meet with me during this time.

should be set at six months, and that ideally the whole data production should fall in one financial year (April to May) as these dates are when contracts and funding are usually reviewed. Therefore, I organised recruitment and both stages within one financial year (2022-23) and reduced the time between the stages to six months.

4.6. Methods of Data Production

This section will present and justify the methods of data production used in this research, including pre-interview data, stage one elicitation interviews and creative methods, and the structure of the stage two interviews.

4.6.1. Pre-Interview Data

A background information sheet (Appendix 1) was completed by all participants prior to interviews. This form included questions related to factors reported in the literature review (see 3.4 and 3.6) which can affect experiences of VT and VR, namely own experience, time working in the field, time working in their current organisation and current and usual caseload.

While individual experiences of abuse were not the focus of this research, to assess whether being a victim-survivor has an impact on VT and VR in DAAs, participants were asked whether they consider themselves to have lived experience of domestic abuse, sexual violence, or other forms of violence against women. Discussions of experiences of VT can upset and re-traumatise victim-survivors (Baird and Mitchell 2013) meaning participants may not want to share whether they consider themselves victim-survivors. Therefore, the background information sheet gave them the options to answer yes, no or prefer not to say. An asterisk directed participants to the bottom of the page[27], where they were informed that they would not be asked questions about their experience (see section 4.8 for the related ethical considerations).

4.6.2. Stage One - Data Production

This research was structured in two stages. Stage one involved initial interviews with participants. Following design consultations, participants were offered four different options - three were elicitation interviews with creative methods, and the other was an interview

[27] The positioning of this was finalised at the bottom of the page – section 4.7.1 will discuss this positioning following pilot feedback.

without a creative activity. Elicitation interviews involve using visual materials, such as photographs, objects, drawings or videos as stimuli to prompt discussions with participants (Pauwells 2019). Participants then discuss the content of the stimuli and explore their deeper feelings, thoughts and positionality regarding it.

The first creative option was picture creation through the medium of drawing, which involves participants making an image on a topic to discuss with researchers (Scott 2020). However, while this approach can be used for participants to express their experiences and individuality, some participants will feel anxiety around drawing due to confidence in their skill (Lyon 2020). To acknowledge this anxiety surrounding creative methods, and participants confidence in engaging with them (Rainford 2020), the creative options ranged from those which could be perceived as more artistic (drawing) through to a middle option, and a creative option which does not require physically making a creation.

The middle creative option provided to participants was the sandboxing method. The sandboxing method was adapted from the therapeutic world technique (Lowenfeld 1939). It enables participants to create scenes in sand using figures which represent their response to a topic or question (Mannay 2020). In sandboxing interviews, participants were given a box, half-filled with play sand, as well as 210 figures which can be placed anywhere within the box to create their scene. The sand itself is also a vehicle for communication in building a scene, for example, figures can be buried, or the sand can be moved to create hills or troughs to aid in representing participants' reflections (Watson et al 2021). As well as creating static scenes, sandboxing also enables participants to change their scene throughout the interview, telling a story or demonstrating change (Mannay et al 2017; Mannay, 2020). While this option does require participants creating a scene, the figures themselves do not need to be made, the creation lies in their positioning.

The final, and least creative method offered to participants was object elicitation. Object elicitation uses existing items as a focus point for discussions with participants (Grant et al 2018). For this option, participants are asked to bring an item to the interview which they believed represented their response to a question or topic. This option enabled participants to take part in elicitation interviews without them needing to create anything, making the method more accessible to those who have anxiety around, or lack confidence in, their artistic abilities.

Following the creative data production and the elicitation interviews, the interview continued in a semi-structured format to ensure the data produced could adequately address the research questions[28]. Participants were given the option to forgo any creative elements, and progress immediately to the semi-structured interview. Many studies utilising creative methods find that some participants opt out of creative methods (Mannay et al 2017; Mannay 2020; Rainford 2020) and managers in the design consultations also expressed the need for an option that was not creative (see section 4.5). Semi-structured interviews are formatted so that interviewers have a guide of questions to ask, but where they have leeway to follow lines of enquiry which are raised organically in the process of speaking to participants (Brinkmann 2013). Interview guides for semi-structured interviews should be formed from prior knowledge and literature reviews into a topic, so that relevant lines of enquiry are addressed consistently with all participants (Kvale and Brinkmann 2015). Accordingly, the interview guide for stage one interviews (see Appendix 2) was informed by understanding of context and concepts (see Chapter Two) and the empirical evidence (see Chapter Three) and included questions on the VT related schema (see section 2.3.5) VR criteria (section 2.3.8) and possible aggravating and mitigating factors for these factors (Chapter Three).

4.6.3. Stage Two - Data Production

The stage two interviews began with a summary of the data generated in the participants first interviews. These were summary sentences of each key point with some illustrative direct quotes. The purpose of this was twofold – firstly, to confirm that their experiences had been correctly understood, and that any quotes had not been taken out of context to ensure validity of transcriptions (Birt et al 2016). Participants were also asked clarifying questions on points if required. While providing word-for-word transcripts of their first interviews would have checked validity more accurately than reading a summary to them, these would have taken considerable time for participants to read due to interview lengths, and participants could only take limited time out of their working day for the research.

[28] Many of the questions in the interview guide were directly addressed in relation to participants discussing their creations. Therefore, in these cases the interview schedule was used as a checklist to discuss any points not raised in the elicitation interview, and questions were not repeated unnecessarily.

Stage two interviews then turned to a semi-structured format, with prompts asking for reflections on the creative methods they used (or why they chose to forgo them) and about the effect of the Covid-19 pandemic and lockdowns on their VT and VR effects (see Appendix 3 for stage two interview guide). Participants were then presented with initial thematic findings from their stage one interviews. These findings were discussed, with participants reflecting on whether they agreed or disagreed with the findings and how they were categorised, adding in whether they have any experience of the themes which they had not previously raised. Finally, considering the intent to create a training output from the findings of this research, participants were also asked what they would find useful in a training session on VT, VR, and how to manage the effects of working as a DAA. These opportunities to review the findings and feed into potential outputs align with PAR approaches, which prioritise facilitating participants' agency beyond data production, moving away from a tokenistic view of inclusion at the data production stage alone (Kindon et al 2007).

4.7. Piloting the Research

The quality of research can be improved by conducting pilot studies, which provide an opportunity to test research tools prior to gathering data, make researchers more informed about their research area and identify at an early stage if there are any research weaknesses (Malmqvist et al 2019). Therefore, I conducted a pilot study to ensure that the developed tools were suitable for the research, and to provide an opportunity to evaluate the appropriateness and sensitivity of the research questions and the creative activities. The pilot involved a doctoral student who had a background in VAW. My priority was to trial the sandboxing method as this was untried by me, and to test the questions to ensure they were appropriate in tone and effective to gather information relevant to the research questions. I also wanted to photograph the completed sandbox and see which camera settings would be clear and in focus, ready for documenting data production.

4.7.1. Background Information Sheet

In the draft information sheet, the disclaimer for victim-survivors which stated that the research was not concerned with their experiences of abuse, and they would not be questioned on them was at the bottom of the page with an asterisk to direct readers. Following discussion with the pilot participant, who was a survivor-professional herself, this

was moved to directly under the victim-survivor question so that participants would have the information straight away, without having to look down the page. This was to alleviate any stress or anxiety survivor-professionals may feel when asked if they have lived experience, as they were immediately provided with the information that they would not be questioned about their personal experiences of abuse.

4.7.2. Sandboxing Feedback

The pilot participant reported that she thought using the sandbox partnered well with discussions of VT and VR as physically making something was calming, cathartic and stopped her from dwelling on the discussions, which reinforced its use in this research. However, there were points of feedback which were addressed following the pilot.

Whilst the pilot participant managed to create the scenes she wanted with the figures at hand, she stated that there were some representations which were missing, including pet figures such as a dog, and more figures to represent creativity, as there was a violin, but nothing to represent artistic coping mechanisms. The pilot participant also noted the lack of female superhero figures. The acquired sandboxing figures conformed to gendered stereotypes, with all female figures being representations of fairies or princesses (also raised in Mannay and Turney 2020). To remedy this, before the pilot I added a selection of female Playmobil figures; however, this did not adequately address the variety needed. In her scene, the pilot participant used a Superman figure, but then acknowledged that she would have preferred to use a female superhero to represent herself. In response to this feedback, a Batgirl figure, a dog figure, and a small pack of children's crayons were sourced and added to the available figure options. Following these additions, the available 210 figures for participants to use can be seen in Figure 2. For ease of selection, figures would be pre-grouped into broad categories (such as people or animals) prior to interviews instead of being mixed.

Figure 2 - Figures for Sandboxing Activity

To build on the pilot participant's comments regarding sandboxing being cathartic following an intense discussion, I introduced an action following the questions on VT. After participants had removed the figures for the first question on the effects of work, I asked participants to gently shake the sandbox so the sand settles, which provided them with a physical action and visual aid that the discussion on effects had ended and that the sands had settled.

It was also decided during the pilot that while participants created their sandboxing scenes, I would busy myself either doing the drawing option of the research, ask general questions not related to the research, or complete paperwork, so that I was not just watching them as they made their decisions and creations. Dual sandboxing with participants and researchers making sand scenes has been adopted in previous studies (Mannay et al 2017). However, I vetoed this approach to eliminate the risk of me taking the figures which they would want to choose, thereby changing their scene, or from me influencing their creation with my own. Therefore, while participants engaged with sandboxing I organised paperwork, or set up the camera in preparation for photography.

4.7.3. Prompts and Questions Feedback

Prior to the pilot, the interview guide comprised of a list of the cognitive schema within VT, aspects within VR and a list of potential coping mechanisms. However, as participants did not have in depth knowledge of schema meanings, these needed to be re-written in full as a question so participants would be adequately directed around the lines of enquiry. For example, in the pilot, I used the prompt of asking about intimacy in line with the VT schema; while this encompasses relationships of all kinds, the term intimacy alludes directly to sexual activity, which participants may not want to discuss. Therefore, this was amended to ask about relationships with partners and others, so that it encompasses more than just sexual connotations. Kim (2011) discusses the importance of conducting pilots so that questions can be modified to gather authentic experience, as opposed to simply prompting and asking questions to gather expected or desired results. Therefore, following the pilot, the prompts were revisited to clarify their meaning, and example questions on each of the psychological needs within VT were included.

4.8. Ethical Practice

In line with school policy, prior to any data generation, an application on the research and potential issues was submitted to the Social Research Ethics Committee for approval, which was subsequently granted (SREC reference 66 see Appendix 4). This section will explore the ethical considerations throughout the project, and how I worked to minimise any potential harm.

4.8.1. Informed Consent

As noted in section 4.4, I previously worked in the VAW sector in Wales, and I have existing relationships with organisations and workers at different levels in DAS. While being an insider can assist in recruiting participants, I needed to be mindful of participants agreeing to take part in the project because they knew me, and not because they freely consented to being a participant. The voluntary nature of the research was communicated to all participants from expression of interest stage, but this was particularly stressed to participants with whom I have a previous working relationship. Reflections on being an insider conducting this research, and the effects of my prior relationships with participants are explored in the conclusion.

Additionally, to thank them for engaging in the project, participants were given a retail voucher. However, to ensure that this was not a factor influencing their participation in the project, participants were not told about this until they had completed the first interview.

Once I had received expressions of interest from potential participants, I sent them a Participant Information Sheet (Appendix 5) and a Participant Consent Form (Appendix 6) which was completed before the interview took place. Participants were informed they could raise any queries or concerns at any point. The Participant Information Sheet included information about the purpose of the research project, outlining the stages and why they have been asked to take part, as well as how their information and data produced would be stored and used. There was also a section on potential benefits and risks of taking part in this research. The Participant Consent Form asked participants to confirm that they had read and understood the content of the Participant Information Sheet and agreed to participate.

4.8.2. Protecting Participants

While the majority of research involves potential risks or burdens of some level to participants (Fisher and Anushko 2008), I specifically needed to consider risks regarding the sensitive nature of the topic. Discussions around VT and VR need to be carefully navigated to reduce any re-traumatisation, and re-traumatisation from their own lived experience also needs to be considered. Research into sensitive topics, or traumatic experiences can lead participants to revisit negative thoughts and feelings (Anderson and Corneli 2018; Silverio et al 2022) which can have a detrimental impact on their wellbeing. To respond to the research questions, this study could not avoid addressing potentially upsetting topics, such as negative effects from the work on participant safety or trust levels, or how relationships may have been affected because of these changes. However, I assured participants that they need not share anything that they did not feel comfortable discussing. I also conducted all initial interviews in person so that I could better read participant body language and expression, to determine if they were uncomfortable or whether the line of questioning needed to be adapted (Brayda and Boyce 2014). At the end of each interview, participants were provided with resources (Appendix 7), including helplines for various organisations and links to two online VT materials, one by the British Medical Association (BMA 2022) and one by Visible, an organisation to support survivors of child sexual abuse (Visible 2019). While

these steps do not negate the risk of harm to participants, they could mitigate negative effects of participation.

As the research questions did not warrant exploration into their own lived experiences of abuse, I actively refrained from any questioning about their own experiences, beyond whether they identify as a victim-survivor, and questions about the effects of this identification on this work. As noted in section 4.6.1, participants were asked whether they identify as a victim-survivor of domestic abuse, sexual violence or other forms of VAW on the background information form (Appendix 1). To ensure participant control over these discussions, they could answer yes, no, or prefer not to say. A statement was also included beneath the question, outlining that they would not be asked about individual experiences beyond whether they have experience, and how it interplays with effects of the role.

Even if participants marked yes on this form, their consent to discuss the interplay of effects of being a victim-survivor was checked before following that line of enquiry. Therefore, during the interviews, a statement was read from the interview guide (Appendix 2) to participants before discussing any potential interplay. The statement confirmed that they had selected being a victim-survivor on the form, reiterated that I would not enquire about their experience beyond what was needed for the project, and asked them to confirm their consent. The statement also gave participants the option to non-vocally decline if they wanted to avoid the topic.

A further risk for participants was through being identified from the study, by either individuals or organisations. While some PAR projects do not hide the identities of co-producers (Godfrey-Faussett 2022) I deemed it necessary to anonymise participants throughout this project. This decision was reinforced following a number of stage one interviews, where participants checked with me that they would not be identifiable throughout the project for fear of reprisal. Interviews raised many topics which could be held against participants by colleagues or employers, including negative attitudes towards management and substance misuse (outside of employment). Therefore, participants and organisations were assigned pseudonyms. Where opinions and experiences which could harm participants are shared in this thesis, they will be presented without pseudonyms to further reduce the risk of identification, instead framing them as “one participant”.

4.8.3. Protecting Myself

Researcher wellbeing is becoming more recognised (Clift et al 2023) and as someone who has engaged with safety practices and wellbeing services in my previous role, on starting the project I was aware of the options which could assist with managing my own safety and wellbeing.

Steps to maintain my physical safety needed to be actioned throughout research (for example, with a buddy system while lone working). However, my main considerations for protecting myself were in an emotional sense. Studying sensitive topics can trigger emotional responses in researchers (Silverio et al 2022), which can be detrimental to researchers' wellbeing, personal and professional life. A key action to reduce the risk of emotional harm was being reflexive about my own emotions, paying attention to how I was being affected by the content of interviews. I kept a reflexive journal to document my feelings around the research. However, while physical risks can be easily assessed, it has been recognised that there can be difficulty for researchers in recognising subtle shifts in mood and behaviour (Silverio et al 2022). The impact of this research on my own wellbeing, and the effectiveness of the reflective journal will be discussed in the conclusion.

4.9. Participants

This section provides information about the inclusion and exclusion criteria and participants recruitment, as well as information about participants who took part in this research.

4.9.1. Inclusion and Exclusion Criteria

The literature review (section 3.8) highlighted that there is a lack of VT research with DAAs, who are the workers in refuges, drop-in centres and outreach programmes (section 2.2.5). There is, however, much existing research on the effects of trauma work on mental health counsellors working in DAS, social workers who work with DA, on perpetrator workers and on SV only workers (see Chapter Three).

As illustrated in Table 3, to expand knowledge of their experiences of trauma work, participants were eligible for inclusion in this project if they were 'front line' workers in domestic abuse services who support adult survivors – the day-to-day support staff who deal with caseloads of survivors of domestic abuse. While vicarious trauma may affect administrative staff in services, general office workers were not included in this research due

to irregularity of direct contact with survivors. However, office workers, such as receptionists, and those in managerial positions were invited to take part if their duties involved frequent contact with survivors.

Table 3 - Inclusion and Exclusion Criteria for Participants

Inclusion Criteria	**Exclusion Criteria**
Workers with frequent contact with survivors	Workers with no contact with survivors
Domestic Abuse Advocates (for example refuge, drop in, outreach workers)	Mental Health Counsellors or Social Workers who work with domestic abuse
Office staff with daily contact with survivors – for example receptionists	Perpetrator or Sexual-Violence only workers

4.9.2. Recruitment

The recruitment of participants stemmed from DAS which were approached, who were therefore acting as gatekeepers for access to participants (see section 4.3). In April 2022, I approached the four organisations contacted during the consultation and asked them to share the call for participants (see Appendix 8) via email with their staff members. Reminders were sent to managers on three occasions to boost awareness.

Following contact from potential participants, I responded to explain more about the project and share the Participant Information Form and Consent Form (see Appendices 5 and 6). Participants discussed where they would like the interview to take place, with the options of their organisation or at Cardiff University, and also their preferred method for the interview. Where contact with potential participants had not been consistent, or where no reply was received following initial expression of interest, reminder emails were sent.

On attending the first arranged interview, I was greeted with an additional DAA who had not contacted me beforehand but who was interested in participating. Following a brief discussion on eligibility, and completion of necessary forms, I conducted an interview with her. Following this impromptu recruitment from interview one, once interviews had been arranged with participants, they were asked if they knew if other people would be attending who had not contacted me, and I made sure to have available time and duplicate resources. Subsequently, this provided awareness of an additional two participants who would be

attending the day before a scheduled interview, which allowed me additional time to prepare.

Once I had conducted 10 initial interviews with DAAs from the four organisations, I contacted the managers from two additional DAS. While no response was received from one of these organisations, the other responded promptly and shared the call for participants, following which I received expressions of interest.

In total, 15 expressions of interest were received (one of which were ineligible, and four of which failed to respond), one participant was recruited on the day, and I was made aware of two participants the day before fieldwork.

4.9.3. Participant Information

In total, 13 DAAs participated in this project. The participants roles varied, and many had changed roles over time, but all had frequent contact with adult survivors and had held roles providing daily support at some point within their careers. Current roles included refuge workers, community outreach workers, referral workers and management.

Table 4 summarises relevant information about DAA participants; this includes their chosen pseudonym, the pseudonym of the DAS at which they are employed, their tenure in their current DAS, their tenure in the overall VAW field (and related fields in brackets), their current and usual caseload (if applicable) and whether they disclosed having experience of VAW. These each relate to risk factors discussed in previous VT research (see Chapter Three) and potential influences on VT and VR, aligning with research question three.

Table 4 - Domestic Abuse Advocate Participant Information at First Interview

Pseudonym	Organisation (Pseudonym)	Current Role Type	Tenure in Current DAS in Years[29]	Tenure in VAW Field in Years	Current Case Load	Usual Case Load	Lived Experience
Clara	Guidance DAS	Refuge	3-5	3-5 (+10-15 years)	6	4	Yes
Martha	Guidance DAS	Refuge	<1	<1	2 (P/T)	3 max.	No
Liz	Autonomy DAS	Community	<1	<1	25	usually less	Yes
Jayne	Autonomy DAS	Managerial with some refuge cases	5-10	10-15	3	ad hoc	Yes
Melody	Empower DAS	Community	<1	<1	18	usually more	Yes
Tegan	Empower DAS	Community	<1	10-15	20	20	Yes
Rose	Empower DAS	Community	<1	1-3	20	usually more	Yes
Charlotte	Liberty DAS	Community	15<	15<	12	12	Yes
Amy	Liberty DAS	Referral Worker	15<	15<	None	None	Yes
Jackie	Liberty DAS	Refuge	10-15	10-15	5	usual	Yes
Yasmin	Encourage DAS	Refuge	1-3	3-5	13	13	Yes
Donna	Encourage DAS	Managerial with past direct support	3-5	15<	Ad hoc		Yes
Sarah	Encourage DAS	IDVA	3-5	3-5	32	32	Yes

Three participants were each recruited from Empower DAS, Liberty DAS and Encourage DAS (nine participants) while two were each from Guidance DAS and Autonomy DAS. This split in organisation employment provided a range of experiences from across the five organisations involved.

The most frequent position held by participants was as a community support worker, with five participants, followed by refuge workers, with four participants. Of the remaining four participants, one was an Independent Domestic Violence Advisor (IDVA), one was a referrals

[29] Tenure in Table 4 has been categorised as <1, 1-3, 3-5, 5-10, 10-15 and 15< years to reduce identification of participants.

worker, and two were in managerial positions with occasional and previous experience of direct support. While the recruitment strategy did not aim for a range of roles to be included, this enabled the effects of specific roles to be explored in relation with the third research question[30]. In line with these differing roles, participants also reported varying caseloads. For refuge workers who provide more intense support to housed victim-survivors and their families, cases for full time workers ranged between five and 13 (with a part time worker having two cases), while community support workers had between 12 and 25 cases each. The participant with the highest caseload at the beginning of the project was the IDVA, who had 32 active cases. For five of the participants, they were working at their usual caseload level, whilst two were at the time working with higher cases than usual, and three were working at a lower than usual level.

At the beginning of the first stage, participants had been working in their current organisation for between 1 month, and 18.5 years, while participants tenure in the VAW field overall ranged from 3 months to 18.5 years.

4.10. Producing Data with Participants

This section will outline how data was produced with participants. It will cover the steps taken before data production, during stage one interviews and the protocol of the stage two interviews.

4.10.1. Before Stage One

As explained in section 4.8.1, participants were each given paperwork to complete before stage one interviews. During organisation for the interviews, most participants sent me their completed forms; however, some participants did not complete the forms before the interview date, and some participants were unknown until the interview dates. Therefore, ethical discussions needed to be a preliminary aspect of meetings on the day of stage one interviews to ensure that all participants understood the requested contribution and freely consented to participate (Sin 2005).

While participants were offered a choice of locations for interviews, all 13 chose for me to visit their organisations. Refuge buildings were not suitable venues as these are victim-survivors' places of safety, and we may have been interrupted by the day-to-day running of

[30] However, due to low numbers, these findings are tentative and would need further exploration.

the refuge. Therefore, all interviews were held in local offices for each organisation, which had either been booked by the participant or by myself through booking systems. Despite interviews taking place in their organisation offices, I assured participants that I would not share who I was meeting with or for what I was meeting them. Some participants chose to share with colleagues the purpose for our meeting, which prompted others to become involved, but this was not asked, nor expected from participants.

I brought materials for sandboxing and drawing activities to all interviews so that the choice of creative method was available for each participant. No participants expressed an interest in object elicitation prior to the interviews, which would have required instruction for what to bring to the interview.

The day before all arranged interviews, I emailed participants to check arrangements, and asked them whether any other people would be attending to take part to ensure I had enough resources and time.

4.10.2. Stage One Interviews

The pre-booked room in each office was private, enabling confidentiality for interviews. In some DAS the rooms were consultation rooms for victim-survivor support, while in others, interviews took place in meeting rooms.

To begin the interviews, I ensured participants had reviewed the ethics and consent documentation, and asked if they had any additional questions, providing space to discuss any concerns and so I could ensure their contribution was voluntary.

Once consent procedures had been completed, participants were given the Background Information Sheet (Appendix 1) to complete. I then introduced myself so participants understood my interest in the topic and my knowledge of the VAW field, sharing my insider status even if they did not have a prior relationship with me, as this can aid in discussions (Bhopal 2010; Rowlands 2022).

To begin the interview, I asked participants to provide some information about their role to provide context to their experiences and information which could be explored in relation to research question three (Appendix 2). I then provided an overview of the offered creative methods, and asked whether they would like to do a creative task as part of the interview, or whether they would prefer a standard question-answer format. Eight of the participants

further enquired about the sandboxing method, for which I then provided a demonstration for what could be done (placing figures in the box and moving the sand around to create a scene). Following this demonstration, seven participants chose to engage with sandboxing, whilst the eighth decided that she would prefer a standard semi-structured interview. No participants chose to use drawing or object elicitation as a method. Therefore, seven participants then engaged in the creative method of sandboxing, and for six participants I conducted standard semi-structured interviews.

With those who chose standard question-answer structure, I proceeded to the second page of interview prompts, starting by covering their experiences and understandings for how their work affects them, firstly in negative and then positive ways, before moving onto the general questions for how they cope with the effects of their work.

With participants who chose to use sandboxing, I initially asked them to make a scene which shows the effects that being a DAA has on them. Once they had finished, and I had checked this with them, I then took photographs of the scene and asked them to explain their creation. After their initial explanation, I prompted further, such as asking about any unexplained features, why they chose certain figures, or whether figures had any additional meanings. Where these points organically raised topics included in my prompts, I followed this line of enquiry as befits semi-structured interviewing (Kvale and Brinkmann 2015), instead of leaving the discussion and returning to it later. Once the discussion about the creation, and the topics around it had been exhausted, I provided participants with the opportunity to create an additional scene or asked whether they wanted to move onto the prompts I had about the effects of the work. Two of the participants chose to create another scene on the effects of their work (with the above stages being repeated), whilst the others opted to progress to standard questions. Once the two participants had created an additional scene each, they then also chose to move onto the standard questions. This led to nine sandboxing scenes being created in total to represent the effects of being a DAA.

Once all prompts and effects of being a DAA, both negative and positive, had been discussed with participants, discussion turned to how they manage the effects of the work. From the seven participants who had used sandboxing for the first section of the interview, six participants wanted to continue with the method, whilst the seventh, Rose, decided to continue with the standard interview format. The process for this sandboxing activity

mimicked the first, with participants being asked how they deal with the effects of their work. Once these creations had been made, photographed and discussed, I again offered participants the chance to make another scene, to which only Clara agreed. As with discussions on the effects, we then moved to semi-structured question and answers for how participants manage the effects of their work. From this section of the stage one interview, seven sandboxing creations were made.

While there was no third section of questioning to cover the third research question of impacting variables, throughout the interview there were questions about aspects which could be of importance. This included asking the 12 participants who identified as victim-survivors about the interplay between this and the effects and how they manage the effects of their work (following reading out the passage outlined in section 4.8.2).

The breakdown of data types and total amount of data produced with participants in stage one is displayed in Table 5. In total, sixteen sandboxing creations were generated, and following transcription, a total of 142,039 words made up the interviews.

Table 5 - Stage One Participant Activity Choice and Data Produced

Pseudonym	**Effects Activity**	**Managing Effects Activity**	**Length of Interview**	**Transcript Wordcount**
Clara	Sandboxing x2	Sandboxing x2	1:29	13,130
Martha	Standard	Standard	0:54	8,820
Liz	Sandboxing	Sandboxing	0:57	8,745
Jayne	Standard	Standard	0:57	7,468
Melody	Sandboxing x2	Sandboxing	1:26	11,218
Tegan	Sandboxing	Sandboxing	1:23	12,019
Rose	Sandboxing	Standard	0:48	6,857
Charlotte	Standard	Standard	0:57	9,907
Amy	Standard	Standard	1:20	12,681
Jackie	Sandboxing	Sandboxing	1:18	16,339
Yasmin	Sandboxing	Sandboxing	1:27	11,579
Donna	Standard	Standard	1:05	12,903
Sarah	Standard	Standard	1:01	10,373
Total Number of Creations	**16**	**Total Length and Words Transcribed**	**15:02**	**142,039**

Once the interviews had ended, I provided participants with the Post Interview Resources (Appendix 7) and the thank you voucher, and I informed them that I would be in touch in six months for the next stage of the study.

4.10.3. Stage Two Interviews

Six months later I organised the second stage interviews with participants, emailing to thank them again for engaging in stage one, and arranging meeting for the second stage. On arranging the second stage interviews, I sent participants their completed consent forms and the Participant Information Sheet for their review and asked if they had any questions (again ensuring informed consent).

Most stage two interviews were conducted face to face in the organisation offices, as with stage one. However, where schedules would not accommodate face to face interviews, these were conducted over Zoom.

In the time between the two stages, two participants had ceased employment in the organisations. I successfully established contact with one, Yasmin, who agreed to a second stage interview via Zoom as arranging a location was a barrier since terminating employment. However, the other, Jackie, was uncontactable. Additionally, Liz did not reply to emails regarding stage two. Therefore, stage two interviews were conducted with eleven out of the thirteen participants, with three virtual meetings, yielding 183,102 words (Table 6).

Table 6 - Stage Two Interview Mode and Length

Pseudonym	**Mode of Interview**	**Length of Interview**	**Transcript Wordcount**
Clara	Virtual	1:05	9,301
Martha	Face to Face	1:41	17,091
Liz	No reply		
Jayne	Virtual	1:30	14,282
Melody	Face to Face	1:45	18,582
Tegan	Face to Face	1:34	16,024
Rose	Face to Face	1:50	18,168
Charlotte	Face to Face	1:29	16,261
Amy	Face to Face	1:32	16,439
Jackie	Left DAS		
Yasmin	Virtual	1:37	15,087
Donna	Face to Face	1:40	21,134
Sarah	Face to Face	1:50	20,733
	Total Length and Words Transcribed	**17:36**	**183,102**

As discussed in section 4.6.3, stage two interviews started with summaries of each participant's initial interview, before moving on to additional questions and presentation of initial findings (Appendices 4 and 10).

4.10.4. Total Data Produced

In total, 24 interviews (32 hours and 38 minutes) were conducted with 13 DAAs producing 325,141 transcribed words. The initial interviews also produced 16 sandbox scenes.

4.11. Framework of Data Analysis

This section will outline the framework of data analysis, describing the transcription process and initial findings, discussing the participant consultation of initial findings and transcription and analysis of second stage data.

4.11.1. Transcription and Initial Findings

To analyse the data produced in this study, I used Braun and Clarke's (2006) stages of thematic analysis (TA) as part of Reflexive Thematic Analysis. While original TA is a flexible method, constituting coding and theme development (Braun and Clarke 2023), following the stages laid out in their 2006 work organises analysis into six stages, which can aid in reflexive TA (Braun and Clarke 2022), where the researcher is acknowledged as being instrumental and an active agent in their analysis. The six stages are: familiarising yourself with your data, generating initial codes, searching for themes, reviewing themes, defining and naming themes and producing the report (Braun and Clarke 2006, p.87). Whilst these stages were initially developed for use in psychological qualitative analysis, they can be used across disciplines.

While the scenes created by participants and the photographs taken of them could serve as data to be analysed alone, it is not the image itself which holds the meaning, but the participants explanation of it, which aligns with an approach often called auteur theory (Rose 2001). Therefore, the images produced were used to support the explanations and experiences within the transcripts rather than as independent documents.

Stage one of the thematic analysis process, familiarising yourself with your data, took the form of listening to the recordings of interviews and transcribing them. While listening to the recordings, I also studied the photographs of their sandboxing scenes, to make sure that I was familiar with their meanings for all aspects of their creations. Transcription was aided

using transcripts generated by Microsoft Stream, which were checked for accuracy in listening. One interview was also professionally transcribed (see section 9.6).

I conducted stage two of their process, generating initial codes, by extracting interesting quotes and summaries of their context on different topics raised within each interview. An example of an initial code is “I don’t like men after this job”. I initially transferred these quotes and context summaries onto four separate sheets of large paper– one for any codes relating to VT, a second for VR codes, a third for coping strategies and the fourth for any factors raised which could influence their experiences. Each participants’ entries were written in a different colour (keyed to their participant code) to make it easier to identify experiences. On entering each code, similar quotes were grouped together on the page, so that related experiences could be viewed together, forming the beginning of stage three of the process, searching for themes. However, while this approach was suitable for the first eight interviews, the VT paper became too cluttered to adequately read. Therefore, I progressed with stage three, and split the initial, grouped themes onto their own A3 sheets of paper. I continued coding for the remaining five participant interviews, putting their entries in the suggested themes, or altering as necessary. This produced 38 initial themes, which are displayed in Figure 3 and Appendix 9. Some of these initial themes mimic the aspects within VT and VR, namely safety, trust and power, while others are more general such as changes in cognition and changes in behaviour, along with other identified themes such as pets.

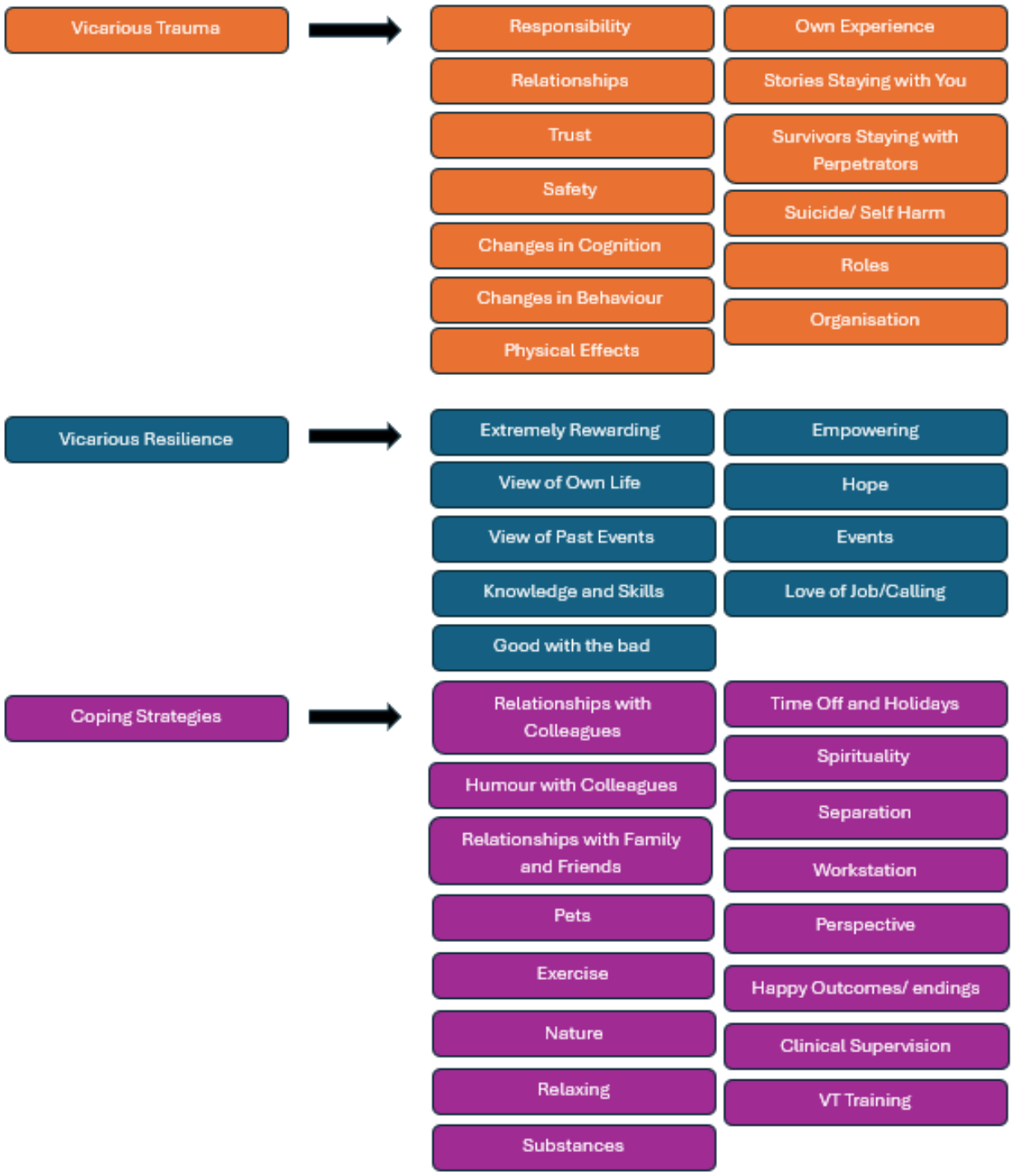

Figure 3 - Thematic Map of Initial Findings

4.11.2. Participant Consultation on Initial Findings

Stage four of TA consisted of reviewing themes, which I conducted in two parts, firstly through participant consultation of the initial themes, and also through my own reflection. Stage two interviews provided an opportunity for participants to review the initial thematic findings.

In discussions around these initial findings, all participants agreed with the themes presented, and shared additional insights into their experiences associated with them. Where participants did not themselves have experience of some themes, such as disruption of intimacy within relationships, they expressed that while they did not identify with them themselves, they could understand and empathise with other DAAs experiences.

For the theme regarding DAA roles, Donna raised concern around difficulty of roles being presented as a hierarchy, mirroring the hierarchy of abuse[31], which is rejected by DAS. This concern was taken on board during further analysis and writing.

4.11.3. Transcription and Analysis of Complete Data

The second part of stage four was my own review of initial themes, which took me back to generating codes covering the whole data set, including stage two transcripts, and creating refined themes as stage five. As with stage one recordings, initial transcripts of stage two interviews were created using Microsoft Stream, which were then checked against the recordings. All transcripts were recoded within NVivo12.

Reviewing themes began with separating the initial themes which related to Research Question three, regarding individual and organisational factors which influence experiences of VT, VR and how DAAs manage them, from the initial three mistress themes (see Figure 3). This was done as in the initial analysis the factors were grouped with the aspect that they most affected so that they could be easily discussed with participants. However, to adequately address the research question, these needed to be explored in depth in their own chapter. For example, as shown in Figure 3, Own Experience and the Roles which DAAs held were initially grouped under VT, but these were moved to their own mistress theme of Organisational and Individual Factors, under the sub-theme of Individual Factors (see Figure 4). This allowed for detailed discussion of each theme and how they related not only to VT, but also VR and management techniques. Further influencing factors were also separated from within the initial themes and refined into the final themes concerning organisational and individual factors.

As noted in section 4.11.1, some of the initial themes under the VT mistress theme directly corresponded to the psychological needs associated with trauma (see section 2.3.5). On

[31] Where certain abuse types are seen as worse than others to experience.

reviewing the initial themes, I decided that findings could be grouped under the terminology of the psychological needs. For example, findings on relationships related to changes in intimacy, while the key component of the responsibility theme was anxiety, which fits under changes to Affective states. On reflection, the initially named 'Changes to Cognition' actually referred to changes in Frame of Reference (for example, desensitisation). Therefore, the psychological needs of Intimacy, Safety, Trust, Frame of Reference and Power were used at main themes, alongside findings related to Memory Aspects and Cumulation, which are also key components of VT. These main themes adequately incorporated all of the VT related initial findings, which also supported using VT as the concept in this research, as all negative effects found fit within the concept.[32]

Similarly, the initial themes regarding positive effects were reformulated into VR aspects and assigned into refined, final themes and subthemes as presented in this thesis. For example, the initial themes of Empowering and Rewarding were combined and presented within the key VR theme of Satisfaction, relating to positive feelings from work.

On reviewing the initial themes within Coping Strategies, I refined them into three key themes. The first was Relationships, as many of the coping strategies related to relationships with colleagues (and aspects of those relationships, such as gallows humour, within them), family and friends, pets, and relationships with work through separation and boundaries. Second were themes surrounding self-help strategies which participants use. As with relationships, some initial themes were combined, such as exercise and nature as they were strongly connected. The initial theme of Happy Outcomes/ endings was renamed as Success Stories, and was kept separate from the other two main themes due to it being neither a relationship nor a self-help strategy.

While the themes in the final thematic map in Figure 4 look clearly segregated, there are links between many of them. These links are presented in Table 7. Some links are of conflicting themes, such as link 4, where knowledge can be both a negative and a positive. Others link VT or VR effects to factors, such as link 9, of cumulation of effects being linked to length in role, and some links are where findings overlap, such as link 13, where pets can

[32] Independence and Esteem were not included as key themes as data was not found for these, which will be discussed in section 9.2.1

overlap with spending time in nature, and exercise. Throughout the following chapters, these links are highlighted when each theme is discussed.

Table 7 - Links Between Final Themes

Link Number	Theme One	Theme Two
1	VT - Effects on Relationships	VR - View of Own Life and Relationships
2	VT - Safety	Factors - Personal History
3	VT - Safety	Factors -Experiences as a DAA affecting Trust and Safety
4	VT - Awareness of Danger	VR - Gaining Knowledge and Skills
5	VT - Trust	Factors - Experiences as a DAA affecting Trust and Safety
6	VT - Unable to Watch Violent Content	Coping - Relaxing
7	VT - Power(less)	VR - Feeling Empowered and More Confident
8	VT - Power(less)	Coping – Keeping Perspective
9	VT - Cumulative	Factors - Length in Role
10	Coping - Colleagues	Coping – Success Stories
11	Coping - Colleagues	Factors – External Clinical Supervision
12	Coping – Family and Friends	Coping – Future Plans
13	Coping - Pets	Coping – Exercise and Nature
14	Coping – Separation and Boundaries	Factors – Role
15	Coping – Success Stories	Factors – Role
16	Factors – Organisation Support and Management Communication	Factors – Supervision with Line Managers

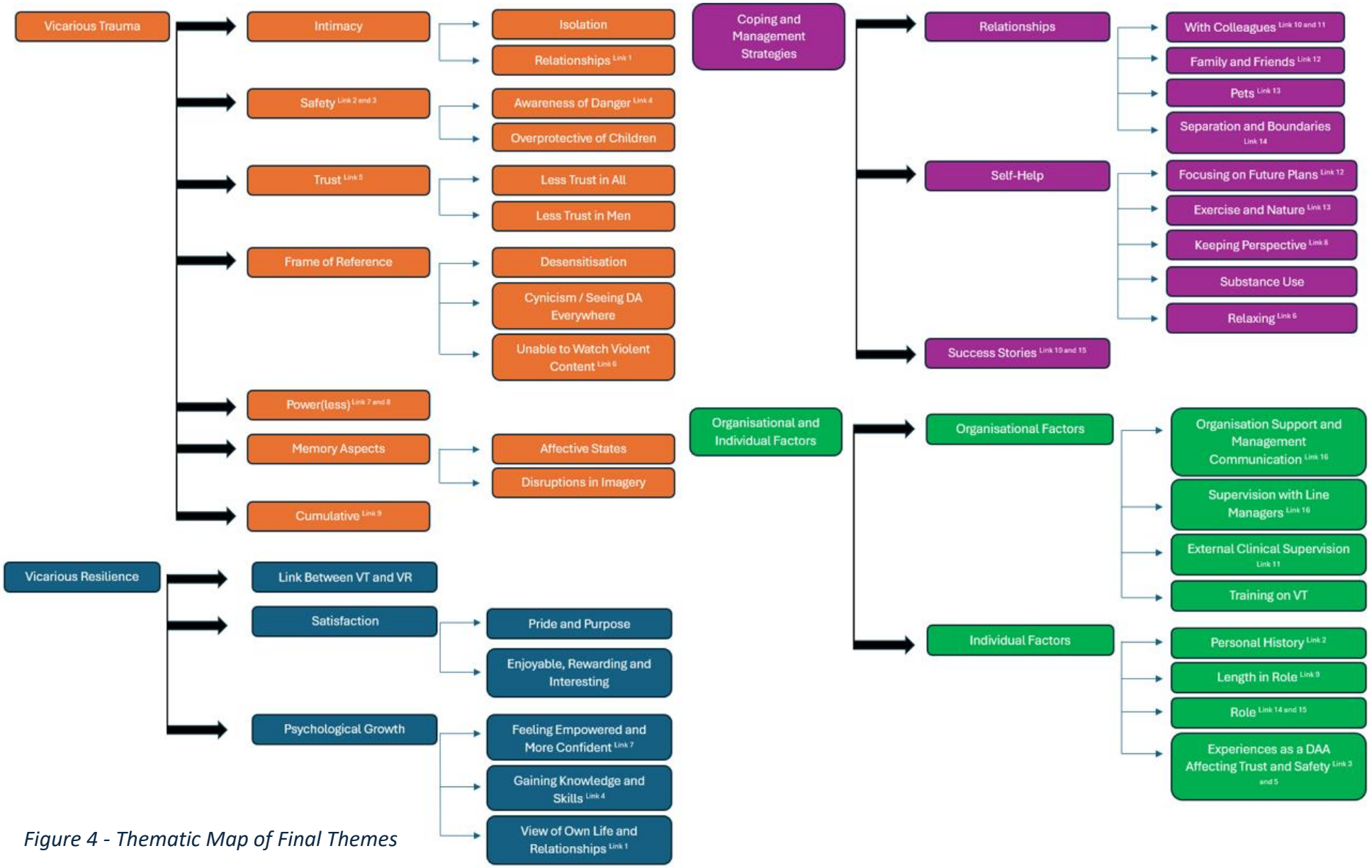

Figure 4 - Thematic Map of Final Themes

4.12. Conclusion

This chapter began by setting out the constructivist and feminist design for this case study, with which principles of Participatory Action Research (PAR) and qualitative methods, including creative methods were appropriate to gain an understanding of the nuances in DAAs experiences of VT and VR. PAR principles were followed, with organisations and participants consulted and engaged at different stages of the project. This included a consultation on research design with DAS managers, an initial stage of data production, and then a second stage where participants reviewed initial findings. The chapter outlined the organisations which were involved in this project, and explored my positionality as the researcher, situating me as an insider-researcher and considering the affordances and limitations of this positionality. Design consultations with organisations were discussed, alongside the changes which were made to the project following these conversations. This was followed by an explanation of the specific methods of data production in the stage one interviews, including a non-creative semi-structured interview, and three optional creative methods. The methods in stage two interviews were also justified, explaining how these return interviews gave participants opportunity to review their accounts from the first stage, while also giving them the opportunity to review initial findings and their reflections surrounding these themes. Before beginning data production, I also conducted a pilot study, which was discussed in relation to the following amendments.

Section 4.8 reflected on the ethical considerations surrounding this project and steps which were taken to mitigate them and protect both the participants and myself as the researcher, before section 4.9 introduced inclusion and exclusion criteria, recruitment protocol and the 13 participants of this research. The chapter then detailed how data was produced with participants in each stage, and the practicalities and format of the research.

The framework of analysis was introduced in 4.11, justifying the use of thematic analysis, initially on stage one findings, before taking initial themes to the second stage interviews for the participants to review.

Now that each aspect of how the research was conducted has been explored, this thesis will present the findings for the three research questions, beginning with research question one in Chapter Five, exploring the effects of being a DAA through the lens of VT, before subsequent chapters will explore the effects of being a DAA through the lens of VR, how

these effects are mitigated and whether there are any individual or organisational factors which influence these effects.

5. Vicarious Trauma Effects

5.1. Introduction

This chapter discusses the findings related to the first research question – what is the effect of being a Domestic Abuse Advocate (DAA) on the individual? This question will be considered in relation to the lenses of Vicarious Trauma (VT) and Vicarious Resilience (VR). In this chapter, themes will be presented that relate to negative effects under some of the psychological needs and cognitive schema which are pertinent to VT, (see section 2.3.5) (McCann and Pearlman 1990a; 1990b). The following chapter will then discuss positive effects through VR. All participants (n=13) shared experiences of how their work affects them in relation to VT. These effects spanned different cognitive schema and physical impacts and behaviours, which have arisen from disruptions to cognition. The following sections will examine effects shared by participants which fall under different aspects of VT, namely intimacy, trust, safety, frame of reference, power, memory aspects and cumulative nature[33].

5.2. Intimacy

This section discusses the impacts related to intimacy, which is the psychological need for connections to others, and the distortions of cognition around this, namely around isolation, and negative effects on relationships with family and friends, and intimate partners (McCann and Pearlman 1990b, p.23). This section also includes non-cognitive effects, such as not disclosing information about their workdays and avoiding known perpetrators.

5.2.1. Isolation

Participants (n=8) shared that they felt isolated from others in their roles as DAAs. One of the ways in which isolation was experienced by DAA participants was related to the requirement of confidentiality. For example, Melody shared how working as a DAA can be isolating as she cannot discuss her job with her friends and family:

> It can be quite a lonely experience, in your personal life… I hear people talking about their jobs and I'm like, I'm kind of jealous, it's quite isolating. (Melody)

[33] Themes relating to the psychological needs of independence and self-esteem were not as clear in the data as the other needs. This will be explored in the conclusion.

Additionally, Melody explained how this impacted on interactions with family members, leading her to lie about how her day has been:

> "Oh how was your day" and you have to be like "yeah, it was alright" because you can't answer their questions if they probe and say, "well what happened" because you have a duty of care to remain confidential. (Melody)

This has not been reported in previous research studies with DAAs, however, support for this can be found in a study by Parkes et al (2019), who reported that Sexual Violence (SV) police officers felt isolated because they could not discuss their work with others. Additionally, Massey et al (2019) reported some Sexual Assault Referral Centre (SARC) workers cannot talk about work with family due to confidentiality. This suggests that the understandable need for confidentiality can have ramifications on trauma workers, who do not have the opportunity to share the burdens of their work with others.

Four participants also shared that even when they were allowed to share information with their family, that their family would not necessarily understand the issues they faced in work:

> They would be very shocked by what they heard. I think there would be a sense that if you're not working in it… you probably don't get it, that it would be very hard to convey they'd be like, what a shocking situation! You'd be like, yes, but that's just Tuesday. Like, that's just one of 20 very shocking situations I've confronted this week. (Martha)

Sarah's brother also once told her before a gathering not to "talk about work because I don't think people are interested". This suggests that being forbidden from talking about your work can segregate DAAs from their social circles. This draws parallels with findings from Iliffe and Steed (2000, p.405), where some participants felt isolated from friends and family who "were judgemental or not interested in DV issues".

A novel finding from this research which has not been previously raised in VT literature concerns the struggle DAAs experience when they become aware of perpetrators in their own social circles from their work files. For example, Jayne explained how she would self-isolate from a group to avoid awkward encounters with those she knows are perpetrators:

> I was in a setting where the perpetrator was in our social group. I had to be really, really careful, like if I knew he was going, I wouldn't turn up, you know I'd make excuses not to go. And it's really weird because you can't explain why, you know you can't let on that you know anything. (Jayne)

Similarly, Amy discussed how she recognised the name of a perpetrator discussed in Multi Agency Risk Assessment Conference (MARAC) as the grandson of her friend. These two participants went on to describe how being privy to cases and this knowledge can make engaging with social circles awkward, which can make them not want to spend time with others.

Another specific disruption is that while participants may have support from others, such as colleagues, three raised that when they are in a support session with a victim-survivor, they are alone. Rose expressed this through a sandboxing creation (see Figure 5), where she buried her own figure and placed a clinical figure looking on.

Figure 5 - Rose isolated in a silo while support looks on from a distance

Rose discussed her sandbox scene:

> Quite a unique feeling of isolation. So, there are lots of people saying “I'm here to support you”, but in actual fact you're actually quite isolated in the moment that you're absorbing or addressing what people are bringing to you. (Rose)

Rose explained that the clinical figure could be either a clinical supervisor or manager, who is faced looking at her, but between them there is distance. This suggests that while there may be structures and staff members in place to assist DAAs, when support sessions are actually taking place, they can still feel alone in their work. This supports literature reporting

that although therapists need to be alone in sessions with clients by design, this can lead to feelings of loneliness. The literature, however, states that therapists learn to cope with this loneliness over time (Melamed et al 2001), and that the loneliness can assist in connecting with the client during the session (Phillips 2020).

This section has explored the ways in which DAA participants experience disruption to intimacy and connection with others (McCann and Pearlman 1990b) through feeling isolated. Findings surrounding isolation due to confidentiality and their family not understanding support previous findings from Violence Against Women (VAW) workers, aligning experiences of this DAA sample. However, DAAs avoiding social circles due to knowing perpetrators and feeling alone during the sessions are novel findings for VAW workers.

5.2.2. Relationships with Family

Developing from feelings of isolation, eight participants reflected that their work as a DAA also impacts on their relationships with their family and children, due to unavailability. As with parents in other professions, this unavailability can be physical, such as being late home from work, but also manifests as emotional unavailability. For example, Clara depicted the problematic aspects of this unavailability in Figure 6, which she initially made to represent all the good things in her life, including her partner and children.

> But literally my work *[moves the sand to cover the figures]* just swamps them over to be secondary in my life, really, rather than the main people. And they just end up with having to have a time share which is not fair on them. (Clara)

Figure 7 illustrates Clara's scene representing being swamped by her work as a DAA, with her family submerged and her face-down in the sand.

Figure 6 - Clara's Original Creation

Figure 7 - Clara's Swamped Creation

Similarly, Yasmin discussed how she is often late home to her teenage daughter, and that she brings the emotional weight of her work home. She created the scene illustrated in Figure 8 and explained:

> [I'm] trying to depict me almost submerged. The smaller figure is my daughter sort of getting a bit of the brunt of it as well… because I'm frequently late home from work, carrying burdens from the day with me. (Yasmin)

The technique of submersion in sandboxing has previously been used by mothers in research to depict juggling responsibilities and expectations (Mannay et al 2017), which is echoed in Yasmin's sand scene.

Figure 8 - Yasmin and her daughter - burdened

This emotional unavailability was also illustrated by three participants through their responses to family members. For example, two participants shared how when their children have issues, they immediately resort to acting as if they are in work. This demonstrates how being a DAA has become their dominant response, rather than taking a parental role. Jayne identified this when her daughter broke up with an abusive partner, and that "she needed her mum, not a support worker". When presented with this in second stage, Amy agreed with this:

> I definitely sort of recognise that… my daughter was going through things. There is a difference between understanding and being able to give advice than almost like you then being back in your workplace treating them as a service user. (Amy)

Additionally, Liz explained her own emotional unavailability with her mother, as when she comes home from work and her mother wants to offload, she is unable to listen to her, saying "I don't have anything else to give". These effects on parenting and family relationships align with previous studies documenting how trauma related to VAW can prevent workers being practically and emotionally available to their families (Ben-Porat and Itzhaky 2009; Cohen and Collens 2012).

Further disruptions to family life were also raised by three participants who reported changes to their parenting. For two of them, that manifested as being stricter with their sons now that they are DAAs. Jackie explained that she fears her son will become a

perpetrator, “It’s the last thing you want is for them to be a perp isn’t it”, while Sarah became aware that her son may be viewed as dangerous because of his actions:

> I'm nagging him about if you're ever walking home… and if there happens to be a woman in front of you, you must never walk behind her and make her feel uncomfortable. You know she's going to be nervous of you. I'm starting to like talk to him as if he's like a perpetrator. (Sarah)

While Goldblatt et al (2009) found VAW work effects education of worker’s children, such as on feminist principles, these findings show that DAAs can fixate on potential perpetrator, or harmful behaviour in their sons. This can be problematic as it may damage their sons’ views of themselves or their beliefs about how their parents see them.

Conversely, Martha reported being more lenient with her children if she supports a case which she can identify as being aligned to her home life:

> I would allow them to get away with more. I would be less strict with them. I would be more, let's have lollies, let's play in the garden, let's have treats, let's eat some chocolate. (Martha)

When questioned on this, she reflected that it may be performative, that she must pretend to be okay to be functional with her children. These findings of changes in parenting practice supports previous research into parents who are child abuse workers. Dursen et al (2014, p.567) found that child abuse workers can change their own parenting strategies in response to their exposure to abuse, sometimes becoming more “democratic” and fair, but sometimes becoming “stricter and more authoritarian”.

This section has illustrated how DAAs intimacy can be disrupted in familial relationships, through physical and emotional unavailability, and through changes to their parenting. While some of these effects may be seen as positive on workers parenting (which will be discussed in section 6.3.2.2), in these cases, interactions were unwelcome, potentially damaging, or forced, and come from a negative place to counteract the accounts they have heard.

5.2.3. Relationships with Partner

Nine participants also reflected on their relationships with their partners being affected by being a DAA. For example, Donna actively reinforced equality in her relationship, which sometimes lead to arguments:

> Equality is really important to me… we argue a lot about cleaning and childcare because… I don't want to be a hypocrite. You know, I'm, I don't want to be in a relationship where it's very one sided. (Donna)

Similarly, Amy shared that she needs to be "assertive" that household chores are not only for her, but also her partner's responsibility:

> He'll say something like, oh, I brought *your* clothes in from the line. No, they're not mine… that type of things. (Amy)

While struggles for gender equality in relationships can be present in all relationships (Carlson et al 2020; Hjálmsdóttir and Bjarnadóttir 2021), these experiences echo the findings from Goldblatt et al (2009), where VAW Social Workers stated that seeing clients' experiences in work "sharpens and dramatize[s] the otherwise trivial" events in the home (p.369) which can also lead to "rebellion against stereotypical gender roles" (p.374) and arguments between couples. Goldblatt and Buchbinder (2003) also found that participants cohabiting with a partner viewed relationship issues through a lens of power and control and re-examined gender roles.

Additionally, Melody reflected on her awareness that loving relationships can change and become abusive over time, and how this can affect how she sees her partner:

> Sometimes I look at my [spouse] and think, "do I even know you? Are you a stranger?" (Melody)

Melody explained how she knows that her spouse is not abusive, but that we never know what a person could be capable of in the future, which was also stated by Amy.

> I know that he's like a lovely man… at this moment, but who fucking knows what the future will bring. (Melody)

> I guess we don't really know anyone, do we? Not in the sense of what people are capable of. (Amy)

This supports previous findings, which state that workers re-examine past and present experiences (Goldblatt and Buchbinder 2003), but also expand them to suspicion of potential, future experiences.

Additionally, community worker, Liz, shared how she sometimes does not want to be sexually intimate with partner after hearing sexual assault cases:

> There has been once or twice where I've had a horrible case where it reminds me of something, and it puts me off, like I don't want to be near [them]… if somebody has been sexually assaulted… if me and my partner started to get intimate that evening, it'll just pop into my head. And I'm like, I'm consenting to this, somebody else didn't. And it just [woah] and it just puts me out of the mood and I'm like I don't want to do this anymore. (Liz)

Previously studies have reported that VAW workers need space from partners after sessions with perpetrators (Goldblatt et al 2009). Studies have also documented negative effects on the sex lives of primary contact helpline workers (Taylor et al 2018, p.859) and in female police officers in sexual offense units, where participants reflected on sexual relationships being disturbed, losing libido and associating sex with violence (Bozga et al 2020, p.40). However, difficulties in sexual relations with partners has not previously been reported in research with DAAs. This suggests that the sex lives of workers in VAW can be affected regardless of role, whether working with sexual or domestic abuse (DA), in helplines, the police or in the community as a DAA.

In summary, these specific effects support previous findings of distortions to intimacy caused by working in VAW (Ben-Porat and Itzhaky 2009; Iliffe and Steed 2000; Pearlman and MacIan 1995; Steed and Downing 1998), expanding on how relationships are affected, and presenting new insights for DAAs as these have not previously been sampled for VT. These insights include being isolated by confidentiality and acquaintances not understanding or being interested in the work, being emotionally unavailable to children, being more alert to gender roles and power dynamics and effects on sexual intimacy. It has also presented findings for DAAs which have not previously been discussed in research with other VAW samples, in self-isolation from identifying perpetrators in their own social groups, being isolated in the moment of support sessions, and being suspicious that presently loving relationships may change to be abusive.

5.3. Trust/Dependency

This section discusses the impacts on trust/dependency, which is the psychological need to believe in and depend on others (McCann and Pearlman 1990b p23). Mirroring Iliffe and Steed's (2000) findings that most DV counsellors did not have disruptions to their trust from the work, four participants in this study said that they were still trusting. Jayne stated that despite her work, she thinks she has "always been a trusting person" which was echoed by Martha saying "I'm quite trusting". Clara also explained that she is trusting because she believes "people generally, probably even perpetrators, come from a good place at the start" so that she does not immediately think the worst of people. However, eight participants in this sample did discuss disruptions to their trust schema, some regarding all people, and others specifically focused on men.

5.3.1. Less Trust in All

Less trust in people overall was cited by seven participants to some extent. Amy reflected that she thinks "everyone is a perpetrator until they prove different", while Charlotte stated, "I don't trust anybody". Yasmin directly linked the continuation of her mistrust of people to her role as a DAA, showing her awareness of the influence of the work on her cognition:

> I just find trusting in anyone sort of exceptionally difficult, really. And I think working in domestic abuse just sort of perpetuates that. (Yasmin)

This suggestion that trauma work can affect trust levels due to seeing the harms that can be caused by others is supported by Crivatu et al (2021) who summarised from existing research that Sexual Violence (SV) workers were increasingly distrustful of people's intentions when they first meet, as they do not know if they could be dangerous.

As noted by Iliffe and Steed in their research with DV counsellors (2000), some participants found themselves being more wary of others. Three participants in this research explained that they were not necessarily less trusting, but more cautious around all people because of the job.

> It makes you more guarded, definitely, especially meeting new people. (Jackie)

Rose also explained how she is aware that people are sometimes "not what they appear to be", and because of this she is more cautious of all people, until she knows them better, as

there can be “two-sides” to everyone, and they often only show you aspects of themselves that they want you to see.

While the participants themselves stated that this does not make them less trusting, being wary and cautious of others could be viewed externally as a manifestation of them being less trusting, which is why this finding has been included within the disruption to trust theme. These findings evidence how being a DAA can cause disruptions to trust schema, including feeling less trust, or feeling more cautious, about all people, and this supports previous research into VAW workers and demonstrates their applicability to DAA workers specifically.

5.3.2. Less Trust in Men

In keeping with Cohen and Collens (2012), seven participants shared that they while they are not less trusting of all people, they are less trusting of men in particular. Liz explained that “I don’t like men after this job” while Yasmin described herself as “anti-men”. This demonstrates how disruptions in trust for DAAs can be focussed on, or heightened for particular groups, which they frequently perceive as being harmful, and not worthy of trust. Additionally, Sarah reflected on how she has decided that she will now stay single, as she does not want to risk being a victim:

> I probably will just be single the rest of my life… there's just so, so many perpetrators out there… I don't want to take that risk. (Sarah)

This lack of trust regarding the forming of new intimate relationships was also reported in research with DV counsellors (Iliffe and Steed 2000) and in SV workers (Crivatu et al 2021) as workers feared becoming romantically involved with an abuser. This suggests that all VAW workers can experience distortions in trust surrounding men, who they perceive as likely to be perpetrators.

As in the previous section, whilst they did not think they were less trusting of men, two participants spoke about being more wary of men than they were before the job. Donna shared that she is still trusting of men but acknowledged that she is more nervous and alert around men when she is alone (specifically reflecting on an incident where she was approached by a lone man on a cycle path), but that she does not feel this nervousness with women:

> I wouldn't have felt that if it was a woman. I felt that because it was a guy and he was on his own and I was on my own. (Donna)

While Rose is cautious of all people, she states she is more observant specifically with men and how she believes that is an effect from the job:

> I find myself far more observant and vigilant around men… I believe that that's a consequence of the work we do. (Rose)

These acknowledgements that DAAs feel more wary, if not less trustful of men supports Steed and Downing (1998) research into SV psychologists, where half of the sample (n=6) reported an increased wariness toward men, including their partners.

These findings link to the effects on relationships with partners through distorted intimacy (section 5.2.3) as these disruptions in trust of men can affect intimacy, either through being distrustful of all men, being wary of instigating romantic relationships because of lack of trust in men, or through being wary of men's violence. In summary, the participants' accounts support previous research into VAW workers that whilst some workers stay trusting, for others their trust schema can be changed, sometimes specifically regarding men. These findings illustrate how DAAs ability to depend on and believe in others have been skewed, in line with the parameters of VT (McCann and Pearlman 1990b). These findings also confirm these disruptions, and the existence of VT in the DAA population, which has not previously been explored.

5.4. Safety

This section explores safety, which is defined as the psychological need to feel safe, and the disruptions around this (McCann and Pearlman 1990b). While there can be separate realms to safety, such as emotional and financial, this section focuses on DAAs perceptions of physical safety, and the risk of physical harm from others. This section also includes changes to behaviour which have been made because of these disruptions, such as risk assessing and changing routes and routines.

As with findings of trust in the previous section, most participants (n=9) shared that they still feel safe in some circumstances, especially when they are in their own home and with their families, as illustrated in the quotes below:

> I feel quite safe in my house. (Amy)

> Safety is my home, where I live, when I lock the door and I feel safe there. (Rose)

However, many of these feelings of safety have conditions attached to them, such as being locked in their house, or with their partner. Interestingly, being at home with their male partner is where women are most at risk. DAAs would be aware of this, which shows how for participants living with their male partners (n=8), their feelings of physical safety can contradict their knowledge.

5.4.1. Distortions to Safety – Awareness of Danger

Ten participants shared how since starting the role, they are now more aware of danger and risks to their safety than they were prior to being a DAA. Melody described this feeling as being on "red alert all the time" while Amy spoke of her "antennas going off". While others referred directly to being aware of dangers in general, Clara raised how this can specifically become apparent when people are arguing, describing how her partner does not see an issue when their children have arguments with their partners, but she does:

> I think sometimes you are more concerned because you see where an argument can turn into. (Clara)

Donna also explained how she is specifically aware of danger when she is alone, especially when she is alone in her home. Linking to the previous point of safety conditions contradicting knowledge, she explained the irony that statistically she knows she is most at risk from someone she knows, but that she has an irrational fear of a stranger breaking in or attacking her:

> I'm not okay with being in the house on my own and I think that's definitely the job… which is really ironic, because we know it's going to be somebody you know majority of the time. But that fear of is somebody being there… breaking in or, you know, somebody attacking you. It's like that fear is still there and you can't even explain it. (Donna)

This quote also illustrates how Donna has recognised that the role caused these irrational fears, demonstrating self-awareness of changes to her cognitions because of being surrounded by accounts of violence and abuse.

These findings of feeling less safe, and more aware of danger support previous research. For example, Steed and Downing (1998) found participants had increased vigilance in safety of

themselves and other people, and feel more vulnerable, while Iliffe and Steed (2000) found that more than half of the DV counsellors they researched felt less secure.

A novel finding regarding safety and awareness of danger centres around DAAs being aware of perpetrators in their local area, due to the cases they are party to (n=7). For example, Amy raised how finding out perpetrators live near to her can be unsettling, while Liz stated that she does not feel as safe as she did prior to being a DAA because she knows details of cases which happened in her area.

> I get my list through from MARAC and I do my research and I'm thinking that man lives down from the street from me and he's got this many convictions… I'm quite aware of there's a lot of people around that may be a risk to me. (Amy)
>
> I don't feel as safe because I realise that the people I am speaking to, they all live in [her local area]. (Liz)

Similarly, during the research Sarah shared how she was moving to work in her local office, closer to her home, from a neighbouring county and because of that she was now aware of perpetrators in her area.

> I've been in sort of like ignorant bliss up until now about what's happening on my doorstep, you know, and I've never sort of like made any effort to try and find out what's happening in my local area... Best not knowing (Sarah)

These experiences evidence how DAAs can specifically feel more unsafe, and aware of dangers due to supporting victim-survivors in their local area, and awareness of local perpetrators, which has not previously been raised in research with samples of other VAW workers. However, similar issues have been raised as being experienced by other professional groups, such as social workers (for example in Green et al's (2003) study).

Seven participants also shared how they have made certain changes to their behaviour due to becoming a DAA and the effects of the role. While many people in the general population make changes to their behaviour to feel more secure, and many women are taught methods to protect themselves such as not walking alone at night (Tandogan and Ilhan 2016), the behavioural changes cited by these participants are believed to stem from being exposed to repeated accounts of abuse and trauma. The changes to behaviour reported by DAA

participants resemble those enacted by victim-survivors following experiencing sexual assaults, including day-to-day changes and using security measures (Ullman et al 2018).

While some participants stated they have always engaged in methods to keep themselves safe, such as keeping their keys in their hands when they walk, or not wearing headphones so they can be aware of their surroundings, Sarah explained how since becoming a DAA, she now takes extra measures as she is frightened of being a victim:

> When I'm in car and I'm driving, I lock the- I've got a button that can lock all my doors. I never used to do that. (Sarah)

Additionally, three participants spoke of changing their routes or routines due to the heightened awareness of danger which they now have from working as a DAA. For example, Yasmin and Liz both referred to changing their patterns due to fears that potential perpetrators could notice, which may put them at risk.

> I walk my dog at different times so that no one thinks I've got a pattern… I would feel threatened if I thought someone had noticed. (Yasmin)

> When I'm walking home from work, I realise I've walked this way too many times now, I'm gonna turn a different route. (Liz)

Due to her fear of being in her house alone, which was mentioned earlier, Donna shared that to protect herself, she has previously taken a weapon to bed with her when her husband was away for the night:

> I've gone to bed in the past with a knife or you know, with some kind of object… just to kind of, I felt safer. (Donna)

However, she explained how she now tries to force herself to not do this, as she wants to "overcome the fear" and not change how she lives or behaves. This is also the case for her with walking alone, as the below quote illustrates:

> I wish I could walk and not have to worry about these things. But I still walk. (Donna)

Because of her awareness of danger, and knowing perpetrator cases in her area, Sarah explained how she is now less confrontational and "a lot more meek". She explained that previously she would have been more "chopsy" and intervened in arguments in public to protect others, but now she is aware of dangers, she feels safer in alerting authorities to intervene instead.

> I didn't realise there was so many people in this area that carry knives, that have warning markers for guns. And I would never have thought it was an issue in this area. And it makes me think twice that does now, let the police deal with it. (Sarah)

These changes to behaviour illustrate the intensity and severity of these disruptions to safety schema, as they have adapted their behaviour due to the changes to their cognition. This supports Crivatu et al's summary of trauma effects (2021, p.60) such as trauma workers avoiding using taxis to feel safe after supporting victim-survivors who had been attacked by taxi drivers.

In summary, DAA participants have experienced distortions to their safety schema around awareness of danger, which is a feature of VT. However, these effects are nuanced, as some changes to awareness and behaviour would be understandable considering the knowledge that DAAs are party to, therefore it is complex to determine to what extent these changes are rational. Nonetheless, whether these changes are rational, or irrational, the existence of these changes to the schema of safety evidence VT in this sample. Additionally, these changes could also be seen as a positive effect, as measures can be taken to ensure safety, which will be considered in section 6.3.2.2. The general awareness of danger and actions to mitigate this support previous research on other VAW samples, and also illustrate their application to DAAs. This section has also illustrated the original finding in VAW workers overall with safety being distorted due to participants being aware of perpetrators in their local area.

5.4.2. Distortions to Safety – Overprotective of Children

Additional to being more aware of dangers which could befall them because of their roles as DAAs, six participants expressed a heightened concern for their children and grandchildren, which stem from the role. Linked to awareness regarding perpetrators in her local area, Sarah discussed how being aware of Multi Agency Public Protection Arrangement (MAPPA) offenders being released into areas where her son frequents, and knowing about perpetrators having warning markers for weapons and firearms frightens her:

> Reading [case notes], I'm more concerned about my son. (Sarah)

Similarly, Amy shared that when her daughter was younger (when she first started work as a DAA), she saw every boyfriend as "a potential perpetrator", but that now her children are

grown up she is not as overprotective. However, she is now overprotective of her granddaughter and says she is "a bit obsessed with needing to keep her safe". For her granddaughter, this fear mainly centres around being aware of online harms, which was also echoed by Rose, who is very aware of the dangers of the online world from her cases:

> [I'm] far more conscious of advising them in terms of online safety. (Rose)
>
> For me it's more about the internet. (Amy)

From these fears and overprotectiveness of children and grandchildren, five participants discussed changes in their behaviour. Considering the online fears, Rose discussed "putting safety plans in place" with her grandchildren. Both in person and online, she asked them questions about safe environments and what they can do if they do not feel safe. Amy acknowledged that whilst her daughter is proficient in safeguarding from her own career (and chastises her mother for discussing risks), that "she doesn't know what I know", so she feels it is her place to protect her granddaughter as she feels she is more knowledgeable of dangers.

Regarding real world safety for her son, Sarah shared that she does not let her 15.5 year old son out in the dark because she knows about perpetrators in their area. He was said to be exasperated by her being overprotective:

> He's like saying, "Mum, my friends are allowed out!" (Sarah)

Equally, Tegan speaks openly to her children about dangers which she has learnt through working in the sector, such as breaking myths about the "typical sex offender" look and being "open with them about children being abused, kidnapped, things like that":

> Because you've got this grand concept that [they] look a certain way and they don't… There is no typical sex offender… they are everyday people that you meet on the street. (Tegan)

These experiences support previous findings of disruptions to safety centring around becoming more protective of children. For example, Bozga et al (2020) found that female police officers working with Sexual Assault (SA) "became wary and overprotective mothers" (p.40) with one participant explaining how she sits in the car park outside parties her child is attending instead of leaving as she is worried for the child's safety. Similarly, Sui and Padmanabhanunni (2016) found that trauma workers who have supported rape victim-

survivors instil safety tips in their daughters to protect them. While concern for their own safety is not an impact of trauma work, becoming overprotective of children has also been found to be a concern for male trauma workers, such as police officers who work with SA stopping their children from attending sleepovers (Parkes et al 2019) and male DV counsellors being concerned for their children, or partners safety (Iliffe and Steed 2000).

In summary, some participants shared that they still feel physically safe, but this was not the case for all participants. Participants reports of being more aware of danger support findings from other VAW workers and evidence these effects in DAAs. This section also introduced a novel finding regarding DAAs awareness of danger, specifically around awareness of perpetrators living in their own area due to their work, which is not present in literature regarding other VAW workers. This section has also provided findings which support previous research around participants becoming more overprotective of their children and grandchildren, due to being exposed to accounts of abuse.

5.5. Frame of Reference

This section will discuss frame of reference, which is the psychological need to "develop a stable and coherent framework for understanding one's experience" and why events occur (McCann and Pearlman 1990b, p.23). For these participants, disruptions to frame of reference surround cynicism, seeing DA everywhere, and desensitisation, which will be discussed in turn.

5.5.1. Cynicism and Seeing Domestic Abuse Everywhere

Nine participants shared how they are now more cynical than they were before working as a DAA. For Amy, this was expressed as being "hardened" and having "a totally different perspective on life and people" which was "not always good", while Jayne simply stated that "I'm a lot more cynical". Charlotte's explanation of her new frame of reference combined both aspects, with her explaining:

> I'm more cynical now than I used to be. I'm harder. A lot harder than I used to be. (Charlotte)

Within these nine, six participants said that they were naïve to the negative aspects of the world before they started working as a DAA. For example, Melody explained how she used

to have a positive view of the world which she liked, but this has changed since being a DAA and she now thinks her view of the world was naïve:

> I was extraordinarily naïve before working here, I liked my little rose-coloured world, it was lovely. (Melody)

Three participants also expressed the negative change in their frame of reference through their general view of the world and how this has become darker. Tegan said "it's a dark world" while Liz explained how she "thought the world was a horrible place" due to being surrounded by accounts of abuse. These disruptions in frame of reference directly stemmed from the traumatic accounts of abuse which they were exposed to on a daily basis.

These disruptions in frame of reference and worldview support findings from previous research with trauma workers, as they become "better acquainted with the dark side of human nature" (Arnold et al 2005, p.253). Ben-Porat and Itzhaky (2009, p.513) also found that social workers who work with Intimate Partner Violence (IPV) had more distorted worldviews than other social workers, due to perceiving humanity as "aggressive, evil and malicious". This was also echoed in Steed and Downing's (1998) research into SV counsellors, where participants had lost their faith in humanity.

Alongside becoming more cynical in general, Sarah also disclosed a change in her frame of reference regarding spirituality. She explained that she used to believe that everyone had a guardian angel, and that "everything happens for a reason", but that since working as a DAA, she has stopped believing that due to the harms that people cause each other:

> I used to be quite… into angels, reiki. I've done diplomas in crystal healing. But yeah, I find that I've left… I'm not as into it now I'm doing this job… And I used to believe that we all had angels on our shoulder. And I just look at some of these people. I just think they're evil. (Sarah)

> I used to always believe everything happens for a reason, and now I just think there's no reason to this, all this shit. No, there's no reason why that should be happening. I don't believe that. (Sarah)

This contrasts with Arnold et al's (2005, p.251) research where some trauma psychotherapists described a deepening of their faith, and Bell's (2003, p.520) study where

DV counsellors spoke of faith helping them as “things happen for a reason”, and demonstrates how changes to frame of reference can affect spirituality.

Eight participants also shared that they now see domestic abuse (DA) everywhere. Some participants spoke of picking up of “red flags” in relationships, which other peers may not have noticed, while others spoke of noticing abusive behaviours on television programmes. Rose defined this as a “burden of awareness” which since being a DAA she views every interaction in life through:

> The biggest lesson [starting as a DAA] was, *is,* that you literally carry this burden of awareness around with you. And you filter everything, every life experience, every conversation, every interaction through this prism of awareness. (Rose)

This view of the world meant that participants suspected of DA, even when this was not the case:

> If I see things on the news, in particular of a woman that's died in a house, I will automatically think it's DV. (Donna)

She also specifically referenced Nicola Bulley’s disappearance (BBC website 2023), and how she (incorrectly) thought Nicola’s partner had been involved:

> Nicola Bulley, straight away. I thought that was something. (Donna)

This specific disruption to frame of reference aligns with research conducted by Beckerman and Wozniack (2018), who found that DV counsellors experienced shifts in worldview, and were alert to abuse, scrutinising others’ interactions in public and their private lives. Similarly in their study on DV counsellors, Iliffe and Steed (2000) found that participants had become acutely aware of power and control issues in their surroundings.

However, some (n=5) participants said there can be positives to being aware of the negative side of the world and having this knowledge meant they can put strategies in place to make themselves feel safer (this will be further explored in section 6.3.2.2). For example, Melody said that “ignorance is not bliss”. However, Sarah presented ignorance as a protective factor:

> I think ignorance is bliss [laughs]. I hate going to MARAC and hearing about all those scary people walking the streets because there's nothing I can do about it. It just

> makes me worry, now, you know? I think, yeah, ignorance sometimes can be bliss. (Sarah)

These findings evidence how participants can experience VT thought disruptions to their frame of reference, supporting previous research, in them becoming cynical and seeing DA everywhere.

5.5.2. Unable to Watch Abuse or Violent Content

Another disruption to frame of reference is that participants (n=7) changed the content of what they can watch or read for leisure since starting work as a DAA, as they no longer find enjoyment in seeing anything containing violence or abuse, including the news. For example, Liz shared that there are some things she now does not want to watch, because the experiences she sees on screen are "actually true for some of my women", and she does not "want to watch [abuse] on screen when [she's] heard about it".

> It does affect how I view the media and stuff, TV and films, yeah there are certain things I can't watch anymore, like I can't deal with that, no. I don't want to see it. (Liz)

> I don't want to be going home and you know, you're sort of like talking about it all day and reading stuff… I used to love a good, like horror or psychological thriller. Now it's all like a rom-com… something really like light-hearted. (Sarah)

Similarly, Donna explained how she cannot listen to any physically violent content, and that she needs to mute the television when this happens:

> Any hints of rape scenes, any hints of violence. I mute. I have to mute, drives [spouse] crazy when watching films. (Donna)

Alternatively, for three participants the content they consume will depend on the day they have had in work, and whether they have been exposed to trauma:

> If I've had a bad day, I think… I won't watch anything heavy tonight. (Amy)

These participants' experiences suggest that avoiding this content is not always a choice to limit their consumption as a coping strategy, but that they veer from traumatic material as they cannot bear the additional exposure to violence and abuse, marking a disruption in how they view the world, or their frame of reference (McCann and Pearlman 1990b).

Similarly, Massey et al (2019) interviewed SARC workers who disclosed that they also avoided watching distressing content.

5.5.3. Desensitisation

A third aspect of having a disrupted frame of reference is desensitisation, or not being shocked or upset when confronted with abuse details and harms. Iliffe and Steed (2000) found half of their DV counsellor sample were unable to be shocked by DV content. Participants in this study (n=10) also discussed being desensitised, with Yasmin explaining how “it takes worse and worse things to shock you” while Martha described it as your “baseline normal” being “skewed”.

Interestingly, some participants said they often did not realise how badly desensitised they were until new staff members start the role and they observe them being shocked by cases:

> I think you don't even realise it until you get a new member of staff come in. And then you, you can feel yourself thinking, oh God, [I] didn't even think about that. And again, I'm not saying that's good, how they're feeling, but it's almost like, oh, you'll get used to it. (Amy)

> I'm getting more desensitised, but I hadn't realised it. It’s only since the new people have started. (Sarah)

Melody discussed desensitisation when creating her scene pictured in Figure 9 and said “I don’t get fazed by much anymore really, I think [it] is a big thing”. During the first interview, she described how she was second guessing career choice because she had fears over being desensitised.

> [Being a DAA is] not really any big deal once you get used to it. But that’s just it, I kind of don’t want to get used to stuff like this, almost. Like I don’t want it to be commonplace that I’m reading about a woman who’s been raped, and be like, oh, it is what it is, just another Tuesday. (Melody)

Figure 9 - Melody Second Guessing

This draws parallels with Bozga et al's (2020) study which reported that female police officers wanted to resist becoming desensitised in dealing with sexual offenses. However, by the second interview, Melody had come to see desensitisation as protection from VT, and compared it to being a paediatric cancer nurse, saying if you were upset all the time, you would not be able to do the job:

> I've actually come to accept that rather than be upset by it because I think it's a necessary shell that we need to develop as support workers or else you'd just be like really sad all the time if you didn't have that shell. (Melody)

Amy also stated this alternative view of desensitisation, saying how without becoming desensitised, DAAs "wouldn't be able to cope" and how perhaps it should be viewed as developing a way to cope with the accounts with which you are being presented:

> I don't really think that's an awful bad thing because I think if you continually felt like you did when you first started… you wouldn't be able to cope. I don't think it's so much desensitised. It's more you've developed a way to deal with it (Amy)

This echoes findings from Massey et al (2019) where SARC workers believed that staff who do not desensitise to the abuses they are hearing leave the organisation sooner than those who do become desensitised.

In summary, the findings from this research support participants experiencing VT through disruptions to their frame of reference, becoming more cynical, seeing DA everywhere, being unable to watch abuse and violence through media, and becoming desensitised from

exposure to abuse accounts. These experiences support previous findings from research into other VAW workers (Arnold et al 2005; Beckerman and Wozniack 2018; Ben-Porat and Itzhaky 2009; Bozga et al 2020; Iliffe and Steed 2000; Massey et al 2019; Steed and Downing 1998) and show how this sample are also affected in these ways. The findings also illustrate the tensions in how desensitisation is viewed, whether it is a negative effect which harms the DAA, or an aspect of emotional management which is needed to successfully cope with the role.

5.6. Power

This section will discuss disruptions to the schema of power, which relates to the psychological need to direct control over others (McCann and Pearlman 1990b). While some DAAs responded to questions around power positively (see section 6.3.2.1 on empowerment), for some DAAs in this study, issues around power concern the view that they are powerless to contribute to ending VAW, and how their job can seem meaningless because of this.

During their first interviews, two participants discussed the scope and pervasiveness of DA. Amy specifically stated that it makes her feel powerless:

> I feel powerless… I don't feel like we make a huge amount of difference, although I'm sure we do for a few. I feel overwhelmed with the amount of domestic abuse within the small area. Yeah, powerless. (Amy)

Amy discussed how she had been working for 18 years in the same area, and that she was amazed how she was still seeing new people considering the size of the area. She shared how she used to think organisations could end DA, but that she no longer feels this way:

> I used to think that actually, we can do this, if we all work together… I don't think we can. (Amy)

In the same vein, Jackie spoke of how there would never be a worry of the sector disappearing, as there will always be DA:

> I think we'll always have a job. (Jackie)

When the summary of findings related to power were presented to participants in their second interviews, six additional participants agreed that they can feel powerless as DA is not reducing or being eliminated (making n=8 in total). Martha shared how she is now

"aware of the reality" of DA, which has led to her feeling less hopeful, and that levels of DA are not reducing, saying "it isn't changing, or isn't changing at a pace that you could see", while Tegan said "it won't ever end… It's never going to change."

Meanwhile, Yasmin reflected that while you can help one person, the wider issue is not changing, that "you can do so much good… But at the moment we're fighting a losing battle".

This reinforces conclusions that VAW workers feel "disempowered" in their jobs (Crivatu et al 2021, p.60), specifically workers feeling powerless to make change (Iliffe and Steed 2000) and feeling hopeless because VAW work is "never-ending" (Massey et al 2019, p.693). This implies that viewing their support work through the wider lens of ending VAW can be detrimental to DAAs (and other VAW workers) and their schemas of power in exerting control over situations[34].

5.7. Memory Aspects

Vicarious trauma can arise through the temporary or permanent alteration of memory systems, which can take the form of affective states (emotions) or disruptions in imagery, such as nightmares or flashbacks (McCann and Pearlman 1990a; 1990b). This section will first examine evidence which substantiates the change in affective states of participants, before considering disruptions in imagery.

5.7.1. Affective States

Participants shared their emotional states from supporting victim-survivors and later reflecting on victim-survivors' stories. These emotions were related to feelings of responsibility, which caused anxiety and fear, sadness, and emotional exhaustion.

All participants (n=13) referred to the responsibility of the role and the unrealistic expectations of victim-survivors, and the effects these have on DAAs, specifically around anxiety. This anxiety was reported as being heightened when participants needed to work on-call or were returning to work after time away (including weekends and holidays). In general, Amy said she felt "extremely responsible", while Martha spoke about the

[34] Strategies to combat this will be explored in section 7.3.3 on Keeping Perspective

difficulties that she experiences because of the responsibility of being the "vessel" for victim-survivors' emotions, and how absorbing these brings a "weight":

> You are almost the place they put these things, the vessel for it, the emotional sponge if you were. You're the place it goes… there is a sense of you being the safe place they put these things. Which has a responsibility. (Martha)

This reference to being an "emotional sponge" parallels findings from Massey et al (2019, p.693), where a participant said they "absorb" the emotions of others, "like blotting paper". These descriptions of absorbing, and of being a vessel for victim-survivors' emotions highlight how DAAs internalise the accounts that they hear and are still affected by them once the session has ended.

To represent the responsibility she felt, Jackie created the scene illustrated in Figure 10. In this creation, she has buried her figure in the sand, representing her being under the weight of the role:

> You feel sometimes like… there's a lot of weight on your shoulders. (Jackie)

Figure 10 - Jackie Buried Under the Weight of the Role

This feeling of responsibility and fearing for victim-survivors can also manifest in having anxiety over giving the "wrong" advice, which could lead to victim-survivors getting harmed and generally worrying about the safety of victim-survivors. Donna explained that she is "scared of making the wrong decision", but also that as a manager, she has fears about giving "the right advice to the support worker" to keep them safe as well.

> I get scared some of the time that some of the residents who I support may be dead, so if I don't get hold of them, I worry that they've overdosed, or somethings happened to them. (Clara)

> I found myself fearful about the risk of her committing suicide. I've got to say was hard to deal with. (Rose)

Additionally, Jayne shared how she has attended two deaths of victim-survivors in her refuge, one through suicide and one overdose, and explained how these had affected her:

> I did deal with two sudden deaths and I carried on as normal and then it builds up and builds up. (Jayne)

These fears for victim-survivors, and feeling responsible for their wellbeing support previous findings, such as DV counsellors feeling responsible for clients, with participants saying you are never sure that you will not read their names in the paper after being killed (Iliffe and Steed 2000). Similarly, Bozga et al (2020, p.38) found that female police officers working with SV feel constantly burdened and "overwhelmed with responsibility".

Tegan raised the responsibility from the high expectations of victim-survivors through her creation of the image in Figure 11. Tegan's sand scene depicts her as a superhero faced with victim-survivors and their high expectations, stating that victim-survivors view DAAs as "an emergency service" and that that they "can work miracles". She explained that these expectations are "just overwhelming, absolutely overwhelming".

Figure 11 - Superhero Tegan Versus High Expectations

All participants agreed with this point in the second interviews, giving examples of the expectations which provoke anxiety and stress for the worker. For example, Melody explained that victim-survivors expect her to “conjure up a house”, while Jayne shared how a victim-survivor wanted her to “force her adult children to see her” and when she explained that is not something she could do, the victim-survivor told her she was “not doing [her] job”.

These feelings of responsibility can build to physical effects of anxiety, such as panic attacks. Amy cited how being “overwhelmed with it all” can lead her to “develop a panic attack and what comes with that”. Other participants also cited physical effects of anxiety because of the responsibility which centred specifically around lone working, being on call or returning to work after time off. To illustrate, Martha described a “Sunday night sense of foreboding” before returning to work, which manifested as anxiety and “dread”, while Sarah was prescribed anxiety medication because of this worry:

> Makes me anxious, fearful… I just had a 2-week holiday, first time in seven years I’ve had two weeks off, but… there's that worry what's going to happen while I'm away, you know, because the clients are high risk of harm. (Sarah)

Yasmin also felt anxious before going on call, where she would be the sole person responsible for the victim-survivor. She explained that it was due to “not knowing what was coming your way” when she gets called in out of hours, and that “it could be anything”. Additionally, Donna explained that the anxiety caused by the responsibility of the role lead to effects on her physical health, with it affecting her sleep and her appetite.

Separate to feelings of responsibility and the anxiety this causes, six participants described experiencing sadness and feeling emotionally exhausted due to being a DAA. For example, Sarah said work is sometimes “really upsetting”, and that she “can’t get over” feeling emotional due to cases. She referenced a specific case during discussions, where a victim-survivor had been abused by “everyone she's [come into] to contact” with and how this makes her sad and “it just makes me want to cry”. When other participants were asked whether there were any specific cases that affect them, Yasmin got upset when remembering a case which she thought she had forgotten about. This suggests that even when DAAs think that they have stopped being affected by cases, that they still carry the sadness with them, which can be recalled when thinking of the case:

> Oh, shit, it’s making me upset thinking about that now, although I thought I'd put it to the back of my mind, and I clearly haven't. (Yasmin)

Emotional exhaustion was cited by Liz as an effect of being a DAA. Figure 12, Liz’s sand scene, features a toy which represents her and has its arms up in the air, explained by Liz as “she’s had enough. Get me out!”. She further discussed how she sometimes returns home from work very emotional, linking this to being emotionally exhausted:

> Sometimes I’ll just come home and I’ll just cry to the dog… I’m literally emotionally exhausted. (Liz)

Figure 12 - Liz Surrendering

These findings corroborate previous research into the emotional effects of trauma, and VAW work, illustrating how DAAs are emotionally affected by their work, through fear and anxiety related to the responsibility of the role, sadness, and emotional exhaustion from hearing victim-survivors’ experiences. Arnold et al (2005 p248) found that 71% of psychotherapists experience negative emotional responses such as sadness and anxiety. For VAW samples, most female participants in Iliffe and Steed’s (2000) research into DV counsellors disclosed feeling emotionally drained or exhausted, while SARC workers in Massey et al (2019) reported feeling sadness from their work.

5.7.2. Disruptions in Imagery

Disruptions in imagery have previously been found to be experienced through overwhelming images, dreams, and intrusive thoughts (Steed and Downing 1998). A key

component of disruptions in imagery is trauma workers experiencing nightmares from supporting clients. Three participants in this study discussed having nightmares centred around specific cases which they had supported as DAAs. Jackie stated how working on "extreme" cases can sometimes lead to her having nightmares, while Rose disclosed how she had woken really angry from a nightmare around a specific case:

> I had a nightmare and I was dealing with a really difficult case that was taking up a lot of headspace. (Rose)

Similarly, Jayne shared that after attending deaths in her role, she had experienced nightmares, "I used to have nightmares [from them]".

While those three participants reported nightmares on specific cases, two additional participants shared that they now have recurring nightmares on generalised abuse, surrounding them either being attacked themselves or having a nightmare where they are trying to protect women/children from a perpetrator. Sarah described the content of her nightmares:

> I'm in a house and someone's trying to break in, a man… I often have like, dreams about people breaking into my house, or I'm in a house trying to save a woman with lots of kids and this perp is try trying to get in and I'm trying to save everyone… I never used to dream like that before. (Sarah)

Sarah also shared that "I have had a couple of dreams about people being raped recently". Additionally, Donna has generalised abuse nightmares which happen a few times a year, following which she needs to wake her spouse for comfort:

> They are usually about somebody chasing me, somebody breaking into the house, fear of violence, somebody's going to hurt me. (Donna)

This draws parallels to previous research of VAW workers experiencing nightmares (Arnold et al 2005; Beckerman and Wozniack 2018; Bozga et al 2020; Steed and Downing 1998), including internalising the experiences of their clients, shown by Sui and Padmanabhanunni (2016, p.130) where a rape worker reported having nightmares of the rapes of herself and her daughter.

An additional component of disruptions in imagery are flashbacks and intrusive thoughts when workers are awake. These could be attached to specific details of cases that DAAs had

supported (n=2). Clara refused to share the particulars of this story as she worried it would affect me, but she said:

> One of the ladies I support now, something happened to her for a long time and when I see that item now it makes me feel sick, because it's an everyday item around the house, and I actually feel like a nausea feeling when I see it. And that's from listening to her interviews in the SARC and knowing that that [item] was used against her, and on a weekly basis. (Clara)

This suggests that in line with the VT concept (McCann and Pearlman 1990b), Clara had internalised the account of abuse regarding that item from the victim-survivor and how it physically affected her, but also that she was aware of its impact on her, and that she was wary of passing that trauma onto me, third-hand. Similarly, Donna supported a case of a rape in a local park and stated, "sometimes that pops into my head if I pass it or you know, I think about her". These findings align with previous research where case details have been recalled, for example, in dreams for SA police officers (Bozga et al 2020) with the images of "little red sandals" (discussed in section 3.2) and intrusive images in sexual abuse therapists in Steed and Downing's research (1998).

Even when not attributed to specific items or places, almost all (n=11) participants shared that some stories stay with them. Jayne explained "what she told me will never ever, leave my head. Never", whilst Charlotte said, "it's not affecting your day-to-day living, but… anything can sort of trigger anything off". These quotes echo the findings of Iliffe and Steed (2000) where almost all DV counsellor participants had visual images which they stated would never be forgotten.

In summary, this section demonstrates how DAA participants experience components of memory aspects which are consistent with VT (McCann and Pearlman 1990b), including affective states and disruptions in imagery. For affective states, participants described feeling anxious due to the responsibility of the role, including being an "emotional sponge" and fearing giving the "wrong" advice, feeling sad or emotionally exhausted. These findings all corroborate previous research into VAW workers, as do the disruptions in imagery which manifest as nightmares and flashbacks.

5.8. Cumulative Nature

As discussed in section 2.3.5, a key component of VT is that it is not caused by a one-off event, but rather the cumulation of listening to traumatic accounts. While certain stories can stay with workers (section 5.7), five participants acknowledged that it was not these specific cases which changed their cognitions or behaviours attached to them, but instead that these changes happened gradually, and accumulated. Amy and Jackie both cited a "gradual" change in their cognitions and behaviours, and that they cannot pinpoint a specific time when their attitudes changed:

> I think it changed gradually. I can't say that I can remember like, you know. (Amy)

Similarly, Rose spoke of "this constant drip, drip, drip [of] trauma", illustrating the pervasiveness of being exposed to trauma accounts through the role, while Yasmin expressed this as a constant conveyor belt:

> It's just this constant conveyor belt of "my perpetrator did this", "mine did this", "mine did this and he's doing this and he's terrorizing me through the courts now, wanting to see the children", and on and on and on and on it goes. (Yasmin)

This was echoed by Martha, who explained that when she is affected by the role, it is "less about any one particular person and more about just like the sheer volume" she is exposed to over time. These findings support Massey at al's research into SV workers (2019) where participants discussed the effects of the cumulation and volume of the work. These accounts demonstrate that in line with the VT concept, effects on DAAs are cumulative and gradual, opposed to being caused by one specific account which they can identify.

5.9. Conclusion

This chapter partially addressed research question one, what is the effect of being a Domestic Abuse Advocate (DAA) on the individual, situating effects through the lens of Vicarious Trauma (VT) and the disruptions within it. The cognitive schema related to psychological needs which are pertinent to experiencing VT were discussed in turn, presenting evidence for how DAAs experiences fit within the VT concept.

Firstly, disruptions to intimacy were examined, including experiences surrounding feeling isolated and changes in relationships with family and with intimate partners. Disruptions to trust/dependency were then explored, with some participants still being trusting, while

others had less trust in all, or less trust in men, specifically. Disruptions to feelings of safety followed, with findings regarding awareness of danger and being overprotective of children being discussed. Fourthly, disruptions to DAAs frame of reference, or their worldview were presented, with reference to cynicism and seeing domestic abuse everywhere, being unable to watch abuse content and desensitisation. Disruptions to the schema of power were then explored, explaining how DAAs can feel powerless due to the scale of DA, before changes to memory aspects, specifically affective states of anxiety through responsibility, sadness and emotional exhaustion, and disruptions in imagery through nightmares and flashbacks were discussed. Finally, this chapter examined how, consistent with the VT concept, these disruptions happened cumulatively, and gradually overtime.

Many of these findings support previous research into trauma and Violence Against Women (VAW) workers and contribute to the knowledge base by evidencing their existence in DAAs. However, some findings present new insights and nuance into experiences of VT in overall VAW workers, specifically regarding self-isolation due to knowing perpetrators in their social circles, and having a heightened awareness of danger due to the knowledge of perpetrators in their area. The next chapter will present the combination of negative and positive effects which were experienced by DAAs and consider the remainer of research question one, the positive effects on DAAs through the lens of vicarious resilience.

6. Exploring the link Between Vicarious Trauma and Vicarious Resilience

6.1. Introduction

Following the discussion of negative effects of being a Domestic Abuse Advocate (DAA) in Chapter Five, this chapter will continue to explore the findings related to the first research question, what is the effect of being a Domestic Abuse Advocate (DAA) on the individual. However, in this chapter there will be a focus on positive effects. In earlier drafts of this thesis both VT and VR were discussed together in one chapter. However, the findings regarding these concepts were separated into two chapters to enable sufficient space for, and focus on, the findings relating to each concept. However, while both aspects are important, as participants accounts were primarily concerned with negative rather than positive effects, this chapter is necessarily shorter than Chapter Five. The chapter will begin by discussing the link between negative effects related to Vicarious Trauma (VT) and the positive effects of Vicarious Resilience (VR) (Frey et al 2017) before examining the positive effects which fall under the two aspects of VR, namely positive feelings and psychological growth.

6.2. Relationship between Vicarious Trauma and Vicarious Resilience

During the initial interviews, all participants explained some positive aspects of being a DAA (n=13) alongside the negative effects discussed in the previous chapter. Participants only raised one or two positive effects in the initial interviews. However, when presented with initial key findings in the follow up interviews, which included diverse examples of VR, participants shared their agreement with experiencing the wider range of positive effects, which evidences the importance of the multi-stage research design.

Without asking about the interaction of positive and negative effects, in the first interview Clara stated that working as a DAA in refuge, the effects on her life are “like wading through mud. But pink, glittery, gorgeous smelling mud”; a simile which illustrates the effort of hard work, but the associated positives aspects. This expression of hard work and the link with positive effects was echoed by Donna, who compared working in the sector to vigorous exercise:

> I think about it as exercise so like running I, you know it's hard running, but the feeling you get after you finish the run is amazing. (Donna)

Other participants discussed the link between VT and VR more generally. Yasmin, for example, stated that as a DAA "you see the worst of humanity, but you also see the best of it", while Melody reflected that seeing the positive effects of her work makes the negative aspects "worth it".

> To hear from someone directly about how my support has impacted them in a positive way is a reminder that, you know, the shit part of this job is totally worth it. (Melody)

This coexistence of positive and negative effects supports previous research findings in other samples, aligning them with the experiences of DAAs. For example, Arnold et al (2005) found that in their sample of trauma psychotherapists, all participants experienced both positive and negative outcomes (n=21, 100% for both), and discussed how they can be interlinked. For example, a participant discussed that they now appreciate life because they see how fragile it is (Arnold et al 2005, p.252). Similarly, Hernandez-Wolfe et al's (2015 p.163) research into mental health torture workers found that trauma can cause "both stress and joy", with VT and VR coexisting, and workers being changed "in positive, but not painless, ways" (p.153).

However, findings from this research do not necessarily suggest that VT and VR are balanced. In her initial interview, Yasmin answered the first question after her sandbox with admittance of positive and negative effects before discussing the positive effect first, saying that being a DAA affects her "in a positive way as well as maybe a negative way". However, later in the interview she then said the following:

> I think the worst of [humanity] is sometimes what sticks in your mind, even though you are seeing the very, very best of it as well... I think sometimes it's the darker side that prevails. (Yasmin)

Yasmin's initial foregrounding of positive effects over negative effects could have suggested that positive effects are the most important to her. Yet, her further discussion of the dark side of the job prevailing would suggest that the negative outweighs the positive, and her distorted frame of reference in VT (with the worst of humanity sticking in her mind) outweighs her VR (seeing the best of humanity). Conversely for Tegan, the negatives come

first, and then it is an effort to be attentive to the positive effects as these are the ones she wants to maintain, an approach that aligns with techniques in Cognitive Behavioural Therapy:

> You do just see the negative first and you've got to really try and train your brain; go, as much as that is a negative, challenge it to become a positive. (Tegan)

Similarly, Martha found it harder to think of positives than negative effects, saying "that's a hard one" in response to a question on what the positive effects of being a DAA are. This resonates with the earlier work of Ben-Porat (2015) who explored the link between Vicarious Post Traumatic Growth (VPTG) and Secondary Traumatic Stress (STS) in Domestic Violence (DV) therapists. The study also found that negative effects are not necessarily balanced with positive effects and that when STS is high, growth declines (Ben-Porat 2015, p.930), suggesting that experiencing negative effects has a detrimental effect on experiencing, and recognising positive effects of the work.

This section has considered how participants experience both VT and VR together, aligning with research with other Violence Against Women (VAW) workers and general trauma workers However, this is the first time these findings have been discussed in direct reference to DAAs. This suggests that more research could be conducted to further understand the co-existence of VT and VR and how these interact for DAAs.

6.3. Vicarious Resilience

Despite findings in the previous section suggesting that the negative effects were more prominent than positive effects in participants accounts, all participants reported experiencing positive effects to some level (n=13). These positive effects which align with Vicarious Resilience (VR) can be divided into two main categorisations (Frey et al 2017, section 2.3.8), satisfaction (positive feelings) and psychological growth. This section will explore the themes consistent with these two categories.

6.3.1. Satisfaction

The first component in VR is that of satisfaction, defined as a "feeling of gratification and pleasure from doing helping work and making a difference", which is "reliant on observable client progress" (Frey et al 2017, p.46). Aspects from the findings which fit within this component are pride and purpose, and enjoyment, and instances where DAAs find their

work rewarding and interesting, which will be discussed in turn in the following sub-sections.

6.3.1.1. Pride and Purpose

Some (n=3) participants said that being a DAA gives them a sense of pride. This pride arose due to DAAs seeing the changes in victim-survivors, which they have contributed to, leading to positive feelings in the worker. For example, Jayne discussed how she had met an associate who was a counsellor, and when discussing where they work, she said to Jayne that she (Jayne) had saved one of her clients, and Jayne expressed how nice that felt:

> "You're the Jayne that saved [a client's] life"… that was nice to hear. (Jayne)

> I quite often smile when I'm driving home just from the conversations with the women I support, changes they have made and stuff, I'm like really proud. (Clara)

These accounts from Jayne and Clara align with Silveira and Boyer's findings (2015), where Domestic Abuse (DA) child support workers discussed feeling pride when clients experienced positive outcomes due to their own actions. Additionally, Clara disclosed pride not only from her own actions and how she helped victim-survivors, but also pride in her organisation and the change they are providing in the community. Similarly, Sarah said that it was an "honour" to be working with her colleagues, who provide support at "110%" each day to help others:

> I feel proud that as an organisation we are making a change. (Clara)

This aspect of being proud of the organisation they work for was featured in earlier research, such as Massey et al's (2019) research with Sexual Assault Referral Centre (SARC) staff also found they had pride at working in the organisation.

Many (n=8) participants explained that a positive effect of being a DAA is the purpose they get from the role, that they are making a difference to the lives of others which gives meaning to their work and their lives. Melody discussed how she has worked in previous roles and not felt that she has contributed to society, but how as a DAA, she knows she is making a difference:

> Quite a fulfilling feeling. Like you know, I've had jobs where I worked like 60 hours a week and… I've done like nothing with my day, except fill in paperwork, and give absolutely nothing back to society. (Melody)

> Sense of purpose… I have a strong sense of what I've gone to work for, and how useful I have been and my sense of utility in the world and fulfilling a role that is useful to other human beings. (Martha)

> I feel like I'm making a difference. Whether it's big or small. (Liz)

These findings support previous research into VR in trauma workers, such as psychologists having pride in their work, and having purpose through making a difference to the lives of others (Michalchuk and Martin 2019). Similarly, DAAs who are victim-survivors have reported that their work gives them "a sense of purpose" where they can use their experience "for the good of others" (Gilbert 2020, p.77). Findings regarding VR related to own experience of abuse will be further discussed in section 8.3.1.

6.3.1.2. Enjoyable, Rewarding and Interesting

Linked to feeling pride and purpose, another positive feeling which was reported by DAAs from their work, was in finding the role enjoyable, rewarding and interesting. Firstly, despite acknowledging the challenging nature, and dark side of the role, some participants (n=5) said that they love their job and enjoy the work they do.

> I do really, really love my job. (Yasmin)

> I love my job. I mean, I love the sector and yeah, all of it. It's just so special. (Donna)

Amy also discussed how enjoying the role, and supporting victim-survivors may seem morbid as they are seeing the pain people are put through, but that she does enjoy her work.

> You feel like a bit morbid enjoying it, definitely. (Amy)

This supports findings from Arnold et al (2005) where trauma psychotherapists reported that despite seeing clients' pain, it is exciting to be part of the victim-survivor's journey, seeing them improve their lives. Similarly, participants (n=7) also spoke about how they find being a DAA rewarding, as they get to be involved in victim-survivors' journeys and escapes from abuse, and get to see victim-survivors become happy with their lives:

> I feel like it's quite a nice, rewarding, empowering feeling in this job. (Melody)

> I think it's extremely rewarding. (Amy)

> I am happy when they're [victim-survivors are] happy. (Tegan)

This rewarding feeling was discussed by some participants specifically around events or victim-survivor intentions. For example, Clara discussed how events such as Christmas can be very rewarding due to seeing the happiness in adults and children in refuge when undertaking festive tasks:

> It is extremely rewarding and especially like Christmas time and things where you are putting up trees and doing activities… and then you see them all sat round by the tree having a hot chocolate or what have you and it's so rewarding, it really is. (Clara)

Some participants (n=4) also raised that it is very rewarding when victim-survivors say they want to volunteer or work in the sector following their support:

> I've had people want to volunteer or want to go to college for like social work… I think that's quite a rewarding feeling. (Melody)

Workers finding roles in the VAW sector rewarding has previously been found in previous studies which aligns with these findings. For example, Schauben and Frazier (1995, p.57) found that the most frequently mentioned positive aspect was "watching clients grow and change" and "being a part of the healing process" for victim-survivors. Similarly, Massey et al (2019, p.694) found that SARC workers find their job "hugely rewarding".

As found in Bell (2003), some (n=5) participants described how they find the job interesting due to the variance in each working day while assisting victim-survivors. For example, Jayne said that in "any other job I'd just get bored" but that working as a DAA, she does not get bored as "no two days are the same".

In summary, these findings demonstrate the satisfaction component of VR which is felt by the participants from being DAAs, with the role giving pride and purpose, and being enjoyable, rewarding and interesting, which supports previous findings from those within the VAW sector, and wider trauma workers.

6.3.2. Psychological Growth

The second component within VR is that of psychological growth, which is defined as "positive changes in self-perception, interpersonal relationships and philosophy on life" (Frey et al 2017, p.45). Findings from participants relating to this component of VR have been presented in the following themes: feeling empowered and more confident, gaining

knowledge and skills and changes in views of their own lives and relationships, and these are presented in turn.

6.3.2.1. Feeling Empowered and More Confident

Contrary to participants sharing feelings of powerless due to being a DAA (section 5.6), nine participants stated that the role has made them feel more powerful and confident. The feelings of power and confidence were explained through participants understanding their power in helping people and seeing their value as a worker.

During her first interview, while creating a scene to show the effects of being a DAA, Clara picked the figures in Figure 13 below to represent herself, a client and a dragon. She stated that "the dragon represents my nature, I am a force of nature" and how she works to help her clients and give them strength. She explained how since starting the job she is more "outspoken" and has the knowledge of options which can help people.

Figure 13 - Clara and the Dragon

Alongside Clara's scene and description, participants shared feelings of empowerment, including Charlotte stating she is "not a little mouse anymore" and Melody saying she is a "much more assertive person". For example, Liz explained that if she is in an uncomfortable situation, she is more willing to express her discomfort:

> This job has given me the confidence to say things to people. (Liz)
>
> I think I'm more assertive. (Amy)

Additionally, Martha described how since starting as a DAA, she has become more confident in her ability in the job. She explained how sometimes victim-survivors request refuge when other services would be more appropriate, and how over time in the role she has become more comfortable in signposting them to more applicable services:

> Not that it's still easy to say no to people, but at least I'm confident that I'm saying no for good reasons and I'm not just leaving them hanging. I'm putting other things in place that are usually more appropriate. (Martha)

These findings surrounding empowerment and confidence corroborate previous research. For example, Ben-Porat and Itzhaky (2009) found that family violence therapists reported being more assertive since beginning their roles, while DA child workers in Silveira and Boyer's (2015) study reported increased confidence at work.

6.3.2.2. Gaining Knowledge and Skills

Another area of psychological growth reported by participants surrounded the knowledge and skills they have gained since becoming DAAs. As referred to in sections 5.4.1 and 5.5.1, where participants reflected on their awareness and knowledge of DA as a negative consequence of their role, five participants stated that the knowledge gained in their role is a positive. Firstly, participants expressed that the knowledge and skills they have gained is positive because it means they are able to help people, both within and outside of work. For example, Clara stated that she is "like a walking DV book" while Liz discussed the benefits of having an "awareness of options" which can help others. This knowledge also extended beyond DA, with Jackie and Amy sharing that they now know "other stuff" which can help people, such as information and processes for housing.

Similarly, an aspect of growth from knowledge which participants reported experiencing was understanding perpetrator behaviour. For example, since working in the sector, one participant now understands why her father was abusive and has forgiven him:

> I feel like it's made me do a lot of work in regards to like forgiving my dad about things and understanding. Not justifying the abuse, but understanding why that was. (Anonymised[35])

[35] No participant pseudonyms have been used in presenting findings around experiences of abuse for increased confidentiality.

Another participant[36] also discussed her father's abusive behaviour, and stated how being a DAA has given her the knowledge to understand why some people abuse, specifically surrounding her father being a victim of sexual abuse himself as a child:

> He is a victim, initially that's how he started life, was as a victim, so I think that if anything, the job kind of lends insight into why. (Anonymised)

An additional finding regarding growth from knowledge came from the first participant, where she shared how this understanding has also led to her forgiving her mother for staying in a relationship with her father:

> Forgiving my mum for staying as well. (Anonymised)

Since being a DAA, she also now identifies as a victim-survivor, after years of not accepting the label because she believed it was not her experience to claim as a child, but her mother's:

> I would always say no on forms if I was a victim… because it took me a long time to think that me as a child, that I had the right to say that, because I thought that's for my mum to say, not for me. (Anonymised)

These explanations demonstrate how being a DAA had given her the knowledge to change how she viewed both of her parents due to the abuse, as well as how she thinks of herself, a child who was raised in her situation. Further presentation of how being a DAA helped victim-survivor participants understand own experience of abuse will be discussed in section 8.3.1 as an individual factor for experiencing VR.

Similarly, another participant[37] explained how since working in the VAW field, she has been able to identify her own husbands experience of being victimised by an ex-partner:

> Once I actually started working in this field and talking to my husband, I realized that he had been in an abusive relationship. This was the weirdest thing. And he found it really, really difficult to talk about it because he blamed himself. (Anonymised)

She went on to discuss how identifying her husband's prior abuse was "painful", but "liberating" as he stopped blaming himself for his ex-wife's behaviour.

[36] No participant pseudonyms have been used in presenting findings around experiences of abuse for increased confidentiality.
[37] No participant pseudonyms have been used in presenting findings around experiences of abuse for increased confidentiality.

Chapter Five included discussion of how being aware of dangers can distort feelings of safety, and lead to participants changing their behaviours as a consequence. However, some participants reflected that this awareness and these changes can be positive, as explained by Melody saying that "ignorance is not bliss". This was because DAAs can use this knowledge to protect themselves and their families:

> Some people who have kids have no idea what the world is like and they let their kids go off to the park by themselves, you guys are fucking crazy! What are you doing letting your kids go there?! (Melody)

While she shared that "ignorance is bliss" (section 5.5.1), when asked whether there could be any positives to her knowledge, Sarah stated that "safeguarding myself and my children" has "got to be a positive" of her new knowledge. Support for this can be found in Green et al's (2003) study of feelings of safety in social workers, where participants discussed the benefits of having "local" knowledge as they can "identify and avoid potential issues" (2003, p.101).

Similarly, Jayne's experience in section 5.2.2 of responding to her abused daughter as if she were a service user could potentially fit here with positive effects, as she had the knowledge and skills to help her daughter. However, as discussed in the section 5.2.2., for Jayne and her daughter, that was not appropriate in the moment, as she "needed her mum, not a support worker".

In summary, these findings illustrate how DAAs experience psychological growth through gaining knowledge and skills such as processes, understanding of abuse and safety planning. These findings corroborate previous research with other trauma samples. For example, during a study examining NHS counsellors and psychologists, participants reported that in their roles they have developed skills to help people, and their knowledge has improved (Coleman et al 2021). Similarly, mental health crisis workers discussed that doing the role helps build knowledge and skills on the job (Genever 2022), while youth counsellors have reported that the skills they have learnt in work have proved useful in supporting themselves and others outside of work (McNaughton 2023).

6.3.2.3. View of Own Life and Relationships

Alongside feeling changes to their confidence and power, and gaining knowledge and skills, many participants (n=9) described a change in the view of their own life. For Liz, this

manifests as recognising that she does not take her own advice and is harsh on herself, such as being negative about her image, whilst in her role she advocates for victim-survivors to have positivity and empowerment:

> Why on earth am I worried about what I look like and blah blah blah, and then telling these women to do the same when I'm not doing the same myself? (Liz)

However, for other participants, this view of their own life has changed so that they are more thankful and appreciative of their lives, which they previously would have thought were "boring", or that they were lacking in different areas:

> I think I perhaps have a greater sense of my own good fortune than previously. (Martha)
>
> I think at least that I ain't got much, but it's mine. (Jackie)
>
> You hear some people's stories of what they go home to, it does sort of put it into perspective actually you're quite lucky. (Tegan)
>
> Do you know how many times a day I say, my life is so boring and I am so happy about that? (Melody)

This re-evaluation of their lives, and recognition of their own good fortune echoes findings from Arnold et al (2005, p.251) where over half of participating trauma workers (52%) were more aware of their own "good fortune". Equally, DV counsellors have reported realising how "blessed" they are (Bell 2003, p.516), while two child DA workers in Silveria and Boyer's study (2015, p.521) described having "gratitude" for their own lives. These findings also draw parallels with research findings where trauma workers discuss how their perspective of what a problem is has changed (Hernandez et al 2007; Silveira and Boyer 2015).

Seven participants also discussed changes to their views of their own personal relationships. Participants described how they now think they are "lucky" to be in a healthy relationship, and they were grateful for their relationships:

> I'm very, very lucky in my home life. I have a really good partner who I've been with for, gosh, 11 years, and my children adore [them] and we have a really happy life to be honest, I'm really, really privileged. (Clara)

> I feel really grateful for having such a good support network, you know, great family, great friends, you know, not at risk from anyone in my life. And I think to myself, yeah, I'm lucky. (Sarah)

Sarah also went on to discuss how whilst she may not have material things in her life, she sees that she is "rich" because of her relationships. In addition to feeling lucky regarding their relationships, participants also described appreciating their partners now that they are DAAs, and appreciating their behaviour.

> I definitely appreciate [them] more. Because I've realised there are so many more green flags than I ever would have thought before. (Liz)

> A lot of times I go "thank God that we've got each other" and I've got you… you don't treat me like that and you know I don't treat you like that. (Donna)

These experiences reinforce findings from previous research into VAW workers regarding changes in view of relationships, and suggest they also apply to DAAs. For example, a DV counsellor who participated in Bell's study (2003, p.516) said that they "appreciate" their life and family since starting their role, whilst family violence therapists reported positive changes in relationships with their spouses (Ben-Porat and Itzhaky 2009).

In summary, these findings demonstrate how the psychological growth component of VR are experienced by participating DAAs. Findings surrounding feeling empowered and more confident, gaining new knowledge and skills, and changing their view of their own lives and relationships corroborate findings from previous trauma and VAW workers, extending them to DAAs.

6.4. Conclusion

This chapter has presented and discussed the findings relating to the first research question, focussing on the interplay between positive and negative effects, and also of positive effects consistent with Vicarious Resilience (VR). It has discussed how DAAs experience both negative effects consistent with Vicarious Trauma (VT) and positive effects concurrently, which supports previous findings from other samples, applying it to DAAs; however additional research could be conducted to further explore the connections between VT and VR in DAAs.

Evidence has also been presented on DAAs experiences of VR, within both subsections of satisfaction and psychological growth. Satisfaction from being a DAA surrounded feeling pride and having a sense of purpose, as well as enjoying the role, finding the work rewarding and interesting. For the psychological growth component, DAAs reported feeling empowered and more confident, gaining more knowledge and skills which helps themselves and others, and reported changing how they view their own lives and relationships. These findings all support previous research into VAW and general trauma workers, and they expand the previous knowledge base by evidencing their existence in DAAs.

The next chapter will move to discuss findings relating to research question two, on how DAAs manage the effects of their work, both negative and positive.

7. Management and Coping Strategies

7.1. Introduction

The previous two chapters explored the negative and positive effects of being a Domestic Abuse Advocate (DAA) on the individual, through the lenses of Vicarious Trauma (VT) and Vicarious Resilience (VR). In relation to research question two, this chapter will discuss how Domestic Abuse Advocates (DAAs) manage the negative effects of the work, and how they build on positive effects. The chapter initially focuses on different relationships which can influence how DAAs manage effects of their role, including: relationships with colleagues; relationships with friends and family; pets; and relationships with the role and victim-survivors, and how separation and boundaries can help. Section 7.3 examines different self-help strategies employed by DAAs, addressing how DAAs: focus on future plans; exercise and engage with nature; keep perspective to avoid becoming overwhelmed or feel powerless; use substances; and relax in different ways. The chapter then explores how exposure to victim-survivors success stories can help with promoting VR. Organisational practices, such as external clinical supervision, are not covered in this chapter, as Chapter Eight responds to research question three by examining the role of organisational factors.

7.2. Relationships

This section explores different relationships which help mitigate negative and enhance positive effects of being a DAA. Relationships with people will be examined, starting with colleague relationships, including the use of gallows humour, before discussing the impact of relationships with friends and family. Relationships with pets are then considered as a protective factor, before the section turns to DAAs relationships with work.

7.2.1. Colleague Relationships

Participants (n=11) reported that relationships with their colleagues help them cope with negative effects of their job and build positive effects. Some participants (n=3) spoke of how they have formed friendships with colleagues due to having similar experiences from the workplace, or thinking in a similar way. For example, Donna said over her years in the Violence Against Women (VAW) sector, she has made “friends for life” with her colleagues, while Clara explained these relationships developed due to a “bonded onslaught” of similar cases and experiences:

> I think that's why people who work in this sector get along really well, cause it's like a bonded onslaught. (Clara)

Participants (n=8) also explained that relationships are built because colleagues are supportive of each other. These experiences were not universal, as some of the sample reported not feeling supported by their colleagues:

> There's a lot of egos. They don't work together as a team. They always want to do better than everyone. (Jackie)

However, others discussed how they feel supported by their team:

> I have a strong sense of refuge and what we are for and who we are and what we do and that I am supported and will be supported and do support the other people who work there. (Martha)

> I've never met such a nice group of people in one place. Nobody has got anything negative horrible to say about any colleague, which is amazing… It's so nice. Everyone's really supportive. Everyone just wants to see you do well, and you want the same for other colleagues… It's quite refreshing that you've got a workplace that is not trying to stab you in the back. (Tegan)

These findings align with research from Slattery and Goodman (2009, p.1369), who found that Domestic Violence Advocates (DVAs) who had more support from co-workers were less likely to experience STS (Secondary Traumatic Stress).

Nine participants described how colleague support helped them, specifically when informally debriefing with each other regarding cases on which they are working. They described how sharing an office with colleagues means that they are "constantly bouncing ideas off each other… and checking in on each other" (Martha) and can identify when others are struggling and need support:

> They can tell if it's been tough. So usually when I come off [the phone], they'll either go, "well, that was a different tough one" or, you know, I go, "oh my God", you know, so it's almost that automatic support is there. (Amy)

> I do like to talk to my colleagues and so say I've had a particularly difficult call or something is not sitting right, you know they're very good upstairs that we will

> openly talk about this scenario, that scenario and we'll bounce ideas back and forth. (Tegan)

Sarah shared how this support, and informal debriefing, stems beyond being in the same office as colleagues. She explained how she had a WhatsApp group with her colleagues, and that if she has a difficult case she can contact them at any time, and they will share experiences and she will receive their support:

> [A perpetrator] was found not guilty. It really upset me. I cried, but I sort of like messaged my colleagues on the group WhatsApp saying I've had bad results at court and it really upset me... Just the support you get from colleagues and sort of sharing their experiences. (Sarah)

Amy explained that debriefing to colleagues is important when workers are unable to talk to family and friends about their experiences, due to them not understanding:

> They wouldn't [understand]… that's why I think it's so important to offload when you're in the office. (Amy)

Similarly, Iliffe and Steed (2000, p.407) found that Domestic Violence (DV) Counsellors thought that debriefing/peer support was the "most important strategy" for coping with distressing, or difficult sessions. They also explained how this informal debriefing with colleagues allows workers to ensure that they have provided the right support for victim-survivors (Iliffe and Steed 2000). Support for these findings also comes from Massey et al (2019) where Sexual Assault Referral Centre (SARC) workers shared that informal support is a protective against negative effects of the job, and echoing Amy's point, this is because they can speak to colleagues about the effects of their job, without worrying about confidentiality. Furthermore, research into human rights content viewers (Baker et al 2020) recommends that trauma workers should process information with people who understand the work that they do, which resonates with the accounts of debriefing with colleagues in the present study.

Some participants (n=4) felt that informal debriefing with colleagues was possibly better than formal, clinical supervision due to timeliness of accessing it, and the knowledge and understanding of their peers. For example, Charlotte shared that "I just find now it's just as easy just to speak to other people" than to wait for clinical supervision, and Jayne agreed

that debriefing with peers is more time effective than waiting for clinical supervision or supervision sessions with a line manager:

> With clinical supervision, and supervision, it's on a set day, whereas you could be going through a crisis and not have a supervision for like three weeks, whereas your peers are there. (Jayne)

Sarah also had a preference for informal debriefing with her peers:

> I get more sort of support from talking to my colleagues and offloading to them. (Sarah)

Sarah's reason for this was that she did not feel that her clinical supervisor shared her background in terms of work experiences (see section 8.2.4 for more information on this point):

> I would have to spend ages explaining that to my, you know whoever I was having clinical supervision with, whereas I only have to say to me colleagues, "oh, so and so was in court today, not guilty" and they just know it, they know the impact that has. (Sarah)

These accounts reinforce Iliffe and Steed's (2000, p.407) findings that participants find peer support the most important coping mechanism because peers can appreciate and understand each other's situations.

An aspect included in relationships with colleagues, and informal debriefing is the humour they share. There are often dark jokes in the face of distressing circumstances, frequently called gallows humour. During Clara's first interview, she created a drawing in the sand (see Figure 14), and discussed humour in general, such as watching comedies, saying, "That's how I deal with [the job]".

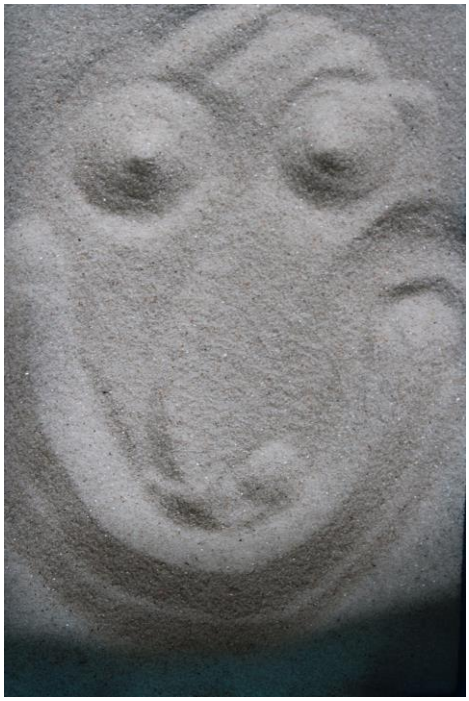

Figure 14 - Clara's Depiction of Humour

However, she also introduced gallows humour:

> It’s like looking at the funny things in the dark things, too, because it really gets you through it. (Clara)

This suggests that Clara uses gallows humour to cope with the negative effects of being a DAA. 12 out of the 13 participants reported that they used gallows humour, and that it was prevalent within their Domestic Abuse Services (DAS). For example, Jackie stated, “I will make a joke out of things sometimes as a coping mechanism” and that “the way we talk in the office sometimes… normal people would be like, woah!” while Melody noted that she has previously made a joke regarding a child’s name on a referral instead of focusing on the details of abuse:

> I'm going to completely ignore the animal abuse and child neglect and horrific scene that the police arrived to, I'm going to just laugh at this kid's funny name, because otherwise it's like I can't wrap my head around how awful these children and animals have been treated and the life they've been subjected to. (Melody)

Melody explained this as a strategy of self-protection, “you have to, or else you just won't survive in a job like this.” Another example came from Rose, who shared that when a

colleague got a black eye, she asked if she needs a safety plan to make light of a situation which they are often presented with by victim-survivors:

> One of my colleagues had fallen over and sort of knocked her eye, so she had a black eye. And we were going, "yeah, yeah, of course you did, of course you walked into a door handle"… we were all conscious of, you know, the fact that we're working with people who deny all of these things. So yeah, I do like dark humour very, very much. (Rose)

Echoing Melody's justification, Rose also said "it does help to release" the negative effects of being a DAA. Similarly, Donna reflected on a VAW training session where the trainer had "gone to town" and spoken about cases which were "awfully violent", discussing "broken fingers" of victim-survivors. In response, Donna and their colleague later engaged with gallows humour:

> And then we both started laughing really inappropriately, like, "oh, only broken fingers, only broken toes. Oh my God, not, not murder"… because for that worker, it was really heavy going for her, but just kind of like, you know, having a laugh about it in that moment was just, it just like lifted it, you know? And she was like, "I feel loads better now, I feel like it's gone". (Donna)

As with the Melody and Rose, for Donna gallows humour was a necessity for coping with being a DAA:

> You've got to kind of make light of some things… because otherwise you won't be able to do the job. (Donna)

Nonetheless, six participants felt that they needed to justify their use of gallows humour, as "not being nasty" (Charlotte) or "laughing at [victim-survivors'] situation" (Donna), emphasising that they were not laughing at the victim-survivors experiences:

> We're not making fun of people's pain. We're simply laughing at a specific aspect of something we've heard or something we've done. (Rose)

Amy discussed some concerns related to previous employment tribunals in other third sector agencies because workers used gallows humour:

> I read about somebody who works for Mind or something, and they took their employers to court because of that type of thing. And I remember thinking, Oh my

> God. Because they were saying that they found it really insulting that people were talking about the clients in the way they were. And I was thinking, Oh my God, we do it all the time. (Amy)

Amy explained that "it's not really about the person or what's happened" but rather that gallows humour is "about you dealing with it and coping with it". She further stated that it is not about "being disrespectful… it's not done in that way".

However, one participant[38] shared that while she sees the gallows humour in her DAS, it is not as prevalent, or as extreme in content as her previous detention job:

> There is dark humour. I'm not going to say there isn't. Yeah, it doesn't delve as dark as what prison humour is. (Anonymised)

She thought that this was because people in detention jobs deal with more suicides and immediate risks to their safety, but as in Chapter Five, these issues were also reported by DAAs. Her previous role and its influence on her experiences will further be discussed in section 8.3.1.

These experiences corroborate the findings of Schauben and Frazier (1995, pp.59-60) in which Sexual Violence (SV) psychologists and counsellors ranked humour as the 5th highest coping strategy, and its use was associated with lower levels of VT, and also Beckerman and Wozniak (2018) who found that DV counsellors use gallows humour to deal with their experiences of work.

Diverting from gallows humour, while one participant said, "I like working alone" (Anonymised[39]), which she attributed to her neurodivergence (see section 8.3.1), three participants specifically spoke about disliking working in isolation. For example, Martha said that working alone is more difficult due to not being able to offload during that shift, while Charlotte said she does not like working from home as "doing this kind of work, you need that interaction".

[38] This quote has been anonymised as no participant names have been used in Chapter Eight to protect participant confidentiality.
[39] This quote has been anonymised as no participant names have been used in Chapter Eight to protect participant confidentiality.

> When you're working on your own, you've got no, there's nowhere to put that [trauma] then. And those are the ones that you'll sort of carry around and take home because there's none of that kind of informal debriefing going on. (Martha)

This reinforces findings from Massey et al (2019) with SARC workers explaining that they struggle with night shifts due to the isolation and not having their colleagues with them.

Martha and Liz explained that as well as the negatives colleagues share to cope with the work, they also share the positives and good outcomes with each other:

> If things go well, we're all really pleased that things have gone well. (Martha)

> I think it's nice even just hearing [good outcomes] from other people. (Liz)

Accordingly, these findings align with the earlier research of Silveira and Boyer (2015, p.523) who found that VR can be facilitated by colleagues sharing positive stories and outcomes with each other as it can "reignite" their passion for the work, demonstrating how colleague relationships can foster VR alongside countering VT.

This section has evidenced how DAAs cope with the negative effects of their work through their relationships with colleagues, including debriefing and engaging in gallows humour, which supports previous research findings from other VAW, and DVA samples (Slattery and Goodman 2009). Participants also noted that they find informal support from colleagues to be more effective than formal supervision in contributing to their wellbeing, due to understanding and timeliness. Additionally, the sharing of positive experiences between colleagues engendered feelings of happiness, supporting the findings of prior research (Silveira and Boyer 2015).

7.2.2. Friends and Family

While relationships with colleagues can help participants in coping with VT and potentially increase VR, participants (n=8) also shared how relationships with their families are important. Charlotte noted that DAAs could not cope in the role without having someone at home to talk to, and that she would not "like it if she went home and [she] didn't have anybody to talk to" about work, while others shared how they offload to their friends or family:

> I hate keeping things bottled up so I talk to my friends or my [spouse] or my mum and that is probably my version of meditation. (Melody)

> When I'm struggling with something, I'll say “I had this case today and it left me feeling like this”. [Spouse] listens. [Spouse] doesn't ever judge me… we will talk about it. You know how it's left me feeling and usually, it dissipates. (Rose)

Donna discussed how she will offload to her spouse if she has had a difficult day in work, saying “if something's really impacted me, then obviously I'll talk to [spouse]… about it”. However, she also acknowledged that her spouse has limits in providing support, as they do not work in the sector:

> [Spouse] is not a natural counsellor or a natural support worker. So there's a limit, you know. (Donna)

> [Spouse] doesn't work in the sector, [they] work in [job], for God's sake… sometimes I expect [them] to be a counsellor. (Donna)

Participants (n=6) said this offloading to friends and family especially helps if they work in similar jobs as they understand more about the pressures, and associated traumas of the role, linking with debriefing with colleagues covered in section 7.2.1:

> I have a few friends, like one of them is an assistant psychologist, all in similar kind of heavy fields, so we do kind of understand each other. (Liz)

> [Spouse] used to work in the refuges… [they] used to put the cameras in and do the panic rooms. So [they] understand. And sometimes [they] would, you know, come home and [they] would say, “oh God, I saw something horrible today”. So it's quite, bounce off each other. (Charlotte)

Melody explained that when with these friends and family who have similar jobs, details do not need to be shared, and they can understand what the other is feeling:

> When we get together we have that shared thing where we can’t say, but we know what the other is feeling. (Melody)

Regardless of who they offload to, participants stressed that they are careful to keep confidentiality to protect victim-survivors:

> I am always very careful. I don't name names. (Martha)

> Obviously we can't give names whatever, confidential. (Tegan)

These experiences of offloading on family and friends corroborate Schauben and Frazier's (1995, p.58) findings that one of highest rated coping strategies for SV psychologists is seeking emotional support and social support from friends and relatives. Linley and Joseph (2004) also stated that satisfaction with social support is linked to higher Vicarious Post Traumatic Growth for trauma workers.

Participants (n=8) also shared how merely spending time with family and friends helps them deal with the role of DAA. For example, Donna explained how the "physical comforts" of being with her spouse help her cope with the job, and how if she has had a negative reaction to her work how she will "ask for more closeness… as a comfort", because she ultimately "feel[s] safe" with her spouse. Liz also shared how she relaxes with her partner after work, and how this is her safe space, which led to her getting emotional during the interview:

> I'd fall asleep on the sofa in front of the tv with my [partner] and my dog either side of me, and I think it's because, no matter what I feel in work, I feel safe, I can sleep here [tears up and starts crying]. (Liz)

Additionally, Clara discussed how spending time with her son helps, while Yasmin and Donna both discussed the benefits of spending time with friends:

> I spend time with my friends… I really look forward to it. (Yasmin)

> I love being social, you know, social with my friends and things. So that's majorly helped me. (Donna)

This section has documented how relationships with friends and family can help mitigate the negative effects of the role through acting as confidants, or just through spending time with them. These findings support earlier research from Taylor et al (2018) into VAW helpline workers, where participants explained that spending time with friends and family helped them cope with the effects of their jobs and maintain their wellbeing. Social support from family and friends was also highlighted as protective against negative effects in Bromley et al's (2024) systematic review of risk and protective factors in VAW advocates.

7.2.3. Pets

When asking participants how they managed the effects of their job, often pets, and specifically dogs, were positioned as important coping mechanisms. Out of the 13

participants in this research, the majority (n=10) owned pets. Five participants shared that they had a dog, two had cats and three participants had both (plus other pets). One participant shared that while she does not have a pet of her own, she has a "family dog", leaving two participants who do not have pets, one of whom said she was thinking of getting a dog as she is the only person in her office without one (Jackie).

Many participants (n=9) who have pets described how their pets help alleviate negative effects from the job. For example, Clara shared how just thinking of her dog's "happy little face" on her way home from work makes her "feel really de-stressed and happy". Similarly, Sarah stated that when she has had a "shit day" in work her dogs help make her happy:

> I got two, like, excited dogs to see me… they just make me happy. Just walk through the door and the world feels better. (Sarah)

Some participants described how spending time with their pets relieves their stress. Melody described her dogs as "little stress balls" who give her the "loveliest feeling" and provide a "stress release when [she] walk[s] them or play[s] with them". Charlotte also said that caring for her cats takes time and stops her from over thinking about her role as a DAA. Additionally, Tegan, who created Figure 15, said her "world is [her] animals", and how spending time with them, such as caring for her daughter's pony, distracts her from any negative effects in work.

Figure 15 - Tegan's Pets

Beyond spending time with their pets and using them as a distraction, two participants described how they cope with their work as a DAA by offloading to their pets and using

them as therapy. Firstly, Jayne stated that her dog was “so naughty, but she is my therapy at the same time”. Liz echoed this, and shared that while her partner works away her pet is “like a therapy dog… poor dog gets an earful everyday”. She also went on to say how when she is feeling the negative effects of the job, how she will sometimes get upset and find comfort in the dog:

> Sometimes I’ll just come home and I’ll just cry to the dog, and he looks at me like what happened?! (Liz)

This section discussed the importance of pets, and the experiences shared by participants corroborates previous literature into pets and animals mitigating negative effects from trauma work. In her chapter on preventing STS, Yassen (1995) claimed that for trauma therapists, caring for pets can restore workers well-being and be comforting. Empirically, Massey et al (2019) found that SARC workers noted dogs specifically as supportive against negative effects of the work.

7.2.4. Separation and Boundaries

The relationships that DAAs have with their work lives, and clients, can also mitigate negative effects of their roles. In their proposal of VT as a concept, McCann and Pearlman (1990a, p.146) cited balance and boundaries as coping strategies for trauma workers. The need for separation between their personal and professional lives was reported by many participants (n=11). For example, Melody explained that DAAs should “separate professional from personal, or else you just won't survive a job like this”, saying that it is “not really healthy” to take thoughts of victim-survivors home. Similarly, Charlotte said that “work is work and my outside life is my outside life” because if “you kept everything with you… it could drag you down”.

Additionally, participants stressed that while their work is important, it is not the whole of their life, and that some things are more important, such as their health and their families:

> I know there've been a few people who say, oh, I didn't have my lunch today. And I say no because I prioritise my food over anything else. Because that's to me, I know what is important. (Charlotte)

> My family and stuff are more important… they are my family. (Liz)

Seven participants also spoke of maintaining separation between personal and professional spheres by sometimes concealing their role outside of work. Martha explained how if she tells people her job, they have a "kind of natural magnetic response" where they "instantly share from their own life or the experiences of somebody close to them":

> I could be in the queue in Tesco's… or at the school gates and when somebody finds out who you work for, it's almost this kind of outpouring. (Martha)

Similarly, Jayne spoke of an incident where she told a stranger what she did when on a bus, and the woman then disclosed to her which was a difficult situation. Donna also shared how she has had acquaintances contacting her on social media to ask for advice, which exposes her to abuse when she is not working.

> I have messages on Facebook sometimes. "I know what you do. Can you support this person?" And I'm like, oh… that's work. This is the number you contact. (Donna)

This sharing of their role with others can blur the separation DAAs try to achieve. In Martha's words:

> In work, I am the place people put those experiences and those feelings. And then on your own time to be the place that, yes. I could see in order to have a safer boundary how you might want to not disclose that. (Martha)

Because of experiences similar to these, some participants did not share their role externally. For example, when Jayne and her team are on work outings, they tell people they all work for the council, whilst Sarah tells strangers that she works "for a charity".

> We've got a standing joke if anyone asks when we're all out from the organisation, when we all meet up, we all work for the council. We don't let on where we work at all. (Jayne)

Participants also discussed not telling victim-survivors about their home lives to ensure separation. For example, Martha lied to victim-survivors about the particulars of her home life:

> There are still lots of things that I won't discuss or I don't tell the truth about my own family or experiences that have to be to keep myself safe. (Martha)

Similarly, while some participants like having family photographs on their desks as it helps them cope with the job ("I'd want pictures… of my family on there, just to ground you",

Donna) as cited in Pearlman and Saakvitne's guidance (1995), some participants (n=2) do not want to display family photographs to keep the separation between work and home:

> I used to have… pictures and stuff at my old job at my desk, but I don't think I would like that here. (Melody)

> If a client were to come into the office and be like "who's that?" So I think that would be difficult potentially. (Martha)

The importance of keeping a degree of separation between trauma work and personal life has been highlighted by several studies. McCann and Pearlman (1990a) cite it in their guidance, and SV counsellors and psychologists have also acknowledged it in research (Steed and Downing 1998). In an alternate trauma sample of Human Rights investigators, Baker et al (2020) also reported that workers found that separation between their professional and home lives was an important coping strategy for their role.

This separation between work and homelife was reported by four participants as being helped by the journey between home and work, as it creates a "ritual[istic]" boundary. It also gives participants time to process the day, ensuring they are not thinking about it once they return to their personal life. Participants discussed how the journey home, whether driving, walking or on public transport, helps them with "winding down" (Martha) and to "offload" (Sarah) the worries of the day.

> I like to have a little bit of time on my own just to sort of go from work to home mode. I mean, I live literally a few miles away from where I work and I catch the bus every day and I find that really good because I can just walk to the bus stop, get on the bus and not sort of have to communicate. Sometimes when my [spouse] picks me up if we're going somewhere, I can feel the difference… I want to think just let it go, just let it go. (Amy)

> I enjoy, my walk home is my release, because some people say "have a lift, Jackie", but I think I need that little 20-minute walk to sort of, before I get in. I like, need to unwind because it's very hard to unwind. (Jackie)

These findings link to practice implications suggested by Massey et al (2019, p.702) in their research on VT in SARC workers, where they emphasised "the importance of creating boundaries between spaces and times". For the participants in this study, the boundary

created is the journey between work and home, and any routines or rituals which mark the separation of time.

Because of this need to separate personal from professional life, working from home was cited as difficult for two participants. For example, Charlotte said she hates working from home because she does not want to associate her home with her role, while Jackie specifically stated that it is "harder working from home… because you haven't got that" time travelling to separate:

> I hate working from home. I hate it. I don't associate. So as I said before, my work and my house and my personal life are totally different. When I'm in the house, I shouldn't be working. (Charlotte)

This echoes Massey et al's (2019, p.696) findings where SARC workers explained that taking calls at home "contaminates" their home space.

Linked to needing to separate their personal and professional lives, some participants (n=7) also discussed how maintaining boundaries with victim-survivors can help them cope with VT effects. For example, Clara explained how she needs to set out boundaries for contact with victim-survivors, as she has previously had victim-survivors phoning her because they "just fancy a chat". Jayne also explained how she keeps boundaries when victim-survivors have left her support, where she will "draw a line" because she does not believe "it's always helpful to know how things have gone for them".

Melody created Figure 16, placing the colourful figures between herself and her friends and family. She explained that "these are the people I am supporting, the anonymous". I questioned her on why she used the term "anonymous", and she provided this justification:

> I try really hard not to get emotionally attached, and them remain clients rather than people in my head… I like to keep them at an arm's length in case they go back to their partner... 'Cause I've had that disappointment in the past, where I have worked so long and so hard and spent so much emotional energy on a client, and then she's like "oh yeah I decided to get back together with him"... [it's] quite heart-breaking really. (Melody)

Figure 16 - Melody's 'The Anonymous'

For Melody these boundaries not only protect her, but also the victim-survivors. After the second interview, she was due to go on extended leave, and spoke of how a victim-survivors she supports got upset when she told them:

> When I told her that I was leaving she burst into tears and I just thought, this is not beneficial for you… no one should rely on someone that much… she was like angry when I told her… I just thought, oh, unhealthy attachment. Oh, like red flag, red flag. That's not what support workers are here for. (Melody)

These experiences support previous findings from Goldblatt and Buchbinder (2003, p.262) where a DV social work student explained how they need to build a "wire fence" between them and victim-survivors which they can see through to help them, but which keeps a boundary for their own protection. Greenberg (2020, p.206) also explained that "boundaries are protective" in trauma work, for example needing to set limits with clients such as what constitutes an emergency for contact, which echoes the findings from this study.

This section has introduced how DAAs use separation and boundaries to cope with the negative effects which they experience from their role. These findings support previous research into trauma and VAW workers, evidencing that these techniques are used by DAAs and providing specific examples for how DAAs separate and create boundaries, which may be of use to other samples of trauma workers.

In summary, section 7.2 has explored the different types of relationships DAAs have, and how these can help them cope with negative effects and build on positive effects of their roles. Relationships with their colleagues were cited as being very important, including

debriefing and engaging in gallows humour, with some participants stating that debriefing was more useful for them than formal supervision sessions. Spending time with family and friends was also expressed as useful in coping with the role, and pets were included by many participants as helpful. The section then ended with discussion of DAAs relationships with work, and the benefits of maintaining separation and boundaries between personal and professional spheres. All findings in this section support previous findings from other VAW and trauma workers. Nonetheless, aside from colleague relationships, which were included in findings from DV Advocates (Slattery and Goodman 2009), these findings are the first to highlight VT coping strategies in DAAs.

7.3. Self-Help Strategies

This section explores different self-help strategies which were raised by participants in managing negative effects of VT, or in promoting the positive effects of VR. The themes explored are focussing on future plans, such as holidays, exercising and being in nature, keeping perspective of their impact, substance use and methods of relaxation. While participants cited these strategies as helpful, it should be noted that not all of the strategies presented in this section are positive, or constructive, specifically the section regarding substance use. However, they have been presented here as these are strategies used by DAAs.

7.3.1. Focusing on Future Plans

Some participants (n=8) shared how focussing on future plans helped them to cope with the negative effects of being a DAA. For example, during the sandboxing task (see Figure 17), Liz illustrated how she copes with the job, with representations of her, her partner, her dog and the house they are living in and renovating. Liz noted how planning tasks helps in offsetting the negative aspects of the job.

Figure 17 - Liz' House Renovations

While Liz was the only participant who spoke of renovating her house as a future plan, seven participants discussed how looking forward to holidays and breaks helps them cope with being a DAA. Clara created Figure 18 in response to what she does to cope with the job, and explained that "the palm tree represents holidays and happy times, sitting in our garden or going out", and explained that experiences like these "gives you like almost like a float in water". She expanded that with these plans to look forward to, "whatever you come into a Monday, that's kind of lifted you to be able to deal with it".

Figure 18 - Clara's Palm Tree

Similarly, other participants discussed how having plans for holidays in the future can give them something to look forward, and then the breaks themselves can "refresh" and "revitalise" them (Melody). Liz discussed an upcoming holiday and said that thinking about it

“keeps [her] going” as she focuses on only having “a couple of weeks left in work and then [she’s] got this time off [to] switch off and relax”; and Charlotte stated that to cope as a DAA, she has “got to have things to look forward to”.

> My little prize is if I need a week away or weekend in Benidorm with the girls. That's what I do and that's definitely a release. (Jackie)

However, looking forward to, and having breaks and holidays do have a caveat (also see section 5.7.1 on responsibility), that staff need to know victim-survivors are being supported to be able to enjoy the holiday and relax:

> It can be really, really stressful if you're going and there aren't enough people to look after things here, can really impact on your enjoyment of it or your feelings about coming back afterwards to catch up on whatever needs to be caught up on. (Martha)

It has been argued that trauma workers need to have a “respite” from their role through breaks from their support work (Figley 2002, p.1438); and trauma therapist Greenberg has discussed how she takes a few vacations a year to break away from work and cope with VT (2020, p.206). However, taking breaks and vacations, or focusing on future plans have not been reported in VAW workers, or DAAs in their management of VT in previous studies. Therefore, this is the first study to present data on the importance of future plans and holidays for workers in the VAW field.

7.3.2. Exercise and Nature

Exercising, and spending time in nature was cited by 10 participants as helping them to cope with the negative effects of being a DAA. Firstly, and linked to section 7.2.3, four of the ten described pets as a good excuse to exercise. Figure 19 illustrates how Melody deals with the effects of the role, with trees, shells and a dog to show how her and her partner walk her dog in nature:

> Lots and lots of walking! Which I love. We live on a beach as well so can’t go wrong. So I’d say these are the things, obviously so the trees we love, there’s a bunch of forests which we love to walk in our area as well up in the mountains. So I’d say that’s probably how I deal with everything. (Melody)

Figure 19 - Pets and Exercise for Melody

Similarly, Amy shared that her dog had recently died, but she had decided to put a puppy on reserve, partly because she missed walking her dog as walking "clears [her] head" after work.

Liz discussed how she has gotten "back into the habit of training every morning" as it "sets [her] up" before going to work. She explained how this daily exercise "has made a massive difference" to her wellbeing and resilience so she can then deal with her role as DAA.

Previous research into VAW workers (although not DAAs) and how they deal with VT effects have found that exercise benefits workers. Iliffe and Steed (2000) found that DV counsellors believe physical activity helps to release negative feelings from the job and processing cases, along with tuning out thinking about cases. Some participants in their research stated that they exercise specifically to reduce negative effects, while others use it as part of a routine to maintain their overall wellbeing. Additionally, Beckerman and Wozniak (2018) and Massey et al (2019) also found that VAW workers use exercise to cope with negative effects of their work.

As well as her daily exercise, Liz also shared a specific activity which she stated helps her deal with the negative effects of being a DAA - cold water swimming. She stated that when she goes cold water swimming weekly with a friend, she thinks of difficult cases she is working on at the time before jumping in the cold water. She described how the cold water takes the difficult case away, and refreshes and "reset[s]" her:

> The cold-water swimming I do… so I will think about [a difficult case] beforehand… then when we go in the water I kind of picture it going away. You know because of the shock, and then when I come out it's like warm and, well it's not pleasant still, but you are warmer than you were 2 minutes ago, I kind of take it as a reset. (Liz)

Some research exists into the benefits of cold-water swimming for wellbeing with the general public, including a randomised control trial which found cold water swimming can improve mood (Huttunen et al 2004) and a case study regarding the successful use of cold-water swimming to improve depression (van Tulleken et al 2018). However, this usage of cold water to reset and be able to cope with VT is an original finding for this research, for trauma workers in general as well as DAAs.

Some participants (n=3) linked the benefits of using exercise to cope with their job with nature. For example, Yasmin likes walking, but cited "the fresh air" as its most important aspect, while Martha said:

> Definitely the walking and the being in nature. That's nice. One of the best things is get up before the kids have like a quiet walk on my own. (Martha)

Other participants (n=8) also discussed the benefits of being in nature, even when not exercising. For example, Charlotte stated that she loves spending time in nature as "it does take a lot of stress away", while Liz spoke of looking up at the clouds "to see space" which helps her relax. Similarly, Rose stated:

> The first thing I do when I get home is put my bag down and go walk around the garden, look at the roses and I'm usually distracted for a bit. Just how simple… I literally just let the feelings go. (Rose)

Interestingly, Donna raised how hearing that nature helps deal with the job can sound trite, but that it does help:

> And just being in nature, that helps me... And you read these things and think, yeah, right, does it really help? But it does really help. (Donna)

Charlotte also stated how spending time in nature helps to cope with being a DAA as it puts the experiences which you hear about in work "into perspective":

> I think that a lot of people forget about the natural world and they just sort of like, you know with their phones and materialism and all that and just like this all wound

> up in their everyday life. And having to get things all the time. I think they forget about what's nice, natural and I think it's important. (Charlotte)

Echoing this quote, Yassen (1995, p.170) suggested that to prevent STS in trauma workers, nature can help as it provides "a larger view of the world and our place in it", and one SARC worker in Massey et al's study (2019, p.699) explained that spending time in nature assists in "grounding" themselves. The benefits of spending time in nature to counter VT have also been studied with mental health professionals (Martinek 2015). These benefits involved having space to process their experiences, as there are "no expectations, no demands in nature" (Martinek 2015, p.78) and also how being in nature helps them heal from VT through being grounded.

This section has explored how DAAs can mitigate negative effects through the self-care strategies of exercising and connecting with nature, supporting previous research into VAW and general trauma workers. The illustrative finding of a DAA using cold-water swimming to cope with VT was also presented, which could be utilised by DAAs and other trauma workers in the future.

7.3.3. Keeping Perspective

Following the feelings over powerlessness and being overwhelmed (see sections 5.6 and 5.7.1) most participants (n=10) thought it was important to keep their impact in perspective. This could include focussing on the little changes they have helped influence and not to expect too much:

> Remembering you can't change the world, as well. So you know, keep it in perspective. (Amy)

Participants (n=5) also discussed how it is important to acknowledge that they are not the only workers supporting victim-survivors, that there are other services who need to do their job in addition to DAAs for victim-survivors to get help, so they need to not take sole responsibility for outcomes:

> I think it's really important to remember we are one little cog in the whole thing because I think sometimes you can feel like it's your responsibility. (Amy)

> One old manager gave me good, really good, like sort of tip. And she said, you know, as long as you know you're doing your job correct at the time, you've got to think of

> the bigger picture. You know, there's other people. You can't change everybody, as long as you know you're doing your best at that time you know and handing over and everything you've got to, you've got to switch off. (Jackie)

This strategy helped participants from becoming weighed down by the role:

> I just deal with what's in front of me, because obviously it gets so heavy otherwise. (Jayne)

Similarly, Melody explained how even if victim-survivors have negative outcomes, supporting the client is their role, and that is their impact:

> [Victim-survivor said to Melody] “You believed in everything I was saying when obviously no one else did. And that's what matters most”. And I'm like, well, damn. (Melody)

Seven participants also shared that even when victim-survivors return to the perpetrator, DAAs need to keep the impact they have had in perspective, acknowledging that they “could be the start of the process” (Rose), have given victim-survivors “a little bit more knowledge” (Amy) and that they may have “made an imprint somewhere” (Donna) which can help them leave in the future:

> Things have got to start off somewhere, haven’t they? And even if you're just a little spoke in a wheel, at least you know you are doing something. (Charlotte)

> Even if a person's gone back, they've been safe for a while and they know this is place of safety. They now know how to get help and where they can get help from. (Clara)

The experiences explored in this section evidence how DAAs can mitigate VT effects through keeping perspective of their impact and their part in the support process. These experiences echo advice from McCann and Pearlman (1990a, p.146), that having “realistic expectations” around their role and what can be achieved can help trauma workers cope with their jobs. Additionally, Iliffe and Steed (2000) found that DV counsellors need to respect their clients’ own agency and choice regarding their lives in order to cope with their jobs, that ultimately victim-survivors are responsible for their choices, not the workers.

7.3.4. Substance Use

Nine participants disclosed using substances, both legal and illegal, to cope with the effects of being a DAA. Five participants explained they sometimes use alcohol to help them relax after a hard day, or week, at work. For example, Martha explained how she is "not a great one for drinking", but how on rare occasions where she has had the "world's worst shift" she would relax with a glass of wine afterwards. Interestingly, participants justified sparingly using alcohol to relax after difficult days as they do not have "a problem":

> If I've had a particular difficult day in work. I have had a glass of wine, but not to, you know, to it being a problem. (Donna)

Similarly, this is why Jackie explained that she does not use alcohol to cope after a difficult day in work, as otherwise that could become a problem:

> I don't want to be having to have a glass of wine after a shift because that's the slippery slope. (Jackie)

However, Jackie did explain that when she was single, she used to go out on the weekend to drink with her friends and let her "hair down" to release from the negative effects of the role:

> My one night out a week… that is my release. (Jackie)

Despite rarely drinking alcohol, Martha explained that she believes that being a DAA is the type of job where if you did drink, that you could become alcohol dependent:

> I have said to colleagues that if I were one for drinking, now would be the time… I could absolutely see that this job would tip you over into that further. (Martha)

Corroborating this, Clara disclosed in her first interview that she did drink more alcohol than prior to becoming a DAA, and that her increased drinking may be associated with her new role. However, Clara also said that she did not see drinking alcohol as a problem as she does not need it "to carry on":

> I do drink more than I drunk before I was a support worker… Maybe it's a reflection on the type of job. (Clara)

It should be noted that some participants (n=7) do not drink alcohol, either much or at all, sometimes due to illness, and other times due to preference. For example, Jayne stated that previously she would have used alcohol to cope with her role, but she had a bad experience

where she acted “out of character” and aggressive, which frightened her, so now does not drink alcohol. In a similar vein, Liz described not drinking alcohol as she did not “like the feeling of being not in control”. Additionally, some participants do not drink much alcohol or use it as a coping strategy on a routine basis.

Four participants disclosed that they smoke cigarettes and/or vape, including discussing how they sometimes smoke to cope with the role, or that they have started smoking since beginning work as a DAA. For example, Jayne disclosed that she smokes, and after a difficult day that she will chain smoke, and she is “not willing to [quit]”. Additionally, Clara discussed how she has started smoking since beginning work as a DAA, and that she thinks her smoking and the role are “connected”:

> I do smoke… I vape sometimes, so that is a substance. But again, when I was a [profession], I didn’t smoke either. So I think that is connected. (Clara)

Interestingly, Amy commented that smoking is common amongst her colleagues, but that she does not know any smokers outside of work, inferring that perhaps it is a way that people cope with the role and mitigate VT effects.

> There's quite a few smokers in our organisation… I don't know anybody personally out of work who smokes. (Amy)

Prior research has found that smoking rates are higher in those who have been exposed to trauma, especially if they have been diagnosed with Post Traumatic Stress Disorder (PTSD) (Feldner et al 2007). However, while Spence et al (2024) found that content moderators who started smoking since they began their role had worse wellbeing, smoking was not associated with Secondary Trauma symptomology. Similarly, Waitt (2015) found that smoking was not significantly related to VT in child protection workers. Therefore, the experiences of these DAAs, where smoking has increased, or they perceive smoking to be connected to the role, may counter previous findings, however further research needs to be conducted to establish links between smoking and coping with VT.

The majority of participants (n=12) reported that they do not use illegal substances to deal with the negative effects of the role. The exception to this was one participant[40] who disclosed using MDMA occasionally to “completely relax”. This uncommon use of illegal

[40] No pseudonym has been used here to protect the participants identity.

substances to cope with negative effects aligns with previous research into VAW workers. For example, Schauben and Frazier (1995) found that alcohol and drug use were in the least common coping strategies for SV and non-SV counsellors. Regarding alcohol specifically, Massey et al (2019) found that SARC workers used light and social drinking to cope, but not maladaptive drinking. However, Steed and Downing (1998) found some SV counsellors reported drinking too much alcohol to cope with the effects of their role. The findings from this study are the first to evidence substance usage to cope with VT in this sample, therefore expanding the knowledge base to include strategies of DAAs.

7.3.5. Relaxing

Nearly all participants (n=12) cited different ways to relax as self-care which help them manage the effects of being a DAA. The methods used to relax varied between participants, and by day, as participants did things that they personally enjoy:

> Just kind of do things that we enjoy. (Donna)

> Just make sure I do something relaxing in the night… Absolutely nothing. Just watch movies. I may get up and potter, I may not. (Jayne)

As Knight (2013, p.232) acknowledged, what works for one person may not work for others, therefore "the challenge to all who work with survivors is to discover what works for them". This section will explore different forms of relaxing which DAAs cited as methods to manage the effects of being a DAA, focussing on escapism through media and cooking and food.

7.3.5.1. Escapism through Media

One technique of relaxation used by participants was escapism through engaging with media. Five participants discussed how they watch movies to relax and "think about something completely different" (Rose) to their role as a DAA and their lives:

> I'm a big fan of movies… it's just escapism isn't it, at its most bare. I just love stepping out of life for a few hours at a time and going somewhere really fun and exciting. (Melody)

Liz created the scene depicted in Figure 20 and explained how she watches superhero films to relax, and it is one of the ways that she copes with the effects of being a DAA:

> I put the superheroes because we love watching Marvel films, and they really make me happy. So yeah that's kind of how I cope about it. (Liz)

Figure 20 - Liz' Superheroes

Rose also explained how she listens to podcasts which "generally drives thoughts out of [her] head", while other participants (n=6) shared that they read, sometimes as a form of escapism:

> [Reading] brings you to a whole other place… it just brings you away from your world for a little bit, it's lovely. (Melody)
>
> I love reading. As a child, reading was my escape and I remember thinking going through counselling that maybe that wasn't great and I remember my supervisor saying to me at the time "there are worse kind of coping strategies than reading, you know, could have been alcohol or drugs, like if yours is reading, that's okay". (Donna)

Supporting these findings, reading and engaging with media as techniques of relaxation and coping with VT were cited by DV counsellors (Iliffe and Steed 2000, p.408) as an important way to "rejuvenate" and decompress from VAW work.

7.3.5.2. Cooking and Food

Six participants explained how they use cooking, and food to relax after work. For example, Charlotte spoke about how she likes "creating things" so tries new recipes each week to experiment with food, while Martha shared that she "find[s] cooking very relaxing".

> That's one of my hobbies… I like nice food… I just like creating things. I try and do, like a new recipe, maybe once, twice a week. I like experimenting with food. And basically I like eating food. (Charlotte)

Additionally, in her sandboxing activity, Tegan chose the cake figure in Figure 21 and explained how one of the ways in which she likes to relax is to bake with her children.

Figure 21 - Tegan's Baking

The creation of food as relaxation fits with Yassen's (1995) proposal that creative expression, which includes cooking and baking, can help trauma therapists in coping with STS.

Four participants shared that it is not just creation of food, but also eating which they use to relax, specifically of unhealthier, or "comfort" food. For example, while Martha said she likes to cook to unwind, she said that if it has been a "really terrible" day, that she will get takeaway on the way home from work, as sometimes "nothing else will do":

> I just go home and like, comfort eat. Yeah. If I had a bad day, God, I couldn't think of anything worse going to the gym, do you know what I mean? I just need to get a big bar of chocolate. (Sarah)
>
> What I would do with a shit day is pop something nice on or have a takeaway. That's probably my downfall… I'm an emotional eater, yeah so maybe I'll take it out on food. I find I'd rather a bar of chocolate than a bottle wine. So but yeah I think if I have a shit day I'll have a nice bath, bar of chocolate. (Jackie)

These findings oppose those from Schauben and Frazier (1995) where SV counsellors disclosed eating more healthily as a coping mechanism, not using comfort food to emotionally eat. However, emotional eating using comfort foods has been suggested as a response to having a lack of "emotion regulation strategies" (Evers et al 2010, p.793) and

that people experiencing negative affect sometimes engage in emotional eating, which can support why some trauma workers engage in eating comfort food to cope with VT.

However, for DAAs to use comfort food and takeaways as a coping mechanism, they need to have disposable money. This was raised in the interviews by Martha who said that some of her colleagues cannot afford to buy a takeaway after a hard day:

> But some of my colleagues I know can have a shit day and they can't afford pizza on the way home. Like, we're not talking wild, fancy holidays. We're literally talking pizza. (Martha)

This supports Ashley-Binge and Cousins' (2020) review of literature for VT mitigation in social workers, where they stated that self-care is most likely to be conducted by people who have disposable income.

Participant experiences in this section explore relaxation as a mitigation of VT effects though escapism by engaging with media, and cooking and eating. Previous research into VAW workers has been supported in engagement with media, and trauma therapists using cooking, with this research evidencing the use of these strategies in DAAs. Additionally, an original finding in DAAs engaging with emotional eating was also explored, which contradicts previous VAW research of workers coping through healthy eating.

In summary, section 7.3 has explored different self-help strategies raised by DAA participants which can help cope with the negative effects of the role. These included focussing on future plans, exercising, spending time in nature, keeping perspective of their job role and impact, substance use, and methods of relaxation. Many of these findings support previous research into VAW and trauma workers and expand the knowledge base by providing evidence of their applicability to DAAs. However, some findings counter current literature regarding VT and workers coping methods, specifically in the use of smoking and emotional eating. Additionally, one participant's use of cold-water swimming to cope with the role of DAA is a strategy which could be of use to other trauma workers.

7.4. Hearing Victim-Survivors' Success Stories

The final strategy discussed in this chapter which can help DAAs cope with the role is not centred around relationships, nor practices that DAAs conduct for self-care, but through exposure to victim-survivors' success stories. While most of the sections within this chapter

have focussed on ways to mitigate negative effects, hearing success stories can provide the positive feelings and view of others which is associated with VR. Many participants (n=10) shared how hearing about victim-survivor successes, or hearing from victim-survivors once they have left support (for example, through thank you cards) can make them feel good, and that they have made a difference. For example, Melody disclosed that while she does not expect a thank you from victim-survivors:

> Hear[ing] from someone directly about how [her] support has impacted them in a positive way is a reminder that… the shit part of this job is totally worth it. (Melody)

In her creation for how the job affects her, Clara included the tree in Figure 22 as a representation for successful outcomes. She explained how it represented "celebrations for outcomes in the end".

Figure 22 - Successful Outcomes

> I'm very solution focussed and I'm very much about getting people to their best lives, really. So it's kind of helping them see past the chaos to get to the final outcomes and I think that that kind of, assists me in doing like an everyday job in this area. (Clara)

Clara also stated that if she did not have successes for victim-survivors, that she would not be a DAA, as she must see the positive endings to deal with the role:

> If I didn't have good outcomes at all, I probably wouldn't do the job. I have to see that someone is leaving in a better place than they come in. (Clara)

Liz explained how hearing about how she has helped victim-survivors achieve their goals in her role is why she "stick[s] at it", while Charlotte explained how victim-survivors approach her after their support has ended to thank her, and how it is "really nice":

> I've had many people come up to you… and say "Charlotte, you're the best thing that ever happened to me. And I love you" and all this… all these extreme things, but it's like, it's really nice to know that you've made a big impact on somebody's life. (Charlotte)

Linking back to section 7.2.1, these success stories do not need to be from their own support, as colleagues share positive outcomes with each other. It should be noted, however, that DAA's specific roles can affect their exposure to success stories, which will be discussed in section 8.3.2 as an organisational factor of experiencing VT and VR.

These experiences of success stories making DAA roles "worth it" support findings from Bell (2003) where DV and non-DV counsellors spoke of identifying positive aspects and outcomes of their roles to cope with their job. Additionally, one of Bell's participants said success stories remind her that "the whole world is not in crisis" and that it is her "reward" for her work (Bell 2003, p.516).

7.5. Conclusion

This chapter has addressed research question two, how do Domestic Abuse Advocates (DAAs) manage the negative effects of their work, and how do they build on positive effects. Section 7.2 examined different relationships which can assist DAAs in mitigating VT and enhancing VR. The relationships discussed were relationships with colleagues, including the importance of informal debriefing and engaging in gallows humour, relationships with friends and family, and the impact of having pets. Section 7.2 also discussed DAAs relationships with work, and how separation and boundaries between the personal and professional spheres can protect from VT.

Section 7.3 considered different self-help strategies which DAAs reported using to cope with VT and increase VR. The importance of focusing on future plans, exercising and spending time in nature were discussed, highlighting the innovative use of using cold-water swimming to cope with VT. DAAs also noted that keeping perspective of their impact can help combat VT effects, specifically around power distortions, before substance use was examined,

including alcohol, nicotine and illegal substances. Different methods of relaxation were then explored, including escapism through the media, and cooking and eating, suggesting that countering existing literature, emotional eating is used to cope with VT.

Section 7.4 focussed on the benefits of victim-survivors sharing their success with DAAs, discussing how being exposed to these success stories can promote VR in DAAs. The next chapter will explore findings addressing research question three, and organisational and individual factors which can affect experiences of VT and VR in DAAs.

8. Organisational and Individual Factors

8.1. Introduction

The previous three chapters presented findings concerned with research questions one and two, exploring the effects of being a Domestic Abuse Advocate (DAA) on the individual, and how they manage the negative effects, and build on positive effects of their work. This chapter will address research question three, focusing on individual and organisational factors which affect how DAAs experience and manage effects from their work. Organisational factors are aspects which are controlled by the Domestic Abuse Services (DAS) in which the DAAs work, or by the management of their DAS. These organisational factors and their reported effects on how DAAs experience Vicarious Trauma (VT) and Vicarious Resilience (VR) are presented first, alongside how they affect their coping strategies. The perceived support from the organisation and communication with management is discussed, before examining the value of training on VT. DAAs experiences of supervision, both with line managers and external clinical supervisors, are then explored with attention to how they interplay with VT and VR.

The second section of this chapter examines influencing factors which are individual to each DAA and their experiences. It begins by discussing the influence of DAAs personal histories, including whether they are victim-survivors, their previous jobs and mental health diagnoses, on how they experience VT, VR and how they cope. The length of time DAAs have spent working in DAS is considered in section 8.3.2, and the influence of their individual roles is then explored in section 8.3.3, before examining the effects of specific experiences they have had while working as DAAs.

This chapter contains sensitive details about participants' lives and experiences, and also their opinions towards the organisations in which they work, and their management. Whilst pseudonyms can protect the identities of the DAA participants, specific experiences, if pieced together with participant data elsewhere in the thesis, could heighten the risk of identification of participants. Therefore, to protect participants, no pseudonyms have been used in this chapter.

8.2. Organisational Factors

This section will explore the factors which can affect a DAAs experiences of VT and VR, as well as their coping mechanisms which are controlled by the DAS in which the DAAs work[41]. While the aspects in this section are controlled by the organisation, it is actually the management within the organisations who enforce policies and procedures and communicate with staff. Therefore, section 8.2.1 discusses the organisations perceived support for DAAs alongside the communication with management who represent the DAS, examining how this impacts DAAs experiences of VT and VR. The section then turns attention to the influence of VT training on experiences of VT. Access to supervision sessions with line managers, and how they affect VT, VR and coping with these effects is then discussed, followed by findings on the effects of External Clinical Supervision (ECS).

8.2.1. Organisational Support and Communication with Management

Working in an organisation which is perceived as supportive has been cited as important for mitigating VT and supporting VR, as Knight (2013, p.235) contends, while a supportive environment can help mitigate VT "an unsupportive one can intensify [VT]". This section explores the support that DAAs receive from the DAS organisations and management, and the communication from management, and how this can affect their experiences of VT and VR.

8.2.1.1. Feeling Supported

In their quantitative research into Domestic Violence Advocates (DVAs) and risk and protective measures against Secondary Traumatic Stress (STS), Slattery and Goodman (2009, p.1369) evidenced the need for advocates to perceive their organisation as empowering as this makes it less likely that advocates will report STS symptoms. While the current study did not quantitatively measure the effects of organisation support on VT symptomology, some (n=4) participants discussed feeling supported by their DAS, which enhanced their wellbeing. For example, one DAA expressed that they have "such good support" from their managers and that working there has been "an uplifting experience".

[41] Only aspects directly controlled by the DAS, and not by the DAA are included in this section. For example, colleague relationships, whilst facilitated by DAS, are not in the control of them or their managers, therefore are not presented in this section. Likewise, the specific role of DAAs, and how long they stay in the role may be influenced by the DAS, but they are also controlled by individuals, as they chose to enter that role, and can leave at any time.

Two participants raised that their DAS were particularly supportive over women's issues, such as pregnancy and the menopause, and how this can make them happier to continue in the role as they receive these benefits and understanding. Discussing her DAS response to pregnancy, one participant said it was "quite a female supportive… place to work", that they are flexible with her needs and appointments. She also explained how their approach to her pregnancy has made her decide to stay in the organisation longer term. One participant who did not think the DAS was supportive overall, noted that as she was going through the menopause she had a "bad time", but that regarding this, her DAS was supportive.

> They're very approachable and they understand… anything to do with women's problems and stuff like that they are supportive.

This support regarding women's issues may stem from DAS striving to be feminist organisations championing empowerment and equality. These DAS are workplaces predominantly run by women, with women workers, and therefore have comprehensive policies on women's issues which benefit workers. These policies are also well enforced as the majority of their workers are women who experience the same issues. Therefore, these findings illustrate how DAAs can feel enhanced satisfaction in their roles as they are supported, and satisfaction with role links to VR. For example, Frey et al's (2017, p.49) study of assessing the impact of organisational support on VR in Domestic Violence (DV) and Sexual Assault (SA) advocates, found that perceiving their organisations as supportive has a positive effect on the "compassion satisfaction component of VR". This suggests that DAAs who feel supported by their organisation may enjoy their jobs more.

8.2.1.2. Feeling Unsupported

However, despite these circumstances where participants felt supported, many examples were provided by participants (n=8) where they did not feel supported in their roles by their managers.

Despite acknowledging the pressures of funding and targets, two DAAs explained how their managers make them feel like they have not done enough beyond direct support sessions with victim-survivors. For example, one participant discussed how she appreciated the importance of "figures, stats, [and] databases" but that she thinks "whatever [she does] is never enough", and that this pressure from managers regarding organisational targets has made her re-think her future in the role:

> I can't keep feeling like my best is not good enough… There's always more, do more, do more and I can't. I'm done. I'm done. (One Participant)
>
> I beat myself up because I think I'm not working fast enough, I'm not working hard enough. (Another Participant)

These DAAs shared that these managerial and organisational pressures made them feel undervalued in their role. This can relate to VT through disrupting their affective states, such as the emotional exhaustion evidenced in 'I'm done. I'm done' (see section 5.7.1). Additionally, another participant explained that she feels that management do not understand the issues that DAAs experience in their daily roles, and that they only visit refuges sporadically to complain about targets which have not been met due to unexpected circumstances which arise in refuge[42].

> They sweep in every once in a blue moon to criticize, is how it's perceived, at least. And then fly off again.

This highlights the need for more communication and consideration between what is expected and what can be delivered when supporting victim-survivors in crisis. This notion that communication could be better between management and DAAs, and how this could improve staff experiences and reduce exacerbation of VT effects was raised by two other participants. One participant explained from her role as a manager about how her staff worry that they will be made redundant due to funding constraints, which effects their wellbeing, but how in reality the managers are "saving your jobs". She explained that to alleviate these concerns, management "could work more on communication" so that there was transparency regarding job security and running of the organisation.

Another participant described an experience of having a false allegation raised against her by a victim-survivor, and how she "didn't feel supported" through the process. However, she has since become aware of her manager's actions "behind the scenes" to investigate her case, implying that communication of how her manager was approaching the issue may have made her feel more supported:

[42] While targets dictate actions for the day-to-day running of refuges, these can be disrupted by unexpected circumstances which stem from supporting victim-survivors in crisis, such as emotional support.

> When the false allegations that were made, I didn't feel supported then. But you know, I since found out what my manager did to get, you know the way she reacted once she found the evidence that it was impossible that I done it. So I've probably been supported behind the scenes, but didn't feel at the time.

Perceptions of being supported by DAS are therefore important, as if DAAs are unaware of processes which may be taking place on an organisational level, then this can make them feel unsupported. In line with this Taylor et al (2018, p.860) reported that when VAW helpline workers perceive a lack of support, this can "cause a circular problem" for indirect trauma – they feel effects, they perceive no support (even if it exists), and then feel more negative effects.

Two participants (n=2) also raised how they perceive any attempt to address VT and DAA wellbeing by their DAS as "lip service", and they are just saying it as it is a "buzzword". One participant shared that she does not think the workers wellbeing is important to the DAS, but that "they'd say it is… it's lip service". Another participant said she thinks her DAS is "well-intentioned" but echoed that any emphasis on caring for the wellbeing of staff is a "buzzword… it's just giving insincere lip service to it". The first of these participants also expanded on wellbeing being lip service, implying that she does not feel valued by her DAS, and that she "could drop dead by here and nobody would notice".

Previous research has also raised how organisations paying lip-service to staff wellbeing can contribute to and exacerbate VT. In Morran's study (2008, p.143) a staff member who worked with perpetrators expressed that management "say all the right things, but show no real interest" in supporting staff. Similarly, in their literature review of VT mitigations, Ashley-Binge and Cousins (2020, p.202) synthesised that VT arises when organisations state that they value empowerment and respect, but this is not the experience of staff members, while female SA Police Officers have shared that they feel like "just a number" in their workplaces (Bozga et al 2020, p.41).

8.2.1.3. Perpetrator Behaviour

Participant experiences stemmed beyond feeling unsupported and that support is lip-service, with three DAAs describing the behaviour of some managers as "perpetrator behaviour". This would comprise of behaviours exhibited in line with coercive control, exerting power and control over staff, beyond that of a typical managerial role, which create

fear in the DAA. One participant explained how she sometimes feels like “a victim” due to the micromanaging and “power and control” of her manager:

> Sometimes I feel quite a bit of a victim. I'm walking on eggshells and I'm thinking, hang on, this is what my women are saying! I shouldn't be saying that about my own boss!

Feeling like a victim can be linked to VT effects of disruption in trust. As this participant was unable to depend on her manager, the disruption to their affective states caused anxiety. The reference to “walking on eggshells” also mimics the experiences of victimisation through coercive control. This participant documented times of needing to make her manager think it was her idea to provide resources to victim-survivors as otherwise they would be denied, and shared that she was due to leave that DAS because of her manager’s behaviour.

A participant from another organisation echoed managers acting like perpetrators, and their reaction when she expressed herself in a meeting, a view shared by a participant in a different service.

> I have said that in a meeting. It went down like a shit sandwich when I said it. But I thought, but it's true, though, and that's why I said exactly that. “Your behaviour mirrors that of the perpetrator”. Because it did.
>
> If you had to describe the behaviour, it would be perpetrator behaviour, you know? Oh yeah, awful, awful.

On being presented with these findings in the second interview, an additional participant shared how she was not surprised by these experiences, as there are people who will take advantage of, and exert control over others, in all areas of society. However, she did explain how it may “feel worse” when it happens in DAS due to the feminist values of empowerment and equality, which as stated in section 8.2.1.1 are aimed for by DAS, and because of their work supporting victim-survivors because of perpetrator behaviour:

> We're going to have those kind of tactics within [DAS] as well, aren’t we. I think that maybe it's kind of, like it feels worse obviously because of the work we do.

These experiences of being victimised by managers and staff, making DAAs feel anxious and “awful” could exacerbate the VT effects already caused by the role (Section 5.7.1).

Supporting this, the one participant shared her belief that dealing with the negative effects of working as a DAA would be easier if the culture was not as hard. She explained this culture as in her DAS she did not feel valued, and that she would be replaced "like that [*clicks fingers*]" if any managers wanted to "get rid of" her:

> It's that combination… one or the other, but the two together, it's really hard and it does take its toll, definitely… I think it's a real hard place to work. I mean, the work is hard, but the culture is really hard as well.

These participants were asked whether they have raised these issues within their DAS previously. One stated that she has, but "it just doesn't go anywhere" as "organisations… preserve people at the top". Another participant, however, explained that she does not want to complain as she is "always going to be in this sector" so she needs to keep management "on [her] side" as she is "still going to be in contact" with them, even after she leaves to work in another DAS.

While previous research has found that unsupportive organisations can influence VT effects (section 3.7.3), and micromanagement is recognised as harmful for workers (White 2010), participants describing this behaviour as that of a perpetrator is undocumented, and most likely due to the knowledge of DAAs which they have applied outside of domestic relationships, to work relationships. It is concerning that people working to support victim-survivors from perpetrators are experiencing similar behaviours in their workplace, by those who hold power within organisations who often cite feminist values. Regarding VT, Cohen and Collens literature review also surmised that "promoting a non-authoritarian and inclusive style of working" (2012, p.572) helps trauma workers cope with the effects of their role, which was not the experience of all the participants in the present study.

The findings in this section have explored participants' experiences regarding the organisational support and communication from management in their DAS. It noted that while some participants feel supported by their DAS, especially regarding women's issues, others feel that support provided regarding their wellbeing, and related to VT is "lip service", supporting the findings of previous research (Morran 2008). Others also shared that communication between managers and staff could improve so there is more transparency with organisational processes which affect workers. Participants in three of the five participating DAS described some management behaviour as that of a

"perpetrator", which is a novel finding of participants applying their sector terminology to the micromanaging and power and control of others.

8.2.2. Training on Vicarious Trauma

For DAAs to be able to identify and address VT effects, they need to be able to recognise signs when they occur (Bell et al 2003; Cohen and Collins 2012; Steed and Downing 1998). Eight of the 13 sampled DAAs had attended training organised by their DAS regarding the nature of VT and coping strategies previously and found this training beneficial. Of these eight, three participants shared how attending VT training caused them to reflect on their own experiences, and realise that they were experiencing VT. For example, during the VT course, one "completely lost it" and "couldn't carry on doing the course" as she realised that she "wasn't in the right place" whilst two others said they could then name their experiences:

> I found it really, really good... It was almost like, oh! That makes sense.
>
> I had not really recognised that I was possibly suffering from vicarious trauma… it made me realise that I'm possibly at risk of this and that, you know, the dreams and things, that's what it is. And I hadn't, like, made the connection before. I knew it was like putting a word to it.

Similarly, Bell et al's (2003) literature review of organisational prevention of VT surmised that trauma specific training can assist workers in naming any changes they are experiencing as VT. Conversely, one participant explained that she had not attended VT training, but acknowledged that drawing attention to changes (through taking part in this research) can help as you become "more aware of" any you have experienced, which was also noted by another participant:

> Just by talking about it, thinking about it, you're more aware of it.
>
> Just having these conversations makes you realise.

One participant also explained that she engaged with this research as she wanted to find out about strategies that she could use to mitigate VT effects, evidencing her desire to find out more about the topic and how useful the second stage findings were for her.

Six DAAs believed that VT training would be especially useful to new starters so that they understand the changes which they may experience, are aware of the effects of the job, as

well as normalising being affected by the role. For example, one explained that it should be part of the "induction package" due to it affecting DAAs "from day one" while others expressed similar thoughts:

> So important for new starters… Because I don't think you know what you're walking into when you start this job.
>
> I think really if you were able to give that to new staff as well so that they almost got it in readiness then to what they might come up against.
>
> I think training, yes, when people are pretty new to it… I think it would do people a lot of good to just be like this is actually quite normal. Because you wonder how many people come here are shocked and confused, carry these giant feelings around with them not knowing what to do.

Providing VT training at the beginning of their employment, so that staff are prepared for VT is consistent with Pearlman and Saakvitne's (1995) belief that all trauma workers should be warned early about VT, perhaps even at interview stage. For Pearlman and Saakvitne (1995, p.135), this is because new workers are owed "the respect of informed consent" regarding VT and how it will affect their lives.

Additionally, three DAAs thought that VT training should be provided as a recap session to DAAs later in their careers. All three explained that this should be done as new DAAs may not appreciate the training when they first start, or think "that's not going to be me", but that after some time in the role they will engage more in the content:

> Do it when they arrive and then keep doing it every… two years or whatever is sensible… because there will be people who sit in that and go, "well, that's not going to be me. I'm not going to, that's not going to be me". And then it will be.
>
> When someone's coming in new and they're like… "that's not going to be me"… I think I probably had that attitude.

When presented with initial ideas for a training output in stage two of this study, four participants shared their recommendations for what VT training should look like. For one, this recommendation was mainly centred on the wish for organisations to "really take [VT] seriously". She explained how safeguarding for vulnerable populations is always prioritised, but that the wellbeing of staff also needs to be stressed:

> I'd like organisations to really take it seriously, because every organisation I've worked in has ensured that I've done safeguarding for children, safeguarding for adults, and it's not occurred to them that staff need space sometimes just to think, just, how do I cope with this job? How is this job affecting me?

Additionally, one participant commented that she "can't stand" online training sessions, and that would put her off engaging with a VT session, explaining how she finds having her face on the screen "really, really uncomfortable". However, another participant shared that whenever her organisation holds in person training, it is held in the refuges "because it's cheaper", but that they are a "terrible environment in which to deliver training", due to interruptions from residents and telephone calls. Therefore, to ensure the training is delivered in the best way possible, DAAs could be consulted on their preferred format of delivery.

This section demonstrates how DAAs can benefit from training into the effects of VT, and strategies to manage VT, as they can help them recognise disruptions they experience, and act to mitigate these disruptions. Participants also shared the importance of providing this training to new employees, offering refreshers to more tenured staff, and discussed practicalities for where these trainings should take place.

8.2.3. Supervision with Line Managers

Supervision sessions are grounded in health and safety law and take place across all sectors, to varying degrees. They consist of regular, individual meetings between staff and line managers, to discuss their job, workload, health, safety and wellbeing. These regular meetings can provide an opportunity for staff to raise any issues which are affecting them with their manager and receive support if necessary. Therefore, these supervision sessions provided by line managers could assist DAAs in addressing VT, by being able to debrief on troublesome cases, and request additional help with VT effects if they feel it is needed. Positive outcomes or feedback on performance can also be shared by managers in sessions, which could also cause VR through satisfaction. Some DAAs (n=2) shared that they find their supervision sessions useful and that they discuss cases and caseloads, and they ask for support if it is needed. For example, one participant shared that she has "regular one-to-ones" which provide "really good supervision", which helps manage her caseloads, while another stated she likes supervision "just to talk through [her] cases".

However, linking with the findings in section 8.2.1, three participants, working in three different DAS, shared that they do not find supervision useful in addressing VT. Two of the participants explained they do not find them helpful because they do not trust their managers, so they do not want to share any problems they are having with them:

> I don't trust my line manager. So my supervision isn't meaningful in that sense… if I needed to [raise an issue] I wouldn't feel it would be great.
>
> It is hard to be totally open and honest in the supervision… I won't share everything because I don't feel like I can't trust my manager enough.

Whilst managers need to be careful that supervision sessions do not turn into therapy, Knight (2013, p.323) stated that it is important that staff can have an "affective check in" during supervision sessions. If staff feel encouraged and supported to do this, it can then "normalise and validate" staff experiences of VT; however, for these two participants, this was not possible due to a lack of trust.

Another participant said that in supervision sessions her manager is always asking for more from her and telling her that she has made errors:

> It's not awful… But it just feels like it's more, more, more, more, more, more. And it's you've done this wrong, you've done that wrong. Done this wrong. You've done that wrong. You've not done this. You've not done that.

Supporting this, Bell et al's (2003) review of literature regarding organisational practices and VT recommended that supervision which aims to support staff, and evaluation of their performance should be kept separate. Therefore, while supervision sessions can be helpful in addressing VT as staff can raise any issues, some trauma workers may be hesitant to raise any issues consistent with VT as they fear that they will be evaluated. Therefore, clinical supervision with external supervisors, which will be discussed in the next session may be best placed to support trauma workers in their experiences of VT.

8.2.4. External Clinical Supervision

External Clinical Supervision (ECS) takes places with mental health workers who are not employed directly by the workers organisation, creating space for workers to reflect on their practice and experiences in work, such as any particular cases which have been troublesome (Beddoe 2012). By having an external professional conduct these sessions, a safe space is

created for workers to process their activities, and supervisors can provide objective guidance. Clinical supervision is often cited as an important and effective strategy in countering VT in trauma workers (see section 3.7.2). However, experiences of ECS reported by the DAA participants in this study vary, with it being provided in different ways. This is often due to funding issues, as providing ECS to all DAAs can prove very costly, which DAS are not necessarily funded to provide. Some DAS provide individual sessions for DAAs, of varying time lengths, while others provide group sessions consisting of whole teams.

Many participants (n=8) shared that ECS is "really helpful" for them to cope with VT effects. For example, one participant explained how she had supported a "difficult" victim-survivor, which she raised in her ECS sessions. She then said they had a "meaningful discussion around different ways" she could approach her sessions with the victim-survivor, which was "quite helpful". Additionally, other participants stated:

> I think they're a really good way to decompress and reflect. So even though I wouldn't be someone who would typically need any sort of counsellor, I do like [clinical] supervision.
>
> It is nice to be able to offload, especially… if you find that you know you've got really hard cases and stuff.

However, during the first stage, all participants from the one DAS stated that they were not provided with ECS, though they "used to have it all the time". They explained that ECS was no longer routinely provided due to funding pressures. One participant shared that on occasions where it was offered to workers, it was because they were "on a management plan" and that it was "normally a negative" thing for workers to be given ECS. However, by the second interview, additional funding had become available and ECS had been offered to some teams, with one participant saying "since [the first interview] I have had it".

Another participant also shared that she had attended ECS previously as a DAA, and found it useful for addressing VT, but she was no longer entitled to it as she was in a management role. She stated it was not seen as a priority for managers to have ECS as they do not have the same level of contact with victim-survivors. However, she expressed that all staff in Violence Against Women (VAW) services should be offered sessions as anyone exposed to trauma may need it, so therefore, "it's important for us all to have it". Similarly, an additional participant stated that "we should be all having clinical supervision" and echoing

the summary of the last section, she thought it should be “with someone who doesn't work here” so staff can be completely honest about their feelings and experiences.

One participant explained that she has now chosen to end her ECS sessions as she did not feel like she needed it anymore, and that she “didn’t really want to waste the organisation’s money” by “mak[ing] things up” just to fill the session. This illustrates that DAAs are aware of the financial ramifications of being provided with ECS, and they may terminate sessions if they do not need them. However, Sexual Assault Referral Centre (SARC) workers in Massey et al (2019) shared that they think that people who do not think they need clinical supervision probably do, but do not realise it.

As stated in the opening of this section, provision for those who do have ECS varied between individual supervision, and group supervision with their colleagues. Only one participant reported receiving a combination of both, comprising of individual every month, and group supervision every quarter. Three participants had individual only, whilst five had group supervision. Regarding group supervisions, one participant explained that its main benefit is through learning what other DAAs in your team are “struggling with”, which helps her “work better as a team because we can support them”. This demonstrates how providing group ECS can help with addressing VT through not only expressing experiences and obtaining professional advice, but also through building colleague relationships (see section 7.2.1).

However, whilst this participant saw benefit from group ECS, this was not the experience of the other four participants who attend group supervisions. Three participants raised problems relating specifically to group sessions, on the grounds of participants being worried about confidentiality. For example, one described all attendees answering “like sheep” that they have no problems and that “they wouldn’t say” if they did, while another explained that some people, including herself, may not want to “disclose personal stuff” so that others know intimate details about their lives. A third participant specifically referenced group ECS feeling “less confidential than usual counselling” which can hinder meaningful engagement, and gave an example of a situation when staff carried on discussing supervision content outside of the meeting:

> I've been in those sessions and as much as the boundaries are loudly announced at the beginning, you will find a few days later somebody in the office refers to

> something that was said... It doesn't seem to be particularly boundaried. It doesn't seem to be particularly confidential.

Therefore, it may be beneficial for all DAAs to have access to individual sessions if they felt they needed it, as "people would be more confident" in expressing their issues and asking for help. Various previous studies have also found issues of confidentiality, and group dynamics for group clinical supervision, which supports these findings. For example, Massey et al (2019, p.698) found that SARC workers find group supervision less effective than individual sessions, as they are concerned about "bothering" or "offending others", which echoes the view that DAAs would not say if they did have a problem. Regarding confidentiality within the group, Pearlman and Saakvitne (1995) stated that for group sessions to be effective, time needs to be spent building trust within the group, and confidentiality needs to be established early on. Similarly, VAW helpline workers shared worries of group supervision and whether it would remain confidential (Taylor et al 2018).

Participants also raised practical issues they have experienced with group ECS which can hamper their effectiveness in dealing with VT. For example, one participant discussed how there have been occasions where she was the only one to turn up to sessions, leading to the group being cancelled. She also shared that "I don't think any of us [get any benefit] from the group supervision". Another practical issue with group ECS raised by another participant was a lack of consistency to her group, as the attendees changed each time, which hindered creating trust and rapport in the group:

> The group has changed every single time the group combo has been different, which is a bit of a barrier… It's like the hokey-cokey that group! I just want the same people. How could you possibly have that kind of sort of trust, rapport?

Problems with ECS in general were also raised by some participants (n=6). For example, two participants shared how some DAAs may worry about the perception of them if they need supervision, as it could be viewed that they cannot cope with the role. One participant believed that this may be particularly an issue with newer staff members, while another said that while you may not directly get that response "on the surface" from others, they may still think it:

> Especially like maybe some of the newer ones. It's like "I better not say that in case they think I cannot do my job properly" or something.

> I think on the surface I wouldn't get that response, but I certainly feel underneath it. So it's the what they say and what they do is something different.

Another issue, raised by an additional participant, was that each ECS session needs to be long enough to adequately address VT and other issues. She explained how they are only given half an hour to an hour of group ECS, and how it felt like it was meant to “put the fires out” and “pick up leakage” which could lead to crisis, not address and prevent the build-up of VT effects.

Additionally, the skills of the clinical supervisor were questioned. One participant explained that to support a DAA, the supervisor hired needs to be a trauma-specialist, as otherwise they would not be equipped to assist. She explained that her clinical supervisor was a trauma specialist, and that she thought that is why she found ECS helpful in addressing VT effects:

> Yeah, it does [help]… because she's a trauma therapist. Yeah, I think that's what's needed in our work.

Similarly, for ECS sessions to be useful, another participant stated it is necessary for the supervisor to fully understand the role. She explained that she does not “get anything” from her ECS sessions and that she “waste[s] a lot of time in supervision explaining” her role, leaving her with less time to actively get support; therefore, she would prefer a supervisor with prior experience in the role:

> I’ve got to be honest; I don't get anything from it… She's very nice, the clinical supervisor, but she's coming from a different background than me… You can waste a lot of time in supervision explaining what it is you do and the different aspects... Whereas someone who's worked in it and done the role…they [already] know.

Alternatively, and linking to the participant not liking online training in the previous section, a different DAA raised the issue of having her sessions online, instead of in person, and how this is not conducive to an effective session:

> I think the screen isn't helpful. I think the technology is a real barrier to meaningful counselling style experiences... Not to mention the various technical difficulties that go with it. You're like muted when you shouldn't be… I think the screen is a real barrier.

These issues raised by participants suggest that simply being provided with ECS is not enough to counter VT experiences and assist in their management. Instead, DAAs need to feel that their sessions are useful, and provided in a way which they find helpful. This echoes Slattery and Goodman's findings into DVAs (2009, p.1369) that clinical supervision correlated to reduced Secondary Traumatic Stress (STS) scores if participants found their relationships with supervisors "engaging, authentic and empowering". Equally, in Ashley-Binge and Cousins' (2020, p.199) review of VT mitigating practices for social workers, they stressed that "quality and usefulness" of clinical supervision sessions are most important, rather than them merely having access to sessions.

This section has discussed DAAs experiences and views on ECS, and to what extent they believe they help them in addressing VT. Whilst some participants found sessions helpful and spoke of the importance of speaking to external supervisors, delivery varied between DAS, with some accessing individual sessions, others taking place in groups and others not being routinely provided with ECS. In their initial interview, participants in one DAS did not have access to ECS, with one participant saying they were only given to DAAs as a "negative"; however, by the second interview, this had changed to some teams being offered sessions due to funds becoming available. Participants also raised issues with group sessions regarding confidentiality, and openness, which supports previous research (Massey et al 2019). Additionally, these findings illustrate practical issues with ECS, which DAS should look to remedy in order to provide an effective tool for their workers in addressing VT; namely consistency of sessions, length of sessions, background of the supervisor, and having options for clinical supervisions as either virtual, or in person.

In summary, this section has examined organisational factors which can influence DAAs experiences of VT, VR and how they manage effects from their role. DAAs feeling supported can aid in facilitating VR and mitigate VT, however, participants disclosed instances of feeling unsupported by management, and participants in three of the five DAS described management behaviour as that of a "perpetrator". These issues could be addressed by improving communication between staff and management in DAS. VT Training was also explored, suggesting that new starters and tenured staff would both benefit from attending, due to normalising effects and being able to name VT and VR. Supervision, with line

managers and external supervisors can also assist with addressing VT, providing DAAs feel comfortable in sharing their thoughts and experiences.

8.3. Individual Factors

This section explores the individual factors which can interact with experiences of VT and VR, and how these effects are managed. In this thesis, individual factors are defined as those which are reliant on individual experiences and choices, including their own history and decisions. Participants own personal histories and experiences, including whether they are victim-survivors of VAW, and how this affects how they experience VT and VR will be discussed first. The length of time individuals have spent in the role of DAA and their role within the DAA grouping, focusing on refuge and community workers and the effect this can have on VT, and also VR through DAAs being exposed to success stories will then be explored. Section 8.3.4 then considers how individuals' experiences in their role as a DAA can affect VT through enhanced disruptions to specific schema, namely trust and safety.

8.3.1. Personal History

Previous research has explored the effects of being a victim-survivor on working in the VAW sector, with mixed results (see section 3.4.5). As presented in section 3.4.5, between 55% and 83% of VAW workers have reported being victim-survivors themselves, which is higher than the proportion of victim-survivors in the general population. Out of the 13 participants in this research, 12 disclosed that they consider themselves victim-survivors. Some participants shared how they were not surprised by the high rate of victim-survivors in the sample. One participant commented that "most of the people who work here have all been through something" and the only non-victim-survivor thought that she was "probably the only one" in her team who does not have lived experience of VAW. While all 12 victim-survivors reported experiencing VT effects, the non-victim-survivor also reported effects consistent with VT, illustrating that while personal experience may interact with VT, it is not a prerequisite, and people who have not been victimised are still at risk of experiencing VT.

Eight of the 12 victim-survivors described working in the sector as a "calling" or that they were drawn to the work because of their own experiences. For example, one participant noted that she was "drawn to" the sector, while another shared that "it's been a calling for me". While these motivations could be interpreted as a positive outcome from their experiences, linking to adversarial growth from direct experience of abuse (see section

2.3.7), Jenkins et al (2011) found that being motivated into a VAW counsellor role by their own experience was associated with higher STS and VT scores, compared to workers motivated by altruism, despite many of the second group also being victim-survivors. Therefore, while simply being a victim-survivor may not increase experiencing VT, their study suggests those who are drawn to the work because of their experiences can be more negatively affected. Similarly, Bell (2003) found that those who entered support roles due to their own experience were more likely to be stressed. Therefore, the motivation of these eight DAAs could be a risk factor in them experiencing disruptions related to VT, although this link was not explored in this study.

Six participants explained how they disassociate from their victim-survivor-self, acknowledging their experiences, but clarifying that they do not define them, nor are they additionally traumatised by their own experiences when supporting others. For example, one stated that she has "dealt with" her experiences and "they don't affect [her] at all". Similarly, another participant shared how she "depersonalised" her experiences, and "the person that [she] was before is a totally different person". These viewpoints of disassociation corroborate findings from other DAA victim-survivors (Wood 2017, p.322) where a participant stated that "it's like the person I am today, I look back… and that's not who I am anymore" but that they understand what happened to them.

Over half of victim-survivor-participants (n=8) thought their personal experience helped them to provide effective support for victim-survivors, as they can empathise with what they are experiencing. For example, one discussed how she can "anticipate" victim-survivors' actions due to her experience. However, despite this benefit from having personal experience, seven participants disclosed that they find supporting specific cases, or aspects of cases, more difficult due to their experience, which can re-traumatise them from their own victimisation. One participant explained that she is "conscious of the risk of re-traumatisation" due to some details "pushing [her] own buttons". Additionally, another participant explained how her "trigger" is hearing from victim-survivors where they have "experience of their parents being alcoholics" as it resonates with her own experience.

Some participants (n=4) also said they have struggled as DAAs as at times they felt like they were talking to themselves. One participant explained, some cases "reminds me of me", while another explained seeing themselves "in [the victim-survivor's] shoes". For one

participant, it was not the case itself, but rather the paralanguage of the victim-survivor which formed a reminder to her own experiences:

> I put the phone down [and] I just burst into tears... I think it might have been something about the way she told that story rather than what she actually said that sort of reminded me of me.

Another participant explained that after supporting a victim-survivor, she "completely cracked" and needed to be picked up from work. She described how supporting this victim-survivor was more traumatic than supporting others "because I felt like I was talking to myself". Because of this re-traumatisation, this DAA then passed the victim-survivor to another worker, which prompted feelings of guilt, however this was needed to protect them both:

> I passed her on. I did have a little guilt… but I just realised in a professional sense, I can't help her if it's making me feel a certain way and I'm going to react emotionally rather than logically.

While her reaction was not caused by a specific case, another participant disclosed that during her first week as a DAA, she suffered an extreme panic attack, which led to hospitalisation. Following this, she had a conversation with her friend and realised it may have been caused by her own experience, which was triggered through starting employment:

> She was like, "maybe everything you are hearing at work, is like subconsciously having an effect on you?"… It wasn't like any of the cases were similar to my family… I can't think of anything that could potentially have been a trigger, but it could just be that I've never worked in a sector like this, and had to confront this in like a professional capacity.

These experiences illustrate how being victim-survivors themselves can factor into how participants experience VT effects, as they can be triggered by the stories to which they are exposed. This triggering could increase VT disruptions, as DAAs are not only being exposed to the stories of others but are additionally reliving their own experience, leading to negative affect. These findings corroborate those from Gilbert (2020, p.81) where they found that DAAs experience negative effects from their role because of their victim-survivor experiences, specifically around being triggered by the stories to which they are exposed.

Two participants described disruptions in the schema of intimacy regarding relationships which linked back to their abusive partners. One participant explained how she will "never move in with anyone" because of her previous relationship, and also said that she does not ask for help in any area of life, as "certain behaviours stay with you" and she cannot trust others. She also explained that her current relationship has "most definitely been affected" by prior abuse, and this is where her concern around controlling behaviour in relationships stems from. These findings suggest that whilst VT can disrupt intimacy schema through hearing stories (see section 5.1), some of these disruptions can be linked to DAA-victim-survivors own experiences, and not only second-hand stories, potentially leading to more severe disruption. Echoing these findings, Van Deusen and Way (2006) also found that SA victim-survivor-workers have higher disruptions of intimacy than other mental health workers, while more general support regarding the correlation of own experience with VT and STS disruption scores resides in Cunningham (2003), Pearlman and MacIan (1995) and Slattery and Goodman's (2009) studies. Furthermore, Slattery and Goodman found that own experience of abuse was the only factor to significantly predict STS in DAAs (2009). However, it should be noted that due to the high proportion of victim-survivors working as DAAs, it could be difficult to explore and compare the extent to which these disruptions are caused by own experience, or those of the victim-survivors they support, or whether it is a combination of both.

Only one participant stated that she perceives the experiences she sees in work as less traumatising than her own experience:

> It was… a matter of just like surviving when I was in a relationship … Whereas now it's just like what you have to go through now [as a DAA] is nothing compared to what you had to go through… I could have been killed then. I'm not going to be killed now… it's [a] totally different scenario.

Conversely, two other participants explained the opposite, that the stories they hear from working with victim-survivors are worse than their own experiences. One explained how due to having her own experience, she is not "naïve" to DA, but that it is "a whole new level of things [she is] hearing and seeing". Therefore, her own experience is eclipsed by the experiences she supports victim-survivors with. From being exposed to the accounts of victim-survivors she supports, the other participant explained how she now minimises her

experience of abuse, and it has distorted her views of her experience. At the beginning of her interview, she stated that she is not a victim-survivor, however during the interview, she changed her stance, saying "I am a survivor… ain't I?". Despite her being offered refuge at the time of her experience, this participant minimised the abuse she experienced, justifying that "he was never physical", but that he was emotionally, and is still financially controlling her. She then explained that she "probably [is] playing it down" and that she does not see her ex-partner as negatively as other perpetrators, because she has supported victim-survivors through experiences which she deems as "worse":

> Seeing the men now… He's bloody lovely compared to [them]... Probably put him in a better light really… I could have had a lot worse, definitely.

This quote illustrates the problems of applying a hierarchy to abuse experiences, as this participant is minimising her own experience as she did not experience physical abuse, despite needing support herself, and even being offered refuge. This DAA counselled victim-survivors that this hierarchy does not exist, yet she applied it to her own experience. This evidences the distortions to schema which can occur through being exposed to the trauma of others.

Opposing this minimisation of the above participant's experience, five participants shared that they have changed how they view their own experiences of abuse for the positive, which fits with the psychological growth component of VR. For example, one participant now realises how "lucky" she was in escaping her perpetrator "quite quickly", as by seeing other victim-survivors' cases, she realises that she could have been with him for longer and experienced more abuse and violence:

> He would have killed me eventually… I also hear other cases and I think, God, I was lucky… I tried to leave quite quickly… I think I'd have been with him for years. God knows what my life would have been like.

Similarly, two others explained how their knowledge from being in the sector has helped them name and understand the abuse they experienced, with one saying her knowledge "re-instils in [her] what… a horrible situation" she was in, while another described the job increasing her understanding:

> I knew it was wrong at the time, but I didn't understand it, but [the job] helped me to see what was so wrong about it.

Additionally, as presented in section 6.2.3.4, one participant began to identify as a victim-survivor as she understood that she was also affected by her father's abusive behaviour. These findings align with those from Wood (2017, p.318), who interviewed survivor-professional DAAs to explore their experiences and found that some DAAs began to "name" their own experiences after starting the role. Additional support for these findings can be found in Schauben and Frazier's study of SV counsellors (1995, p.58) where participants reported that their role "helped them heal" from abuse they had experienced, whilst Frey et al (2017) found that own experience of trauma increased VR in DAAs.

DAAs may also have experiences in their personal history beyond lived experience of abuse, including previous job roles, or mental ill-health which could affect how they experience VT and VR. One participant explained that she had a previous detention role, which she believes caused more VT than her role as a DAA. She illustrated that while being a DAA exposes her to upsetting stories, that the trauma faced in her prior role was worse:

> This is, it's unpleasant and it's sad and it's cruel and it's horrible… I don't want to take away from what these victims have experienced, I don't. I really, really don't. But in comparison to what trauma you face in [location] this is like, no.

She also stated that the gallows humour was darker in the detention role (see section 7.2.1). Additionally, she was diagnosed with Obsessive Compulsive Disorder and Post Traumatic Stress Disorder (PTSD) during her previous role, due to the constant risk assessing, which may affect the VT responses given in this study as they could relate back to her diagnoses. She explained that she is "still very much [a] worst case scenario type of person". Therefore, because of her previous role and diagnosis, it is difficult to determine to what extent her employment as a DAA has affected her, as she may be carrying effects from before. While VT research often asks participants about the length of time in their specific field, data is not included of types of previous jobs, which may also factor into experiences of VT; therefore, this is an aspect needing further study.

Despite this participant saying that working as a DAA was not as difficult as detention work, by the second interview she had decided that she could not be surrounded by trauma in her work anymore, and was ready to leave her role:

> I think in all honesty I'm ready to leave this type of role. [*mood drops in room]…* for probably the majority of my working life, it's always been doom [and] gloom… I've got to the point now where I don't want to be around that.

This relates to issues with creating a hierarchy of roles (section 8.3.3). This worker initially believed that her DAA role was less traumatic compared to her detention role, and she was also a community worker who cited the benefits of community roles over refuge roles. However, as can be seen from the above quote, this self-imposed hierarchy did not stop her from being cumulatively affected from both jobs to the point of wanting to leave.

Three other participants also disclosed having diagnoses which may interact with their experiences of VT and VR. One shared that she is bipolar and has complex PTSD, which was diagnosed during her employment. She explained that she does not "know whether that's linked" to the role but that it may have been a combination of factors including the job. However, it is difficult to assess the link between role and her diagnoses due to numerous other personal factors:

> I don't know whether everything just built up.

Two participants also disclosed having an Attention Deficit Hyperactivity Disorder (ADHD) diagnosis, and one explained how this can make her less aware of risk. She explained that she does not have much disruption in her safety schema as she does not assess risk in a neurotypical way due to being "in [her] own world":

> I'm very fixated on the one thing, so I don't sometimes see everything… So I probably put myself in quite risky situations a lot because I'm oblivious.

In VT literature with VAW workers, history of abuse been more commonly studied rather than history of mental ill-health (Bromley et al 2024; Pearlman and MacIan 1995; Way et al 2004). While previous experience of abuse and mental health diagnosis may be related, they are not synonymous, therefore, inferences regarding the effect of various diagnoses on VT are unknown for VAW workers and need further exploration. However, in their review of trauma literature regarding risk factors of VT in general workers, Lerias and Byrne (2003, p.133) surmised that "previous psychological diagnosis" is a risk factor for developing VT, and also that family history of mental ill-health is significantly related to development of VT.

In summary, DAA participants raised several factors from their personal history which could interact with their experiences of VT, VR and how they manage both. While almost all participants were victim-survivors, and they discussed how this can have both negative and positive effects on them, VT and VR effects were also raised by the non-victim-survivor. Therefore, this suggests that while their own experience of abuse may interact with VT and VR, these effects are caused by the job, as one participant did not have their own experiences. Participants also explained their perceptions of how mental health diagnoses and previous jobs affect their experiences of VT. However, further research is needed regarding these aspects to corroborate these experiences and explore their interplay with VT.

8.3.2. Length in role

Despite an acknowledgment that VT is cumulative, and builds over time, being newer to the role has been cited as a risk factor for VT effects, for example through new trauma workers reporting higher disruption to schemas (Pearlman and MacIan 1995; Van Deusen and Way 2006). Supporting these earlier research findings, four participants raised worker's length of time in the role as being linked to VT. For example, one participant explained that when they first started the role, "emotions cross over into your support", but that as time goes on, she learnt to "put that professional hat on", taking a "more clinical approach" and therefore making it "less of an emotive experience" to support victim-survivors. This links to the findings surrounding desensitisation in section 5.5.3, and how as DAAs spend longer in the role, they become more desensitised, but that this makes them better able to cope with the role. These finding support Cohen and Collens' review of studies (2012, p.576) where they summarised that trauma workers experience less "overwhelming emotions and distress" as they increase time in the role, and also Cunningham (2003) where long standing trauma workers reported less disruptions to schema than newer staff.

Expanding on their own experiences of desensitisation overtime and how this is affected by length of time in the role, participants also reflected on their perceptions of new staff members, and how they think they are more affected by the negative aspects of the role. For example, one participant shared her perspective that VT "does affect the newbies a bit more than the veterans", saying that new workers "look utterly horrified" about cases which do not affect more tenured staff. Three participants also linked newer staff not being

desensitised, and experiencing the negative effects “more”, to frequent turnover of staff. However, as these additional comments are second hand assumptions, more research would be needed to establish the validity of the comments.

In summary, there is some evidence from this research that length of time can affect how effects of the role are experienced, as participants raised becoming more clinical and desensitised over time, which can help them cope with the role. However, further research would need to be conducted to monitor and explore these changes over a longer time frame.

8.3.3. Role

The type of DAA role can also impact how workers experience VT and VR and how they cope with the negative effects. Their role has been categorised as an individual factor as workers have control over which position they apply for or continue to hold. The sample for this study contained DAAs working in various roles, and during interviews, most (n=10) participants discussed how their specific role can affect their experiences of VT and VR. While participants expressed that “every domestic abuse role is challenging”, the different requirements and responsibilities of roles mean that experiences vary, due to exposure to victim-survivors at different risk levels, location and timings, as well as differential access to the success stories of the women they have supported. While there can be variance between all specific DAA roles, to reduce risk of identifying participants, and to reduce fragmentation of the sample, this section will consider only the differences between refuge, and community roles, which includes ten of the participants.

DAAs working in refuge support victim-survivors who are high risk, with one participant describing the women she supports as being at “the sharp, pointy end of crisis” where it is “everybody’s worst day”. Refuge was also raised as being a difficult role due to it being multi-faceted, with DAAs being required to constantly do different things. One participant shared that while she enjoys working in refuge, “it is the hardest” DAA role because of the wide variety of tasks, including intensive work with arriving victim-survivors, turning over rooms for them, and “dealing with crisis” while doing the general office work, and how this is “really, really difficult” as priorities need to be constantly managed:

> It's really, really difficult… to do so many multitasking things at once and prioritize… What's a risk? What's not? Who needs that attention more and still meet your targets?

This quote also echoes back to section 8.2.1.2, as it highlights the interaction between organisational priorities for funding, and the needs on the ground for supporting victim-survivors, and how struggling to balance these can heighten VT effects.

Additionally, refuge workers must also manage the behaviour of victim-survivors who live there, including community living disputes, which adds an extra pressure to the job by "refereeing all the time". One participant also raised how part of her role was to evict victim-survivors from the refuge, citing a time of evicting a woman due to her bringing unknown males to the site, which she said "affected" her. While all victim-survivors have rules which need to be followed, evictions can be difficult for staff to conduct, as they could be making that woman homeless, or she could return to the perpetrator.

While there may not be constant disclosures or incidents, refuge workers are often based in the facilities, meaning they are constantly surrounded by victim-survivors. One participant explained that this can affect workers as they do not have separation from victim-survivors, as they could be in the office doing paperwork, but "your office is where they live" so they frequently come to the office, raise queries or disputes:

> [In refuge] you are in it the whole time. There is no escape.

Alternatively, DAAs who work in the community shared that their role allows them more space to process cases which they are working on, and more physical distance from victim-survivors. One stated that she thinks working in the community "has got a bit more of a shelf life than… in refuge" because of the distance she has from victim-survivors. She explained that she is not constantly surrounded by victim-survivors and needing to support them, but that she is "going to people's houses once a week" after which she can go back to the office and "detach [herself] from it". Otherwise, said she is "on the phone to them", which another participant explained is beneficial in dealing with effects of the role as she has private space to process the call once it is disconnected, which would not be possible in refuge as victim-survivors could hear:

> We do put the phone down and go "for fucks sake". That's the relief and release that we need sometimes.

Similarly, another community worker described how after a “really tough” support session, she can “walk away” and “have 20 minutes downtime” to “blow it off, whereas you can’t do that in refuge”. Linking to section 7.2.5 on separation and boundaries assisting with coping with VT effects, these findings illustrate how community workers have the space, and time to process any effects from their work. These tactics are harder for refuge workers due to sharing the space with victim-survivors, potentially meaning that VT effects in community workers can be mitigated as processing can help them cope, while refuge workers do not get the same release within work hours. Therefore, steps could be taken to ensure that refuge workers have methods to separate from victim-survivors, such as having clients spread across refuge locations to allow time between them or having protected and enforced staff-only spaces in refuge.

However, care needs to be taken in analysis that we do not create a hierarchy of jobs, just as VAW workers discredit a hierarchy of abuse, as all people’s experiences are equally important, and each worker may struggle with different roles in different ways. This was raised by one participant in her second interview when she reviewed the initial findings. She suggested that “I don’t think we should have a hierarchy of like what's harder” as each job is different and can produce negative effects for workers.

While research has addressed different roles within VAW and how these interact with VT, such as research into helpline workers (Taylor et al 2018), SARC workers (Massey et al 2019) and perpetrator workers (Morran 2008), there has not previously been research into how VT interacts with different roles within the DAA grouping, specifically the detailed differences between experiences of refuge and community workers. Despite this, however, during their research conclusion, Beckerman and Wosniack (2018, p.484) acknowledged that refuge workers may be more affected because they are “perpetually left in a liminal state of constant trauma” because of the repeated crises they deal with. Therefore, these represent new insights into how roles can interact with negative effects of being a DAA. Regardless, this study does not, and would not want to present a hierarchy of roles as to which is most difficult to hold regarding VT, but the accounts of DAAs have illustrated how subjectively, the role that they undertake does influence the extent to which DAAs can effectively negotiate VT.

As stated in section 7.4, being exposed to success stories can improve VR as DAAs can see the positive changes they have made. However, the extent to which workers are party to these success stories varies with each DAA role and this was discussed by four participants. For community workers, DAAs shared that they are exposed to a "start, beginning and end" of victim-survivors' journeys, which means they can see the progress which is made by each victim-survivor, culminating in a success story which can build their VT. However, for DAAs working in refuge services, their work is focused on the initial crisis support, and getting victim-survivors rehoused safely. Therefore, they do not any access to information on the potential progress of victim-survivors when they leave the refuge. Countering the above experience of seeing the whole victim-survivor journey, one refuge worker stated that they "don't see something through from start to finish" so success stories beyond re-housing are not inherently visible to them, beyond some thank you cards, or intermittent feedback passed from managers. Therefore, it is important for DAAs in all roles to hear success stories, but maybe more so for those who are at the beginning of the process such as those in refuge, at the crisis point of work. To facilitate this, managers could ensure that positive feedback, and success stories are made readily available to all staff members; for example, one participant stated that a video of survey feedback would be shared during a staff meeting, which would help them feel satisfaction in their roles. As with the role differences in experiencing VT, previous research has not explored the variations between specific DAA roles and access to success stories, meaning these findings provide new insights to how roles interact with coping with VT.

Summarising this section, the specific role within the DAA grouping can have an impact on how individuals experience VT and VR, through different roles working with diverse levels of risk and crisis, having different space and time to process experiences, and having different exposure to success stories. These findings present original insights as to how experiences of VT and VR can vary between refuge and community DAAs, as previous research has not examined differences between these roles and the effects of these roles on the individual. The findings suggest that community workers have more access to management techniques, such as separation, boundaries and success stories, while potentially working with lower risk victim-survivors who do not need re-housing. Conversely, refuge workers work primarily with high-risk victim-survivors, have to manage daily refuge running, and have less access to

management strategies, such as separation and access to success stories beyond leaving refuge. However, as noted, this thesis does not strive to create a hierarchy of which role is more difficult, rather it illustrates how subjective experiences within roles can affect how DAAs experience VT and VR, and highlights where additional assistance could be provided to counter VT.

8.3.4. Experiences as a DAA Affecting Safety and Trust Schema

Some participants disclosed specific experiences which they have had since beginning work as a DAA which could exacerbate disruptions to schema, specifically around safety and trust. As these experiences depend on the individual, these are included in the individual factors as opposed to organisational factors. Two participants reported that they had received threats from the perpetrators of the victim-survivors they were supporting, and how these affected them. One participant discussed how she was told that she "apparently" "had a contract on [her] head" from a perpetrator because she was supporting a victim-survivor to escape. Similarly, another participant shared that a perpetrator has previously "managed to get [her] details" and telephoned her, being "aggressive" on the call. This same perpetrator had also been verbally abusive to her in court, when "he found out [she] was in court behind the screen with [her] client". A perpetrator for one of this DAA's other victim-survivors had also made threats against her and the staff, which needed to be reported to the police:

> I had a phone call…he'd found out that she was involved with us and he'd said he knew all about those 'C's in [DAS] and he's got a shotgun.

This participant disclosed that these incidents have led her to "fear" for her safety while in the role, demonstrating how her specific experiences as a DAA are a factor in the disruptions to safety she experiences. While other participants did not report direct threats from perpetrators, one participant stated that this is something that she worries about, saying "it wouldn't take long… for something to happen" and that "some of the perpetrators are just absolutely vile".

Previous research has explored perpetrator threats on trauma workers from perpetrators, for example, Iliffe and Steed (2000, p.402) found that a "high percentage" of DV counsellors had been threatened by their clients' perpetrators, while Dalton (2001, p.52) reported 57.6% of social workers had been threatened at work. Dalton also found that if workers

were threatened in work, this was associated with higher STS scores (2001, p.70), and Beckerman and Wozniack (2018) found that DV mental health workers were afraid of being located and harmed by perpetrators.

Participants (n=3) also reported experiences with victim-survivors which have affected their trust, as they have had victim-survivors who fabricated events or conversations. These experiences have made them wary of victim-survivors, and they have put additional safeguards in place for themselves. For example, following incorrect email summaries from a victim-survivor, one participant has now started thoroughly documenting every conversation so that she is more protected:

> I've had a client who said in an e-mail things that I did not say during our face-to-face assessment and it was terrifying… it's like, holy shit this could like really have an impact on me, professionally.

As well as experiencing victim-survivors fabricating events, which she said was a "big learning curve" and to be wary of clients, another participant has also had a victim-survivor steal money from her when she went to the bathroom on a home visit. Because of this, she is now more wary with her belongings around all victim-survivors:

> When I've gone into… somebody's house, you put your bag down or something like that, now… you just keep your bag close to you all the time.

Instances of theft affecting VT have not previously been reported in VT literature. However, threats from clients and thefts have been previously reported by social workers, which affect their cognition and emotions. For example, Koritsas et al (2010, p.266) found that 18% of social workers had experienced theft in work, while Newhill (1996) found that 57% of their social work sample (total n=1129) had experienced one or more types of violence while in work, including property damage. She also found that 52% of the sample worried about their safety while working with clients (1996, p.491).

In summary, this section has presented findings showing that individual experiences as DAAs can influence disruptions in trust and safety schema, through being threatened by perpetrators, or being made wary of victim-survivors. While these findings present original insights regarding these experiences and their link to VT, the existence of theft and threats while working with traumatised individuals is supported by previous research, alongside negative effects which are caused by these instances.

8.4. Conclusion

This chapter has addressed research question three, are there any individual and organisational factors which affect how Domestic Abuse Advocates (DAAs) experience and manage effects from their work. The factors which were raised by participants were split into categories of individual factors, which depend on individual experiences and choices, and organisational factors, which are aspects in the control of Domestic Abuse Services (DAS) and their management. Section 8.2 addressed the organisational factors, considering the support and communication provided by DAS and management, and finding that while some participants found their DAS supportive, which prompted Vicarious Resilience (VR), others had more negative experiences, feeling unsupported by their organisation and management teams, supporting previous literature. Original insights into factors which can influence DAAs experience of VT concern being subjected to "perpetrator behaviour" from managers, with some managers within three of the five DAS being described this way, utilising coercive control tactics and micromanagement which negatively impact DAAs.

The impact of VT training on DAAs experiences of VT and VR were then discussed, with participants who had received this training sharing how they found it useful in understanding, naming and normalising any cognitive changes and affect they experienced from the work. Supervision sessions with line managers were then considered, finding that while some participants found supervision sessions helpful, others did not as they did not trust their line managers. Conversely, many participants discussed that External Clinical Supervision (ECS) are helpful in addressing VT, however, provision of the sessions varied. Some issues with group sessions were explored which support previous literature, such as confidentiality, group influence and attendance, while some DAAs also raised that for sessions to be most effective, ECS should be conducted with trauma specialists who are knowledgeable of the sector.

Individual factors which affect how DAAs experience VT and VR, and how they can manage these effects were examined in section 8.3, beginning with their personal history. Participants' own experiences of Violence Against Women (VAW) were explored as a factor for VT and VR in section 8.3.1, finding that experiences were mixed, with some participants having positive effects, such as feeling lucky to have left their abuser, while for others, their experiences exacerbated VT effects through similar triggering experiences. While their own

experiences may interact with VT and VR, the non-victim-survivor in the sample also experienced VT and VR, which suggests that own experience does not cause these effects. Personal histories of participants also included their previous employment and health diagnoses, discussing how these may have contributed to VT disruptions. These aspects have not previously been explored in relation to VT and VR in VAW workers, and more research is needed into how these interact with VT.

In section 8.3.2, supporting previous research, participants reflected that over time they became less affected by the role and learnt to cope with its effects; however, this may not be accurate as the thesis has covered many ways which they are greatly affected by the role. Section 8.3.3 provided new understandings for the effects of DAA roles on how VT and VR are experienced. Whilst care must be taken not to create a hierarchy of difficulty of roles, this research evidences variations in subjective experiences between roles. These variations can affect exposure to traumatic material and access to coping mechanisms, such as community workers having processing time between cases. There is also variation in exposure to the positive success stories from victim-survivors, which can contribute to VR. Experiences of participants while working as DAAs were considered as factors affecting experience of VT and VR in section 8.3.4. While the threats and thefts raised in this section have not been previously linked to VT, prior literature supports these instances with social workers.

Following the previous four chapters which addressed the research questions, the next and final chapter will conclude the thesis, and reflect on the contributions of the study, its limitations and recommendations for future research, policy and practice.

9. Conclusion

9.1. Introduction

This chapter concludes the thesis, drawing together the key contributions of this research. This study was the first to explore Domestic Abuse Advocates' (DAAs) experiences of Vicarious Trauma (VT), and it expands on previous findings into Vicarious Resilience (VR) experienced by DAAs. It also examined how participants manage these effects, and whether there are any factors, both organisational and individual, which interact with the impact of these effects, adding to the current knowledge base and exposing nuances related to their specific roles.

Section 9.2 will illustrate how the study has attended to the research questions, considering how these key findings provide novel information and extend existing knowledge. Reflections on the practicalities of conducting this research, and of being an insider, will then be explored in section 9.3. The importance of the research design will be considered in section 9.4, reflecting on each methodological choice and using my own and participants' feedback to highlight the benefits of a multi-stage approach and of using creative methods, specifically the benefits of using sandboxing to conduct sensitive research. Section 9.5 acknowledges limitations of this study and offers suggestions for future research, before section 9.6 sets out my reflections and recommendations for researchers working in sensitive areas. Section 9.7 presents recommendations for future practice, including a discussion of outputs from this study.

9.2. Key Contributions

This section addresses each of the three central research question in turn to consider how the study findings add to the existing knowledge base.

9.2.1. Through the lenses of vicarious trauma and vicarious resilience, what is the effect of being a Domestic Abuse Advocate on the individual?

This section focuses on the key contributions explored in chapters five and six, which address research question one, on the effect of being a DAA on the individual, focusing first on Chapter Five which addressed the question through the lens of VT.

The main contribution of this research was through exploring VT with DAAs, as this participant sample has not previously been questioned about this phenomenon. While the effects of trauma work have been explored in other samples, due to differences in sectors, and exposure to different types of trauma, there could have been variance in how VT is experienced by different workers. Consequently, this research was the first to highlight how VT can be experienced by DAAs, and it also exposed important nuances in the disruptions to cognitive schema, which relate specifically to DAA roles. For example, while disruptions to intimacy regarding isolation have been explored in other samples (for example, Ben-Porat and Itzhaky 2009; Iliffe and Steed 2000), this study documented how DAAs can feel isolated due to having perpetrators of Domestic Abuse (DA) in their social circles. A further nuance specific for DAAs relates to disruptions to their frame of reference, through seeing DA everywhere because of their knowledge, which was described as a "prism of awareness" which all interactions are filtered through. These findings have demonstrated how pervasive VT effects can be, and understanding experiences is the first step in assisting these workers with their wellbeing.

The findings from Chapter Five illustrate the negative effects of being a DAA on the individual, and these effects are consistent with the concept of VT (McCann and Pearlman 1990a). While the concept of VT is well established, these findings are also important as they evidence the value in using the 30+ years old concept, as it is still applicable to trauma workers. However, while five of the seven VT cognitive schema were identified in the experiences of participants, two of the schema, esteem and independence, were not expressed by participants in relation to their roles as DAAs[43]. Nevertheless, it should be noted that in their proposal of the concept of VT, McCann and Pearlman (1990a) stated that VT does not disrupt all schema, but rather causes disruptions to the schema which are most salient to the worker. Therefore, it is possible that the missing two schema are the least salient to the participants in this study, perhaps explaining why they were not identified in their experiences. If this research was repeated with a different sample of DAAs, it is possible that evidence of DAA experiencing these remaining two schema may be found, and others which were found in this study may also be absent.

[43] One participant described becoming more independent and stubborn in asking for help; however, she related this to her own experience of domestic abuse, and not to her role.

It should also be noted that there were overlaps with the VT findings and those which are included in the conceptualisation of burnout (Maslach and Jackson 1981), namely emotional exhaustion (section 5.7.1) and depersonalisation (section 7.2.5). However, this was to be expected due to the similarities between these concepts (see section 2.3.6).

Chapter Six turned attention to positive effects of being a DAA on the individual and how these align with the concept of VR. While all participants expressed that they experienced negative effects, they also all reported positive effects. Aside from DAAs experiencing a sense of purpose, which was previously explored by Gilbert (2020), these findings provide a contribution to knowledge by novelly demonstrating the applicability of the VR concept to the experiences of DAAs, while corroborating findings on specific alterations from other trauma samples. DAAs specifically referenced the benefits of the knowledge they have, and while this can present problems in line with VT, being aware of DA and perpetrators can assist them in helping others, and in making safety plans for themselves and their loved ones.

Participants also considered how VT and VR are not necessarily balanced with one sometimes being more prevalent than the other. Further research could be conducted to explore the co-existence of these concepts and how they interact in DAA samples (see section 9.4).

In summary, this research has contributed to knowledge by finding that DAAs can experience both VT and VR, undergoing many different changes within each concept. It explored the experiences of the under-sampled population of DAAs, finding evidence to support the possibility of them experiencing VT and VR, and provided examples for how their specific roles can lead to disruptions and benefits. It has also evidenced the applicability of using VT as a concept to explore effects on individuals.

9.2.2. How do DAAs manage the negative effects of their work, and how do they build on positive effects?

Chapter Seven discussed how DAAs manage negative effects and build on positive effects of their work[44]. Most of the associated findings expand the knowledge base and provide a novel contribution as they have not previously been found in DAA samples, except for

[44] This section did not include aspects organised by the DAS, such as External Clinical Supervision, as these were discussed in Chapter Eight.

colleague support, where findings support those of Slattery and Goodman (2009). Researching coping and management of effects in specific samples is important as it provides an evidence base for how different trauma workers can cope with VT and enhance VR; while the findings from other samples may be relevant, this cannot be known without research evidence, as there may be variance due to experiences of their specific roles.

Chapter Seven explored how relationships assist DAAs to manage the effects of their role. As found with other participant samples (Baker et al 2020; Iliffe and Steed 2000; Massey et al 2019), the importance of colleague relationships was stressed by participants. However, DAAs emphasised the role of informal debriefing with their colleagues, and how they perceive it as potentially more important than formal support from managers and clinical supervisors.

The second half of Chapter Seven examined self-help strategies employed by DAAs to manage the effects of their role. As a means of relaxation, participants described cooking and eating food; however, participants spoke not only of creating food, but also eating comfort food, including takeaways and chocolate, in order to relax after a difficult day. This contradicts previous findings, such as Schauben and Frazier (1995) where Violence Against Women (VAW) trauma workers used healthy eating to cope.

Methods of relaxation and substance use to manage effects of being a DAA were also explored, aligning with previous research that illegal substances are uncommonly used by trauma workers to cope (Massey et al 2019; Schauben and Frazier 1995). While one participant disclosed using MDMA to cope with the effects of the role, surprisingly, no participants disclosed using cannabis for this reason. However, it is possible that participants were not completely honest about their drug use, for fear of repercussions, or because I was an insider.

In the previous literature, activism was cited as coping strategy for VT (Iliffe and Steed 2000; Yassen 1995). Participants in this study were asked about their participation in activism, but only one participant said that they engaged in activism, and this was during work hours, and did not help them cope with the role. Rather than spending their free time engaging in activism, participants were careful to enforce boundaries limiting involvement with VAW after work to protect themselves.

In summary, this study documented many different ways that DAAs managed the negative effects of their role and enhanced positive effects. The main contributions from attending to this question lie in sampling an under-researched population, which creates a knowledge base for how these specific workers can manage VT effects. These findings highlighted some experiences which contradicted previous research (Arnold et al 2005; Schauben and Frazier 1995), such as DAAs comfort eating to cope with the role, instead of eating healthily.

9.2.3. Are there any factors, including individual and organisational factors, which affect how Domestic Abuse Advocates experience and manage effects from their work?

Chapter Eight outlined the organisational and individual factors which affect how individuals experience and manage effects from their work. Due to the design of this research, it is not possible to establish any directional effects of these factors, such as whether the presence of them makes VT experiences worse or heightens VR. Instead, this research contributed to knowledge by evidencing the existence of and details around influencing factors for DAAs, which interviewees raised as contributing to the changes they had experienced, or how they coped with these changes.

As with the other research questions, some of the findings and details provided regarding these experiences have not previously been explored in DAAs, meaning that these findings expand the empirical knowledge base. The exception to this regards some findings within Organisational Support, general issues with External Clinical Supervision and own lived experience of abuse, where DAAs and DVAs have been previously sampled by Gilbert (2020), Slattery and Goodman (2009) and Wood (2017).

A novel finding regarding this research question was that participants in three of the five DAS sampled described some management behaviour as that of a “perpetrator”, illustrating their application of their sectoral knowledge to the poor communication and micromanagement of some senior staff. Linked to this, many participants explained how they do not find supervision with line managers helpful due to lack of trust in their managers. These findings highlight the importance of improving communication and trust in DAS between staff levels, which could improve experiences of, and how staff manage VT.

Another contribution to the knowledge base from this research question is the finding that the specific role that DAAs were employed in is an individual factor which affects VT and VR

experiences, and access to success stories which can enhance VR. For example, refuge DAAs work where victim-survivors live, meaning they have less access to boundaries which were cited as useful in section 7.2.5. Comparatively, community working enables space and time to process thoughts between sessions. Whilst care must be taken to avoid creating a hierarchy of which role is better or worse, as all DAAs experiences are equally important, DAAs in different roles have different access to coping strategies, such as separation and success stories, and support victim-survivors in different ways. Therefore, additional provisions could be supplied to refuge workers which give them access to these strategies (see section 9.5).

While caseloads were cited as an important factor in previous literature (Schauben and Frazier 1995), despite being asked about this, only two participants raised it as an issue, and in these contexts, this was mainly regarding managing caseloads while colleagues were away, or the addition of paperwork alongside their actual cases.

This study was not concerned with measuring the effect of being a victim-survivor on VT of DAAs, but rather on exploring whether there is any interaction. Twelve out of the thirteen participants identified as victim-survivors of VAW; however, while all twelve did report VT effects, so did the non-victim-survivor. Findings relating to the impact of being a victim-survivor on VT were mixed, with some participants saying their experiences do not overly affect them nor contribute to their VT, while others explained that they find specific cases difficult, with four explicitly stating that they have seen themselves in the victim-survivors they support. Being a victim-survivor DAA also was a factor for VR, with DAAs changing how they view their past experiences. These findings are important, as all potential DAAs should consider how their personal biographies may interact with the role, as these may occur in negative ways. However, there are potential benefits from victim-survivors becoming DAAs, as the VR they experience can help reformulate how they manage the impact of their own experiences.

In summary, this research has highlighted organisational and individual factors which can influence how DAAs experience VT, VR and how they manage both. Some findings support previous research into DAA samples (Gilbert 2020; Slattery and Goodman 2009; Wood 2017); however, some, such as the effect of specific DAA roles provide new insight to influencing factors, extending the knowledge base. These findings could assist organisations

address VT and VR, such as through implementing positive factors such as External Clinical Supervision and VT training which will be discussed in section 9.5.

9.3. Reflections on Practicalities and Being an Insider

This section outlines my reflections on practical aspects of this research and reflections on being an insider. The practical reflections include considerations of the reliance on gatekeepers, access to participants and practical issues with the interview schedule, while section 9.3.2 documents how being an insider researcher affected the processes of data generation and analysis.

9.3.1. Practical Reflections

For recruitment of the sample for this research, I relied on gatekeepers, specifically directors of DAS. Gatekeepers are instrumental in providing access to specific samples, meaning relationships need to be maintained to continue access, recognising the possibility of gatekeepers rescinding access (Clark 2010; Crook et al 2015; Rugkasa and Canvin 2011). While most senior managers responded and assisted with this project, there were occasions where I was waiting for emails to be passed on to potential participants due to organisations being busy, and one organisation never responded to my initial emails. I also encountered one manager who cancelled my meetings with their staff members due to business demands. In these instances, I assured managers that business needs, and those of victim-survivors being supported were paramount, and I re-sent missed emails and re-arranged cancelled meetings on pre-approved schedules. In this circumstance, these navigations with business needs proved only a minor delay in data production. However, concerns about losing access to participants did create anxieties for me about whether further access would be rescinded or denied. Therefore, in studies involving gatekeepers, researchers need to be aware of the practicalities of relying on others for access, and be cognisant that research activities need to fit around business needs.

Additionally, in relying on senior managers to send recruitment information, I had no control over what they were saying when passing on the call for participants. This may have raised an issue if managers included a firm encouragement for their staff to take part, which could undermine them providing free consent. To counter this risk, in case participants did feel pressured by their managers to take part, I reinforced the voluntary nature of participation at many points throughout the research.

Another practical point to reflect on was in the interview schedule. Due to environmental considerations, I strove to conduct stage one interviews for the same organisation consecutively, therefore reducing travel requirements. Supporting reflections from Silverio et al (2022), conducting more than one interview on sensitive subjects can be difficult. However, I found that it was not made more difficult because of the subject matter, but rather that conducting numerous interviews in one day (or on consecutive days) required more cognitive strain and stress to ensure I was not reflecting back on the previous interview, and what had been said or not covered. Therefore, in future research I would refrain from undertaking more than one interview per day.

9.3.2. Being an Insider

As stated in section 4.4, due to my previous employment in the VAW sector I was an insider with existing relationships with managers and participants. Therefore, I worried that they would agree to participate because of previous collegiality (Aburn et al 2021). However, by the time recruitment for this project began, two years had passed since I left the VAW organisation, and many workers who I knew had left the sector. However, I did have previous relationships with some managers and one participant. In these cases, I stressed that they should not feel obliged to take part, whether it was managers sharing the expression of interest with their staff, or the one participant taking part in the study.

The one participant with whom who I had a prior relationship understood that her contribution was voluntary. However, she apologised for choosing the standard, rather than the creative interview option, in case this would "mess up my research'" I reassured her that it would not affect the research, and it was her decision, but this reminded me how prior relationships can cloud judgements around informed consent. However, as with van der Scott's (2018) study, my prior relationship with this participant had been fairly longstanding, meaning she was more comfortable in saying no to anything she did not want to do. Nonetheless, I found the interviews with familiar participants difficult as I was constantly weighing up if I had for asked enough information or asked for more than I did of other participants.

I also needed to be aware of my own effect on following lines of enquiry in the semi-structured interviews. In semi structured interviews, the researcher becomes "a knowledge-producing participant in the process itself" (Brinkmann 2013, p.21), as they choose and

navigate the main lines of enquiry around participant responses. While this was mitigated to some extent by the inclusion of creative methods (Mannay 2010), I still facilitated the semi-structured questioning, and I influenced the data which was or was not gathered. However, a mitigation for this was the stage two interviews, as participants could review my initial findings, and raise their agreements, or disagreements with anything which had been raised in stage one.

Chammas (2020) discussed the issue of insider researchers' analysis being led by their own experience, with the risk of excluding or downplaying potential findings with which they do not identify. In line with this, initially I recognised, coded experiences and proposed themes which reflected my own experience (such as disruptions in safety and trust), or those which resonated with me as they were upsetting and unexpected (such as victim-survivor suicide). While I was aware that I would need to be mindful of how my own experiences may influence analysis, this initial effect happened automatically. Because of this, I needed repeated exposure to each interview to ensure all relevant codes had been considered, and to take regular breaks to ensure I was focussed on what participants were saying, instead of slipping into what I "know". The impact of my own experiences and views on analysis was also mitigated through the stage two interviews. While these were included in line with the PAR approach, they also reduced my ability to control the findings, as participants were given the opportunity to raise their agreement or disagreement with any initial themes, or to raise whether they were missing anything from their initial interviews.

In summary, reflecting back on this research has provided some insight into practical issues, such as relying on gatekeepers, and conducting more than one interview per day, which need to be considered for future research. It has also highlighted how being an insider can complicate conducting research and analysis, as you constantly need to be aware of your own influence and existing knowledge.

9.4. Importance of the Research Design

This section will now appraise the importance of the research design, discussing the use of a case study design and using a DAA sample, using Participatory Action Research (PAR) principles and a feminist lens, multi-stage interviews, and also the benefits of using creative methods.

9.4.1. Using a Case Study Design and DAA Sample

As explained in section 4.2.1, this study used a case study design to explore VT and VR in DAAs. The case was bounded as type two, of multiple units (13 DAAs) within the case of Welsh DAS.

The case study approach enabled the in-depth exploration of insights into VT, VR, and how they are experienced by DAAs. The data produced went beyond description of effects, and measurement of prevalence or severity levels which has previously been researched and instead explored how participants' schema were altered, how they changed behaviour, and nuances within these effects and changes of behaviour.

DAAs were chosen to be the sample, and the units, for this research as they are an under-researched population. However, there has been ample research into various VAW roles, such as Sexual Violence workers. At the outset of this thesis, in section 1.1, the differences between DAAs and other VAW workers were highlighted, explaining that DAAs are exposed to the full range of Domestic Abuse abuses outlined within the UK Government definition (see section 2.2.1), rather than specialising in only one abuse type. Further discussion of DAAs in section 2.2.5 also raised how DAAs work stems beyond emotional support, or specialised roles such as counsellors, and includes a range of advocacy roles, including assistance with housing and financial planning. Frey et al (2017, p.45) also stipulated that DAAs typically have less formal training than counsellors and clinicians.

Reflecting back on the decision to sample DAAs, the choice to focus on these workers was appropriate. Sampling this group has provided evidence of VT in this population, and exposed nuances to how they experience VT which directly relate to their role, such as the "prism of awareness". Additionally, research DAAs has found initial variations within the DAA grouping, which would have been missed had this specific group not been targeted. For example, the variations for refuge workers would not have been exposed as this is a DAA specific role.

The inclusion of multiple DAAs as units within the single case was also beneficial, instead of bounding the case in an alternative format as it allowed for DAAs to corroborate and expand on each other's experiences concerning the phenomena throughout the multiple stages. This therefore has built a picture of how VT and VR are experienced by DAAs, how workers manage the effects, and whether there are any influencing factors.

Welsh DAS were chosen as the case due to Wales being the first home nation to pass legislation on VAW, because of the geographical variation within Wales, and because of my existing networks[45]. Despite participants being from across the breadth of Wales, from both dense urban areas and sparse rural areas, the data did not imply any geographical divide or difference in how VT and VR are experienced. Additionally, while Welsh DAS are aware of staff wellbeing and managers spoke with me regarding VT, none of them had dedicated formal policies. This is useful as the case study has demonstrated that these findings may be applicable across all UK landscapes and DAS, and potentially further. The experiences in this study may also be applicable beyond VAW, to other trauma samples, which could be explored in further research.

9.4.2. Use of Participatory Action Research Principles and a Feminist Approach

Another benefit of this research design was through the use of Participatory Action Research (PAR) principles with the active involvement of the sample throughout the study (Brown 2021), and the use of the feminist lens to counter power imbalances and to centralise the voice of the participant. The DAAs are the people who spend their working lives putting their wellbeing at risk in order to help others, and they are the ones who experience these effects. Therefore, while I as the researcher can analyse their experiences into the conceptual topics, they are the people who understand the reality of VT and VR. By consulting with DAA participants on the findings, this enabled them to be sense-checked by those who live with the effects.

In the second interviews, most participants agreed with the content across themes, with many nodding, saying “yes” or “yeah” to findings, or how they agree, for example, Jayne saying “I totally agree with that”. Being presented with the themes of the findings from other DAAs also provided prompts for some participants, who had not thought of certain experiences or points during their first interviews. For example, during interview two, Melody exclaimed, “Oh my God, I didn't touch on that but that is so true” when presented with information about victim-survivors having high expectations which lead to feelings of responsibility. Additionally, participants shared where they do not have experiences of

[45] The effects of being an insider were discussed in section 1.3

themes, but still said that they understand why other DAAs have answered that way, so it was not that they disagreed with them.

Importantly, this second stage also provided an opportunity for participants to raise any concerns with the initial findings, which I could then reflect upon for presentation (Wadsworth 1998). This can be seen most clearly with Donna, expressing her concern over the findings regarding role being presented as a hierarchy. Therefore, I diverted from my original wording and acting on her assertion I was careful in my presentation of the findings to avoid a hierarchical presentation of role and consider the nuances of how different roles interact with VT and VR.

Furthermore, while the primary intentions for presenting the initial findings to participants in a second stage interview were to engage participants in the analysis and mitigate my insider effects, following these, some participants shared why they found hearing about the findings helpful. Throughout the research, participants had shared personal and sometimes upsetting effects of their work on their lives and how they deal with them. In stage one, some participants even asked me if I thought there was something wrong with them. However, after hearing the initial findings, and getting to feedback on their similarities and differences with others, many participants said they had found it helpful and that they "feel more normal" (Jayne) knowing that others share their experiences. For example, Amy exclaimed "so it's not just me?" with regards to being negatively affected by the role. Jayne also expressed her happiness at taking part in the research because of this, saying "I'm glad I took part in this, now". Additionally, in the second stage interviews, participants provided feedback on output content. This gave me insight into what would be most helpful for DAAs, so as to effectively create Action from the research (see section 4.2.2).

However, while PAR principles were used throughout this study, by involving participants at repeated points, creating Action (which will be discussed in section 9.7), and being reflective throughout the process, the research was not at the more participatory end of the PAR involvement scale. As explained in section 4.2.2, PAR studies can be placed on a scale of involvement, with tokenistic, "superficial" involvement at the one end, and fully participatory "co-research" at the other (Brown 2021, p.3). However, due to practicalities,

this research falls towards the middle-right[46] of this scale, as participants did not take part in all stages of the study, and do not co-own the study.

For a fully PAR study, participants would have been involved in all stages of the study, including the design consultation. However, due to short term contracts, time which participants could take out of their working days, and attrition risks, I decided not to recruit participants at this early stage. This was because it was more important to continue their involvement through both interviews, rather than the consultation, so that they could generate data and feed into analysis and outputs. To counter this, and to still involve experts in the field in the research design, the design consultation was conducted with managers of DAS. The design was further ratified through the pilot, which was tested by a doctoral student who worked in VAW.

Additionally, for a more PAR study, participants could have taken more ownership of the research project, through speaking with me at conferences and talks, and collaborating with me and being cited as authors on any future papers. However, this would involve participants identifying themselves, which participants did not want to do, for fear of repercussions. Participants were asked whether they wanted to use their own names, and all declined, saying they wanted to use pseudonyms, which was also reinforced with participants checking the anonymity of their statements.

There were also limitations in applying the feminist lens throughout this research. While I could be aware of power imbalances between myself and the participants, there is an inherent imbalance between the roles which takes more than awareness to address (Grenz 2014). Being a researcher holds power as researchers have control over the narrative which is produced, deciding what is included and explained in the final report. While I attempted to mitigate this through the involvement of participants in gathering feedback on initial themes, it was still ultimately me who decided on themes, the codes which would be used to illustrate them, and the narrative. I also executed my power in deciding what not to include in the thesis, especially regarding potential identifiable content, which I ethically needed to do to protect participants.

[46] The middle of the scale is participating in the research. As participants reviewed the findings and assisted in analysis, their involvement falls above the middle of the scale.

9.4.3. Use of Sandboxing

Sandboxing has not previously been used to explore VT, VR, management and coping strategies, or influencing factors in trauma workers; therefore, DAA engagement with this method provides a methodological contribution of this thesis. Despite concerns that participants may be uncomfortable in employing creative methods, over half the sample chose to use sandboxing, with some participants making more than one scene. To understand these choices, during the second stage of the research, I asked participants to feedback on using the sandboxing technique and asked about the rationale for those who chose not to use creative methods.

Most of the participants who engaged with sandboxing were positive about the experience, stating how it "really good fun", and how you do not need to be good at art to engage with it. Participants also raised how sandboxing helped in discussing sensitive subjects as "it gives you something else to concentrate on". However, Rose did explain why she chose to stop with one sandbox creation, saying how she struggled to make her "thoughts visual", and additionally, that she felt like she "had to be a 5-year-old to do it". The worry of feeling childlike was also echoed by Melody, however she said once she started, she enjoyed the process.

Participants who opted out of sandboxing cited different reasons, including not being a "creative person", or feeling "more comfortable talking about things". Jayne, however, had been trained in using sand trays as therapy, and therefore avoided it as she knows "how affective the sandbox is".

Section 4.4 noted how creative methods can be used to fight familiarity and enable participants to lead data production. Evidencing this, participants made scenes which I was not expecting and for which I would not have asked direct questions, for example, Melody creating a scene on thinking about leaving the role due to desensitisation. Also, I did not expect pets (specifically owning a dog) to be so important to DAAs in coping and therefore, I initially did not have any prompts for pets. It is possible that as I do not have a dog of my own, I was unaware of the benefits (see 3.7.1). Therefore, by asking participants to create a scene on coping mechanisms, I was greeted with an unanticipated finding as participants frequently sought out the dog (and cat) figures.

However, limitations were raised after conducting the sandboxing interviews. Even following the pilot and widening the figures on offer for sandboxing, during the interviews, some participants raised that there were not figures available for certain things they would like to represent, specifically books and a caravan. While these aspects were captured in discussions, the available figures can both widen and constrain the production of sand scenes.

Feedback on the use of creative methods was gathered in the second interviews, which provide insight into participants' views on sandboxing and its use in exploring sensitive topics with adults. Participants explained how they found the creative method of sandboxing a useful tool with which to explore sensitive subjects, making participants feel more comfortable with the process. Participants also shared their enjoyment with the method, and how artistic skill is not needed, making it apt to use with any sample in different fields (Rainford 2020). Alternatively, some participants did not enjoy the process, or declined its use, linking to ideas of embarrassment which would need to be addressed by researchers who were interested in using the method. Nevertheless, even participants who did not enjoy or use sandboxing referred to the benefits of providing various options of data production to research participants. Further detail regarding these reflections can be found in Maniatt (2023).

In summary, due to the research design used, in depth, case study evidence concerning an under-researched sample has been produced, highlighting experiences of DAAs which could potentially be expanded to other trauma workers. Practical benefits from the research have been informed by DAAs through repeated involvement, and this repeated involvement also enabled participants to expand on answers, agree with others, and feedback on the use of creative methods. While the second stage allowed an opportunity to member check their responses for accuracy, it directly helped participants through giving them the opportunity to hear the responses of their peers, which normalised their experiences. The use of sandboxing marks an original methodological contribution for this research, as it has not previously been engaged with to explore these topics. Participants also described the positives of engaging with this method, including that it made them feel comfortable discussing VT, and also that it did not need them to be artistic.

9.5. Limitations and Future Research

While this study addressed the research questions, there were some limitations which may have affected the findings. Firstly, one of the points of originality for this research surrounded its use of creative methods to explore VT, VR and how participants manage these. However, not all participants chose to engage with the creative methods, and instead participated in standard, semi-structured interviews. Therefore, it is possible that nuances in these participants answers were missed. For example, Melody's engagement with sandboxing provided an opportunity for her to utilise anonymous figures to denote her need for boundaries and separation (section 7.2.5), which may not have been facilitated by an interview. However, in keeping with the feminist lens and PAR principles of this research, choice needed to be central for participants, empowering them in their own involvement, and enabling them to choose how to take part.

Another limitation is that two participants did not undertake the second stage interviews, meaning that any additional insights from them, or potential changes to their experiences were not documented. However, this is a risk of undertaking multiple stages in research, as it is expected there will be dropout of some level over the course of time (Ahern and LeBrocque 2005).

It is also possible that my position as an insider-researcher influenced the responses given by participants, and they may have disclosed further information to a more independent researcher. However, it is also possible that participants would not have shared as much information, as I already have insight into the sector and its possible effects. Additionally, the participant with whom I have a prior relationship with may have filtered her responses to be more acceptable, which could have influenced her responses.

Finally, a limitation of this research was that not all of the participants in this sample were day-to-day support workers, as one was a referrals officer, and one was a manager with previous experience of working front-line. However, whilst they did not all work in support roles every day, the referrals officer spoke to victim-survivors each day, and was exposed to their experiences in depth as data was collated to decide on the support they required, while the manager dealt with victim-survivors when required, and also supported DAAs as staff. Additionally, this slightly broader sample suggests that VT is pervasive across roles in DAS. As Donna said in the first interview:

> If you're in the sector, you're always going to be surrounded by it, doesn't matter what your job is. Even if you're… the finance person or HR person, it's still there, isn't it? (Donna)

Considering the responsibility to ensure the wellbeing of staff as well as of victim-survivors, and content they are exposed to, future research could examine other roles in DAS, such as managers and 'back-office' staff to establish their experiences of VT.

A further avenue for future study could be through utilising a longitudinal design. Though this research included repeated interviews, which provided some insight to changes over time, research could take place over a longer time frame to track changes. For example, research could follow participants from when they start employment as a DAA and over their employment and measure any changes. This could then explore the suggestion from section 8.3.1 that length of time in the role interacts with experiences of VT.

Additionally, building on findings on the co-existence of VT and VR in this sample, future research should be conducted to establish and explore the connection between VT and VR in DAAs. This could gain more understanding of how they are linked and how VT could be reduced, while improving VR.

Following this research into *how* VT and VR can be experienced by DAAs, future research should be conducted to establish the prevalence of these across DAAs in Wales, UK and beyond. Since the completion of this research, a quantitative study has been conducted by researchers to determine prevalence of experiences linked to VT and VR in DAS and Sexual Violence services, and the factors which can influence VT ad VR (Horvath et al, in progress). Prior to dissemination of their survey, I provided feedback to the research team regarding the questions to ensure that it included questioning regarding topics raised within this thesis, for example, determining whether respondents attend group, or individual clinical supervision.

In summary, there are limitations of this research, such as dropout and not all participants using creative methods. However, some of these were inevitable, or accepted as being in line with participant agency. Additionally, participants were not all support workers, but did have daily contact with victim-survivors, however this highlighted that back-office workers can also experience VT and VR. Therefore, future research could explore the effects on administrative DAS workers. A longitudinal design could also assess causality in factors

which influence VT and VR, while further research could also explore the connection between VT and VR so that the relationship is further understood.

9.6. My Reflections and Recommendations for Researchers working in Sensitive Topics

Conducting research into sensitive topics can harm the well-being of researchers as well as their personal and professional lives (Silverio et al 2022) and I experienced this first hand during this study. Following from my own experience, there are certain steps which could be taken by others who are researching sensitive topics to hopefully reduce the risk of harm. This section will explain the effects I experienced and also these recommendations, which include expecting wellbeing risks throughout the entire research process, pacing yourself during the process, and 'checking in' with yourself.

While studying VT and VR in DAAs, I was acutely aware that the process of this research may elicit similar responses in me as I conducted this research. Considering how workers own lived experience of abuse may link to VT, I was also aware that my own lived experience of VAW and of VT may situate me as more at risk to lapses in resilience. Therefore, I needed to balance my own care with conducting this research.

Before conducting fieldwork, I expected that the process which would most affect me would be conducting the initial stage one interviews, as this was where participants would be sharing the main information about their experiences of VT. At the time of data production, I only consciously noted one interview as upsetting in my reflexive journal, following which I undertook appropriate self-care measures[47]. At the time, I did not notice any other shifts in my cognition, behaviour or mood. Once these initial interviews had finished, I believed that the worst of the risk to my wellbeing was over.

However, when it came to transcribing the initial interviews, where I was re-living each discussion, often listening to portions repeatedly to ensure accurate transcripts, the effects of conducting this research began to show. While scheduling of data collection at less stressful times has been previously raised (Silverio et al 2022), the emotional toll of immersing myself in these sometimes traumatic accounts and experiences of others for

[47] It later transpired that the DAA in this interview was going through a crisis at that time, which I may have unconsciously picked up on, leading to me feeling stressed.

prolonged periods of time, when I was at the time navigating my own personal stresses, led to me experiencing low mood, motivation and a heightened negative worldview. Each of these points replicate the accounts of VT of which I was studying. Despite using my reflective journal throughout the research process to take account of my thoughts and feelings, as in Silverio et al's (2022) reflections on conducting sensitive research, I did not identify these subtle shifts in my wellbeing until I had an unplanned discussion on my wellbeing with my supervisors.

Once the discussion with my supervisors had taken place, and I had acknowledged the affect that conducting this research had on my wellbeing, practical steps were put in place for me to take some time away from transcription and initial analysis, outsource the most upsetting recording to a professional transcription service, and I was also referred to the university Occupational Health for assessment. Only after this break and assessment did I identify change of tone in my reflective journal entries, highlighting how difficult it can be to identify subtle shifts while experiencing them. Therefore, researchers working in sensitive areas should stay aware of the risks of being affected throughout the entire process, beyond data generation and including transcription, analysis and write up.

Additionally, pacing yourself, and giving yourself downtime throughout the research is also important. Until the difficult period I encountered, I worked on this research at all hours of the day, including evenings and weekends. Following this period, and my discussions with counsellors, I amended my work times so that I did not work evenings or weekends, to ensure down-time throughout the process, and also scheduled transcription so it was interspersed with other tasks and not overwhelming. While the interview schedule of more than one per day did not emotionally harm me (see section 9.3.1 in practical reflections), it was more tiring to conduct these sessions back-to-back. Therefore, other researchers may want to avoid this to care for themselves.

Finally, researchers should also 'check in' with themselves throughout the process. While keeping reflective journals helps some researchers, as explained above, it was only after a discussion with my supervisors that I could identify changes in my writing. During counselling sessions after referral from Occupational Health, we devised a set of self-care, 'check-in' questions as prompts to reflect on my wellbeing (Appendix 10). These include questions such as how busy is work, and how am I managing it, which I scheduled monthly

time to complete throughout the remainder of my research. I personally found these direct questions more affective in identifying my emotions than the free formed reflective journaling. Therefore, researchers should check in with themselves continually when conducting research in sensitive topics, whether that is through using a reflective journal, or directly questioning themselves, and could use the questions in Appendix 10 as a base, refining it to their own best use.

In summary, this section has explored the personal impact of conducting this research, explaining how the transcription process affected my wellbeing. It also proposed different strategies for others who are conducting research in sensitive areas, including being aware of possible affects at any stage, pacing yourself in your work and protecting relaxation time, also checking in with yourself, using either reflective journals or direct questions.

9.7. Recommendations for Future Practice

This research has highlighted that VT and VR can be managed in many different ways, such as through relationships and self-care. However, it has also evidenced the need for all DAS to provide organisational assistance to DAAs. The two most prevalent practices which should be provided by DAS are training on VT, so that DAAs are aware of the changes which they can experience, and access to clinical supervision, so that they can process any changes and experiences from their work. This section will outline these recommendations, and others, which can assist DAAs.

Findings from this research have demonstrated the need for all DAAs to have access to training regarding VT, VR and how they can mitigate negative effects while promoting positive effects, as well as actions which could be taken by DAS to assist their workers wellbeing. In response to this, and acknowledging funding strains on DAS for implementing training, I am in the process of developing a training resource from this research consisting of a recorded webinar, which can be rolled out to DAAs on induction, and re-watched whenever they feel the need. Alongside the training resource, I am also creating a guidance document for DAS which will outline the following recommendations which stem from these findings.

Linked to the findings given regarding training, as stated in section 9.4.3, participants reflected on hearing the initial findings during the second interview, and how they felt "normal" once they knew they were not alone in experiencing VT. For example, Amy

expressed “so it’s not just me?” while Jayne said, “it’s actually made me feel normal” and that it is “good to see that your behaviour… is common with people who work in the same field”. These reflections on hearing that others feel the same way reinforces the need for VT training in DAAs, which will be included in the training resource. This resource will also draw attention to the VR experiences which can stem for the role, which research has proposed can assist in their development (Hernandez et al 2007). Therefore, the training not only raises potential negative effects, but also encourages DAAs to identify the positive effects from their role, as they are presented with the findings from this sample.

Findings from this research also raise the idea of workers needing space to reflect on how the job effects them, in clinical supervision, and to some extent, training sessions. This can be evidenced in Martha starting her first interview by saying she was not affected much by the job, but then proceeding to talk for an hour about the effects she experiences. At the end of this first interview, she then acknowledged that she is more affected than she realised, and that just talking about it and having the space to think about the effects made her realise. By the second session, she stated how she could then recognise VT in herself. Additionally, Charlotte explained how she does not like attending training sessions anymore as they make her reflect on her experiences, which can be upsetting. However, while upsetting, this reflection may be beneficial for workers as the knowledge and skills provided in the session also gives them tools to work with in mitigating VT effects.

Expanding from this space for reflection, this research also highlights the need for clinical supervision sessions for DAAs. As raised by Sexton, working with trauma:

> is too demanding to do without supervision and this should be understood as an ethical responsibility. (Sexton 1999, p.400)

This emphasises the need for services to provide sessions for their workers. While group clinical supervision is more cost effective for DAS, and as was raised in these findings can be helpful for team building, there can be issues with this being the only form of clinical supervision for DAAs. This research found that DAAs may not raise any issues in these groups, for fear of confidentiality being broken, or because they conform to the dominant narrative of the group. One participant also raised how her group continually changed, which has affected the group dynamics and makes it harder for her to engage. Therefore, while group clinical supervision can be offered, the group should be set, and not amended,

so as to build rapport and trust with the other attendees. In addition, individual clinical supervision sessions should be available to all staff, even if they are not regular, scheduled sessions, as DAAs may be struggling with an issue, but feel unable to raise it when in a group.

These findings also highlight the need to have an appropriate person conducting the clinical supervision sessions. Participants discussed how trauma-informed specialists, and supervisors who are knowledgeable of their role are ideal, as then DAAs do not need to waste valuable session time explaining the nuances of their role, and instead can focus on the needed content. While trauma-informed, and specialised clinical supervisors can be more expensive than standard clinical supervisors, this cost could be outweighed by the benefits they provide to DAAs, and the quality of support they can then provide to victim survivors.

Furthermore, it needs to be made clear to DAAs that clinical supervision is not a punishment, nor a slight on their ability to cope, or their performance in the role. While the negative view of clinical supervision was only expressed by one participant, this finding was concerning, as clinical supervision can be extremely helpful to all trauma staff, and should be normalised and encouraged, rather than seen as a punishment.

Similarly, while some DAAs may choose not to engage with clinical supervision sessions, as they feel it is not beneficial, sessions should still be made available to all staff, with potential sessions scheduled annually to check on their wellbeing. As explained by Massey et al (2019), trauma workers may not realise they need support, when they actually do.

Additionally, DAS could also encourage colleague relationships as these are a very important strategy for DAAs in both mitigating VT and enhancing VR. This could be done through encouraging staff social events, potentially alongside exercise or nature activities which could lead to combined benefits.

Section 8.3.3 highlighted variations in exposure to crisis and victim-survivor support, and access to coping strategies depending on DAA role. While aspects of the refuge worker role which affect VT cannot be reduced, as they are part of the role (such as managing communal living), steps could be taken to provide more access to coping strategies for refuge workers. For example, each refuge could have protected staff-only areas (which are enforced), as DAAs raised victim-survivors entering staff rooms. If there are numerous

refuge sites, it may benefit workers to have their caseload split across locations, so that separation and processing time is built into their day through the journeys between them. Additionally, where possible, success stories from across the DAS could be collected and shared with the whole organisation, so that regardless of role, DAAs can see the benefits from supporting victim-survivors.

Finally, work needs to be conducted in DAS to ensure communication and understanding between staffing levels. As documented in this study, DAAs feeling valued, and empowered in their roles is variable, which can exacerbate VT effects, while workers who feel their organisation upholds feminist values cite enjoyment which contributes to VR. From discussions with managers, all of the DAS involved in this research highly valued and appreciated their workers and prioritised their wellbeing. However, to the DAAs, this can feel like "lip service" (see section 8.2.1.2). Therefore, as raised in these findings, communication needs to be made clear between all levels of staffing so that workers understand they are valued.

In summary, in line with the PAR principles of this research, I am creating practical outputs from these findings, including a training resource and guidance for DAS in how to mitigate VT and encourage VR. Training on VT and VR has the potential to support DAAs to name their experiences and understand techniques which can help them, and confirm that they are also not alone in experiencing VT. Recommendations for DAS include guidance for external clinical supervision, encouraging colleague relationships, providing opportunities for coping strategies for refuge workers, and building on communication between workers and managers, so that DAAs feel more supported.

9.8. Final Remarks

This research has been the first to qualitatively examine VT in DAAs, and it has added important contributions and nuance to how VR is experienced, how effects can be managed, and what organisational and individual factors can affect these experiences. While some of the benefits of this research concern the DAS, and their retention of staff, and also the victim-survivors who access services, and the quality of support they receive, it should be noted that the main recipients of benefits from this research are the DAAs and their wellbeing. Behind every service, and the support which is offered to victim-survivors, are DAAs – workers who dedicate their working lives to helping others. This research highlights

the negative effects this can have on their lives, formulating them into the established concept of vicarious trauma, so that DAAs can name the changes which occur to them, and with which they may need assistance. Additionally, this research brings to light the benefits from working as DAAs, and how the role can bring enjoyment and growth to workers. Therefore, DAAs should be encouraged to recognise their achievements. Participants also shared their thanks that this research was being conducted, and that attention was being paid to an issue which affects their lives, and cited benefits from participating, which could be expanded to other DAAs by implementing the recommendations from these findings.

However, while the coping strategies found can assist DAAs in finding ways to manage their VT and heighten their VR, I want to echo Bober and Regehr (2006), that these findings should not be used as a means to victim-blame DAAs. The existence of VT, or fewer experiences of VR, in DAAs does not mean that they are not protecting themselves adequately, and this should not be inferred. To quote Pearlman and Saakvitne, VT is "an occupational hazard that must be acknowledged and addressed" (1995, p.123) and is not the fault of the worker.

To conclude, the substantive empirical contribution of this research was in evidencing experiences of VT in the DAA population, as this had not previously been researched. Findings on VR, management of effects and influencing factors have also been under-researched in DAAs, with this research adding to the existing knowledge base by exposing nuances in experiences relating to their experiences and roles. Additionally, while VT is a well-established concept, this research has evidenced that it is still applicable to trauma workers, and demonstrated how it is still a useful framework for understanding the negative effects of trauma work.

Using principles from Participatory Action Research (PAR) has also been important in this research, as the multi-stage design has enabled participants to review their own contribution as well as the initial thematic findings. Additionally, the findings from this research are useful for practice and implementing change, as recommendations have been made concerning how DAAs and DAS can mitigate VT and enhance VR. This research has also applied innovative methodology for this topic, using the creative method of sandboxing to provide agency to participants, and distance myself as an insider. Accordingly, the study

centralised the experiences of DAAs regarding VT, VR and management so that they could inform future research and practice.

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Appendix 1 Background Information Sheet

Participant Background Information

Please answer the following questions. This research will examine how these features interplay with your of experiences on the effects of supporting adult survivors of domestic abuse. These answers will only be connected to you by your participant code.

1. Do you consider yourself to be someone with lived experience of domestic abuse or other forms of violence against women?*

   Yes No Rather Not Say

*You will not be asked about your individual experiences of abuse during this project. This research is only interested in the interaction between whether you have lived experience and how this interplays with effects of your role. This is optional and you do not need to share this information to take part as you can indicate 'rather not say' as an option on the recruitment form if this is preferable.

2. How long have you worked for this organisation?

   _____

3. How long have your worked in the violence against women, domestic abuse and sexual violence sector?

   _____

4. How many survivors are currently on your case load?

   _____

5. Is this amount usual or more/less than you usually support?

   _____

For completion by researcher

Participant Code - _____

Appendix 2 Interview Guide for Stage One

Before we begin can I ask you to check this consent form, and put an ink signature on the two of them. I will keep one and you can keep the other, they have my signature on as well.

Okay, next can you fill in this form, and pass it back to me. It's just got some background information on it which will help guide which questions to ask you in the interview. Thank you.

And lastly before we begin, can you tell me a bit about your role, and how often you come into contact with survivors of abuse in your role?

Creation, if not, move to next page

I'm going to ask you to create a scene in the sandbox to answer 2 different questions, starting with looking at the effects of being a domestic abuse advocate, and then once we are done with that topic, moving on to how you deal with these effects.

You can make as many different scenes as you would like for each question, and you can use as many different figures as you would like. If you want, you can use 2 boxes so you can make 2 scenes at once, or do you want to just use the one box and repeat making a scene if you want to? (get answer)

Okay, so I will ask you the first question, you have 10 minutes to make a scene which represents your answer. I will then take some photos of it, and we will discuss what it means to you and explore that topic further, before doing the second question.

Do you have any questions?

Okay, so the first question is - Can you please make a scene which shows *the effects* that being a domestic abuse advocate has on you?

Now I'm just going to take some photos of your creation.

- Okay, can you please explain the scene to me?

After initial explanation, ask for further information on aspects not explained e.g. –

- Why did you choose [this figure]?
- Why did you stand them this way?
- What does this aspect represent?
- Do you think [this] could mean something else to you as well?

Do you want to make another scene? (repeat from question if yes)

General questions for initial interview if not covered:

- How do you think your work as a domestic abuse advocate affects you?
- Do you think your thought processes, and the way you think, have been changed by the work?

  Have you noticed any changes in:
  - Your worldview?
  - Your trust of others and of yourself?
  - Your self-esteem?
  - Your feelings of safety?
  - Your feelings of power in your own life?
  - Your relationships with partners?
  - Your relationships with family and friends?
  - your independence?
- Do you experience any physiological or physical effects from the work?
- Do these effects roll into your personal life?

For workers who have worked for over 2 years in the sector:

- Did you always feel these effects, or have they changed since you started this job?

If they have only mentioned negative/positive effects of the work:

- Do you think you've experienced any positive/negative effects of the work?
- How do you think positive and negative effects of the role interplay for you?

For participants who have stated they are a survivor on their background form:

"On the background form, you have ticked that you consider yourself to be a survivor of domestic abuse/violence against women.

I am interested in how your experience of dealing with other people's trauma interacts with your own experience, and how you deal with this. I'm also interested if there are similarities and differences between how you deal with other people's trauma compared to your own.

I'm not going to ask you about the details of the abuse you experienced, only on the effects of being a survivor conducting this work.

If you are happy for me to ask these questions, can you please nod or confirm for me. If you would prefer not to discuss any of this with me, you can just shake your head and we will move on to another question."

If yes – do you think that being a survivor yourself changes how this work affects you?

- Do you think you're affected less, more or just differently to non-survivor workers?

Do you have anything else to add about the effects of your job on you?

Okay, so now we have discussed the effects of the job on you, we are going to wipe the scene clear. So I'd like you to take the figures out of the box, and give it a gentle shake so that the sand goes back flat.

Okay, so now I will ask you the second question, you have 10 minutes to make a scene which represents your answer. I will then take some photos of it, and we will discuss what it means to you and explore that topic further.

Do you have any questions?

Okay, so the second question is - Can you make me a scene which shows *the ways you deal with the effects* of the work?

Now I'm just going to take some photos of your creation.

- Can you please explain the scene to me?

After initial explanation, ask for further information on aspects not explained e.g. –

- Why did you choose [this figure]?
- What does this aspect represent?
- Do you think [this] could mean something else to you as well?

Do you want to make another scene? (repeat from question if yes)

<u>General questions for initial interview if not covered:</u>

- What are the ways that you deal with these effects?
- What do you do to relax after a hard week?
- Do your colleagues relax/manage effects in different ways to you?
    - self-care,
    - eating (healthy and not),
    - exercise,
    - Do you do any meditation?
    - Are you spiritual? Do you follow a religion?
    - Do you use any substances, such as alcohol to deal with the job?
    - Socialising?
    - Do you avoid dealing with the effects of the work? Or ignore the effects? avoidance

- Does the organisation provide any support with these effects?
    - Do you have access to support and supervision? Is it helpful?

- Do you have access to clinical supervision? How often? Do you think it helps?
- How is your case load managed?
- Are you encouraged to use your holiday days or any time accrued?
- Do you have training on vicarious trauma or wellbeing?
- Do you get to see or speak to women once they have left support and are happy? Or to see success stories or endings to put it a different way?

For those who have worked in the sector for longer, but not always in that organisation:

- Considering this organisation and your previous employment in the sector, has there been any difference between organisational support for the effects you've explained?
- **For participants who have stated they are a survivor on their background form:**

Are there similarities/differences between any coping mechanisms for the effects of the work to what you do or have done to cope with your own trauma?

Do you have anything else to add about how you deal with the effects of your job?

Lastly – do you have a preferred pseudonym you would like me to use for you?

Appendix 3 Interview Guide for Stage Two

1 - Recap what they said in the first interview – read their summary to them.

- Have you noticed any changes in effects since this?
- Have you started any new techniques to manage the effects?
- Has the organisation changed anything since I last saw you?

2 - Pose any participant specific follow up questions

- Do you think your case load makes a difference on how you are affected?

3 – Feedback on Sandboxing

- How did you find using the sandbox?
- Did it help with talking about difficult topics?
- Was there anything you would change if you could about the process?
- If they didn't use sandboxing – why did you opt for the standard interview instead of the sandboxing?

4 – Covid questions (if this wasn't raised in the initial interview)

- Do you think the covid pandemic had any impact on how the job affects you?
- Did you work from home at any point? How did you find that?

5 – Present initial findings

- Do you agree with these?
- Are there any which you don't agree with?
- Are there any which you agree with, but you hadn't thought of before?

6 – Present Ideas for Training and Outputs

- Pre-recorded webinar (roughly 1 hour long) on VT and VR –
  - what they are,
  - what you can expect/look out for,
  - what can help (all of which are informed from these findings)
- This can be watched by new starters as part of induction, or whenever staff need a refresher
- The webinar will be given to all organisations which have taken part
- Organisations will also receive a summary document on findings and recommendations which can be implemented, or which can be provided to funders for staff wellbeing costs

7 – Present options for personal pseudonyms for them to choose if they haven't already

Appendix 4 Ethical Approval

Rhiannon Maniatt

From:	SOCSI - Ethics Office
Sent:	08 November 2022 11:03
To:	Rhiannon Maniatt
Subject:	Your ethics application for Managing Vicarious Trauma and Vicarious Resilience: Comparisons between Survivor Professionals and Non-Survivor Professionals in a Domestic Abuse Context has been given a FAVOURABLE OPINION

Dear Rhiannon Maniatt,

Research project title: Managing Vicarious Trauma and Vicarious Resilience: Comparisons between Survivor Professionals and Non-Survivor Professionals in a Domestic Abuse Context
SREC reference: 66
Link to applications.

The School of Social Science Research Ethics Committee reviewed the above application on the .

Ethical Opinion

The Committee gave a favourable ethical opinion on the basis described in the application form, protocol and supporting documentation.

Supporting Documents Received

Document Title, Date and Version Number

Rhiannon Maniatt Manager Consent Form.docx
Rhiannon Maniatt Manager Participant Information Sheet.docx
Rhiannon Maniatt Post Interview Resources.docx
Rhiannon Maniatt Recruitment Information.docx
RManiatt Data Collection Forms.docx
Stage 2 Interview Questions.docx

Please be advised that you will need to upload final versions of all research tools prior to you commencing your data collection. **When uploading files please ensure they are clearly marked by Name, Date and Version Number.**

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Information to note

1

Appendix 5 Participant Information Sheet

DOMESTIC ABUSE ADVOCATE PARTICIPANT INFORMATION SHEET

MANAGING VICARIOUS TRAUMA AND VICARIOUS RESILIENCE

You are being invited to take part in a research project. Before you decide whether or not to take part, it is important for you to understand why the research is being undertaken and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish.

Thank you for reading this.

1. What is the purpose of this research project?

After working in the Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) sector in Wales for several years, I (Rhiannon Maniatt) acknowledged the variations in experiences of vicarious trauma in domestic abuse workers. My work in this section led me to design this project for my doctoral research.

This project aims to explore the effects of support work on Domestic Abuse Advocates (DAA), and what techniques (both personal and organisational) can affect these. It will also explore whether there are differences in experiences of vicarious effects depending on whether the DAA has experienced abuse themselves, and whether they use different techniques to manage these effects. However, participants do not need to share this information to take part and they can indicate 'rather not say' as an option on the recruitment form if this is preferable.

2. Why have I been invited to take part?

You have been invited to take part because you fit my definition of a Domestic Abuse Advocate – namely that you work in a Domestic Abuse Service (DAS) in Wales, with your day-to-day work being to directly support adult domestic abuse survivors (this could be in refuge, drop-in, or outreach services).

You could also be a receptionist in a DAS, where you have constant contact with survivors via telephone or in person.

3. Do I have to take part?

No, your participation in this research project is entirely voluntary and it is up to you to decide whether or not to take part. If you decide to take part, I will discuss the research project with you and ask you to sign a consent form. If you decide not to take part, you do not have to explain your reasons and it will not affect your legal rights.

You are free to withdraw your consent to participate in the research project at any time, without giving a reason, even after signing the consent form. If you take part and then decide you would like to withdraw your data from the project, this can be done before 31st March 2023, after which, analysis on data will have begun.

4. What will taking part involve?

There are two participation stages to this project – an interview involving optional creative activities first, then 6-9 months later a follow up interview.

Initially, in Spring/Summer 2022, you will be participating in an interview which will ask you about how Domestic Abuse Advocacy work affects you, and how you cope with any effects of the job. This interview will ideally include using creative methods to give you control of the session and act as a discussion point.

At the beginning of the interview, you will be given a pre-interview demographic form to complete, which will gather data on certain factors which may influence how you are affected by Domestic Abuse Advocacy work.

Before the interview, you will be given the choice of which creative method you would like to use, or whether you would just like to take part in a standard interview. The options for the creative interview include sandboxing (creating a scene in sand to answer a question), painting or drawing, and object elicitation (bringing an object which represents your answers to a question). You will then either make the creation at the beginning of the interview or bring your picture or objects with you. Each of these creations or items would then be discussed, followed by other questions in a more standard interview format.

The questions in the interview will be regarding the effects on you from providing domestic abuse support, including vicarious trauma and vicarious resilience, and what techniques and strategies you use to help with these.

This research will also explore any differences in vicarious trauma, vicarious resilience and techniques across professionals accounts when the interview transcripts are analysed. Some professionals will have lived experience of domestic abuse, and some professionals will not have lived experience of domestic abuse. **You will not be asked any details about any abuse that you experienced.** This project is only interested in the effects of being a professional in this field for all participants and in the interviews the central questions will be the same for all participants. You can still take part in this project if you would prefer not to share this information so there is not a requirement to share any information about whether or not you have any personal experience of domestic abuse. The pre-interview demographic form will provide an opportunity for you to decide on what you would like to share and there is an option of 'prefer not to say'.

Creative methods have been positioned as empowering for participants in previous studies. Creative approaches fit with my feminist framework, and putting the participant in control of data production can assist in discussions, so these are preferred for the project; however, if you are not happy with using one of these methods, a standard interview can be arranged.

Interviews will ideally take place in person in a DAS or in a private office space at Cardiff University, in relation to your preferences. However, due to the Covid-19 pandemic, it is possible that Cardiff University could bar in person interviews, or Welsh Government may impose social distancing or lockdown restrictions. There may also be instances where you may be shielding or self-isolating following contraction or contact with Covid-19 cases (depending on Welsh Government guidance at the time). In these instances, interviews can be moved online and held on either Zoom or Microsoft Teams.

Initial interviews will be scheduled for one hour but there will be an option to extend this time frame if you would like to continue for longer. The interviews will be audio recorded for transcription purposes, and any recordings will be kept securely on the University system. Digital photographs of any creative aspects will be taken, which will not include any identifiable images of you. Each transcript will be anonymised and linked to you and any photographs with a participant code, with only myself having the key.

6 months after the initial interview (9 months at the latest) I will return for another interview with you, where we will discuss whether you have any additional information to add to the topics already discussed. I will also bring initial findings and themes from the first stage of interviews to this session for your feedback, and you will have the chance to feed into a training design which will follow this project. This will be a standard interview, unless you decide otherwise and would like to repeat your chosen creative method. This interview will be scheduled for one hour but there will be an option to extend this time frame if you would like to continue for longer. The interviews will be audio recorded for transcription and follow the anonymisation process of the initial interview.

5. Will I be paid for taking part?

No. You should understand that any data you give will be as a gift and you will not benefit financially in the future should this research project lead to the development of a new treatment/method/test/assessment.

However, on completion of each stage of data collection, you will receive a voucher as a thank you for participating.

6. What are the possible benefits of taking part?

By taking part in the project, you will have the opportunity and space to reflect on the effects of being a Domestic Abuse Advocate on your life, and also reflect on the ways in which you currently deal with these effects. Your views will also contribute to the development of training materials.

7. What are the possible risks of taking part?

Due to the nature of the discussion surrounding vicarious trauma and effects on your life, the interviews may prove upsetting for participants. However, I will ensure that the interviews are conducted in a supportive way for all participants and all participants will be given contact information for additional support services if these are needed.

8. Will my taking part in this research project be kept confidential?

All information collected from (or about) you during the research project will be kept confidential and any personal information you provide will be managed in accordance with data protection legislation. Please see ‘What will happen to my Personal Data?’ (below) for further information.

In exceptional cases, I may be legally and/or professionally required to over-ride confidentiality and to disclose information obtained from (or about) you to statutory bodies or relevant agencies. For example, this might arise where I have reason to believe that there is a risk to your safety, or the safety of others. Where appropriate, I will aim to notify you of the need to break confidentiality (but this may not be appropriate in all cases).

9. What will happen to my Personal Data?

For this project, I will be collecting the contact details of all participants who agree to take part – this will be your name, role, organisation and contact email and/or contact telephone number. This is so that I can contact you to discuss the project and arrange different stages of data production. This information will be stored on a password protected spreadsheet on my Onedrive account for safety. A code will be assigned to each participant in this spreadsheet, and this will be used on interview transcripts and creative photographs to link them in place of your name.

A consent form will also be completed by you prior to the first stage of data collection which will include your name– hard copies of these will be destroyed after they have been scanned and they will be stored on my University Onedrive.

Cardiff University is the Data Controller and is committed to respecting and protecting your personal data in accordance with your expectations and Data Protection legislation. Further information about Data Protection, including:

- your rights
- the legal basis under which Cardiff University processes your personal data for research
- Cardiff University's Data Protection Policy
- how to contact the Cardiff University Data Protection Officer
- how to contact the Information Commissioner's Office

may be found at https://www.cardiff.ac.uk/public-information/policies-and-procedures/data-protection or can be made available to you on request.

Your consent form, audio/online recordings and contact details will be retained for a minimum of 5 years after the end of the project or after publication of any findings based upon the data (whichever is later) and may be accessed by me and, where necessary, by members of the University's governance and audit teams or by regulatory authorities. Anonymised information will be kept for a minimum of 5 years after the end of the project or after publication of any findings based upon the data (whichever is later) but may be published in support of the research project and/or retained indefinitely, where it is likely to have continuing value for research purposes.

You can withdraw your participation and your data up until 31st March 2023, after which, analysis will have begun. If you do withdraw your data before this date, all information, including your contact details, consent form, demographics, transcripts, and photographs of creations will be destroyed.

10. What happens to the data at the end of the research project?

Anonymised information will be kept for a minimum of 5 years after the end of the project or after publication of any findings based upon the data (whichever is later) but anonymised verbatim quotes from interviews, and photographs of creative elements may be published in support of the research project.

11. What will happen to the results of the research project?

The results and findings of this project will be the subject of my PhD thesis. Domestic Abuse Services who facilitate the project will also be provided with a report which can inform organisational practice, training, and to potentially apply for funding (for example, for clinical supervision).

It is my intention to publish the results of this research project in academic journals and present findings at conferences. Participants will not be identified in any report, publication, or presentation. Anonymised verbatim quotes from interviews, and photographs of creative elements may also be included in these reports, publications, or presentations.

12. What if there is a problem?

If you wish to complain, or have grounds for concerns about any aspect of the manner in which you have been approached or treated during the course of this research, please contact my PhD supervisors, Dr Rachel Swann (swannre@cardiff.ac.uk) or Dr Dawn Mannay (mannaydi@cardiff.ac.uk). If your complaint is not managed to your satisfaction, please contact the school manager, Louise Jones, via email jonesl76@cardiff.ac.uk or phone 029208 74530.

If you are harmed by taking part in this research project, there are no special compensation arrangements. If you are harmed due to someone's negligence, you may have grounds for legal action, but you may have to pay for it.

13. Who is organising and funding this research project?

The research is organised by me, Rhiannon Maniatt, in Cardiff University, supervised by Dr Rachel Swann and Dr Dawn Mannay in Cardiff University School of Social Sciences. The research is currently funded by Economic Social Research Council (ESRC).

14. Who has reviewed this research project?

This research project has been reviewed and given a favourable opinion by the Social Sciences School Research Ethics Committee.

15. Further information and contact details

Should you have any questions relating to this research project, you may contact me during normal working hours:

Name - Rhiannon Maniatt
Email - ManiattRC@Cardiff.ac.uk
Phone – 07494 853854

Thank you for considering to take part in this research project. If you decide to participate, you will be given a copy of the Participant Information Sheet and a signed consent form to keep for your records.

Appendix 6 Participant Consent Form

Participant ID no:

DOMESTIC ABUSE ADVOCATE PARTICIPANT CONSENT FORM

Title of research project: Managing Vicarious Trauma and Vicarious Resilience

SREC reference and committee: 66 - Cardiff University Social Sciences School Research Ethics Committee (SREC)

Name of Chief/Principal Investigator: Rhiannon Maniatt

	Please initial box
I confirm that I have read the Domestic Abuse Advocate Participant Information Sheet dated March 2022 version 1for the above research project.	
I confirm that I have understood the Domestic Abuse Advocate Participant Information Sheet dated March 2022 version 2 for the above research project and that I have had the opportunity to ask questions and that these have been answered satisfactorily.	
I understand that my participation is voluntary and I am free to withdraw at any time without giving a reason and without any adverse consequences (e.g. to medical care or legal rights, if relevant). I understand that if I withdraw past the date in the Domestic Abuse Advocate Participant Information Sheet, information about me that has already been obtained may be kept by Cardiff University.	
I understand that data collected during the research project may be looked at by individuals from Cardiff University or from regulatory authorities, where it is relevant to my taking part in the research project. I give permission for these individuals to have access to my data.	
I consent to the processing of my personal information including my name, job role, organisation and contact details, for the purposes explained to me. I understand that such information will be held in accordance with all applicable data protection legislation and in strict confidence, unless disclosure is required by law or professional obligation.	
I understand who will have access to personal information provided, how the data will be stored and what will happen to the data at the end of the research project.	
I consent to being audio recorded and having my creations photographed for the purposes of the research project and I understand how it will be used in the research.	

Participant ID no:

I understand that anonymised excerpts and/or verbatim quotes from my interview and pictures of my creations may be used as part of research publications.	
I understand how the findings and results of the research project will be written up and published.	
I agree to take part in this research project.	

Name of participant (print)	Date	Signature

Name of person taking consent (print)	Date	Signature

Role of person taking consent (print)

THANK YOU FOR PARTICIPATING IN OUR RESEARCH

YOU WILL BE GIVEN A COPY OF THIS CONSENT FORM TO KEEP

Appendix 7 Post Interview Resources

Thank you for taking part in this interview!

Your input is greatly valued, and you will receive a £10 gift voucher as a token of gratitude for this interview. I will be back in touch in a few months to arrange your follow up session.

If you have any questions about the project, please contact me on –

ManiattRC@Cardiff.ac.uk / 07494 853854

Post Interview Resources

Talking about vicarious trauma and resilience may have triggered some negative feelings. If you need any support, please contact any of the organisations below for free assistance.

Helplines

Live Fear Free Helpline (24/7) – 0808 80 10 800 / www.gov.wales/live-fear-free

Mind Cymru – 0300 123 3393 (Mon-Fri 9am-6pm) / www.mind.org.uk

Samaritans Cymru (24/7) – 116 123 / jo@samaritans.org

Vicarious Trauma Self Help Resources

Below are some web addresses where you can find resources for coping with vicarious trauma.

Visible - Vicarious (Secondary) Trauma and Self-care Resource -
https://visibleproject.org.uk/wp-content/uploads/2019/05/Visible-vicarious-trauma-web.pdf

British Medical Association – Vicarious Trauma Signs and Strategies for Coping -
https://www.bma.org.uk/advice-and-support/your-wellbeing/vicarious-trauma/vicarious-trauma-signs-and-strategies-for-coping

Appendix 8 Call for Participants

Appendix 9 Initial Findings

Vicarious Trauma Related Initial Findings

Responsibility

- feeling overwhelmed, overly responsible, surrounded by the job, survivors have high expectations.

Relationships

1. **Isolation** – a lonely experience. Often can't confide in family due to confidentiality. Even if they could, family wouldn't understand.
2. **Relationships with family affected** – with kids 'not as present as I could be'. If family need general support 'I don't have anything else to give' and 'she needed her mum, not a support worker'. Some more lenient with their children if they have an upsetting child case. Some more worried and overprotective of their children and grandchildren, with some restricting behaviours. Struggle to see friends/family if they are with a perpy partner you've warned against.
3. **Intimacy/Relationship with Partner** – One argues about equality issues e.g. childcare and housework a lot, 'can't be a hypocrite'. One has no sex after bad cases as they don't want to think of perp and associate them with their partner. One thinks of the potential for their partner to abuse them as people can change and turn abusive 'do I even know you'.

Trust

1. Some **still trusting**
2. Some **less trusting of men** in particular (especially if only support women?) 'I don't like men after this job', 'anti-men' and one who thinks she will stay single as doesn't want to risk it. One still trusting, but more nervous and alert around males when alone, that they don't feel with females.
3. Some **less trusting of people overall**, 'I think everyone is a perpetrator until they prove different'
4. **Trust issues with some VAWDASV services** – other DAAs lying on referral forms to pass on clients
5. **Trust in police gone** (2nd interview inclusion)
6. **Trust in survivors/clients – one** had a false allegation from a client which led to her being suspended – struggled to trust survivors for a while after it.

Safety

In work a mixed picture -

1. Some feel safe
2. Some have their guard up e.g. if male approaches refuge
3. Some not so safe – perpetrator threat at office with shotgun

4. Out of work - Some cited working in their local area reveals local perpetrators so they feel anxious and less safe knowing who is in their area

Changes in Cognition Since Started Job

1. **More aware and knowledgeable of dangers** – many said they were so naïve before the job. Say its hard 'I liked my little rose-coloured world' but the knowledge and awareness is good (link to VR changes).
2. **More cynical** – 'it's a dark world', 'when surrounded by stories, thought the world was a horrible place'
3. **De-sensitised** – don't realise how bad until new people start job, one was thinking of leaving as didn't want to become de-sensitised and for horrible stories to not affect them. Some discussions of is it becoming desensitised, or is it just that you learn to cope. Either new staff, or long tenured – do you learn to cope/become desensitised or leave?
4. **See DV everywhere** – notice is more around them and in the news. One doesn't see it more, but gets told more by people once she shares her role. Or is it that there is now more news coverage of it, or being in-tuned to the coverage that was always there?
5. 2 feel more **powerless** – been fighting against DA for so long and it hasn't stopped it. One shared how there can't be any people left in her area to be victims after 18 years in the sector, she must have seen them all, but new victims and perpetrators keep becoming known about.

Changes in Behaviour

1. A couple are second guessing if wants to be in the field – **may leave job**.

Risk Assessing

1. **Some risk assess constantly and change their behaviour** due to it e.g. on the route walking home, passed a man too many times so changed route after a bad day. Do DASH RIC without thinking. E.g. if alone will pretend to be on the phone. One has taken a knife to bed when home alone as worried about what will happen.
2. **Some have constantly altered behaviour as could be a risk –** lock car doors when in, which chair to sit at (close to door), look for exits, no headphones when walking, repeatedly locking house doors and windows.
3. **Some risk assess more for their family –** won't take them to certain places, or allow them to do some things.

Changed viewing/leisure preferences

1. Some have changed and **will now not watch heavier shows/read heavier books** etc, 'I don't want to watch it on screen when I've heard about it', 'I used to love that sort of stuff, but can't now', prefer light, 'mind-numbing' shows.
2. Some **avoid heavy shows if they've had a hard day**, or if the programme concerns something from that day
3. Some **still look for heavy shows and prefer** them

Physical Effects

1. Feel **anxious**, 'Sunday night foreboding' especially if not finished all tasks, or if going on leave and worry about clients. One has **panic attacks** around work due to feeling so responsible.
2. Feel **tired** – sleep a lot. One feels safe at home so sleeps.
3. **Loss of appetite** with stress

4. Have **nightmares** – some have them around/after difficult cases and deaths, two now have generalised abuse nightmares e.g. someone getting into the house or chasing them.
5. **Affect/Emotion** – one goes home and cries to dog
6. **Headaches** for many – some attribute them to other ailments/hormones, but say colleagues have them too, so may be linked?

Own Experience

12/13 survivors

- Some **disassociate** from survivor-self - "that was me then, it would never be me now", "not that same person anymore", "know it was you but separate"
- Some **struggle when cases similar** / certain cases - don't like hearing of SV* – one had to pass on a client as she felt like she was talking to herself
  *but due to daughters experience at the time, now its passed
- One had **panic attacks after starting sector**, but not had it since identifying the link to her own experiences (case not the same)
- One found a DV call hard, not because of the case but "something about the way she told me the story that reminded me of me"
- Some find **identifying with cases helps their support**. Able to relate to clients, can remember how scary court is, easier to support
- Many – **being a survivor helps** with empathy, instant understanding, anticipate their actions.

Stories Staying With You

Some say they do: - specific case with a household object, now can't look at the object. Pass the location of a violent rape she supported on and will think of it then. 'Stories sit with me at night'. 2-3 stories stay with me. one thought she had put it to rest, but one case made her upset to mention (24 score on CAADA DASH).

Survivors Staying with Perp

- Some say it upsets them more than they let on.
- One tries not to get attached as 'heart breaking' on return.
- One said such a regular occurrence you harden to it.

Suicide / Self Harm

- Some had to deal with suicide in refuge or after on-call and had difficulties after.

Roles

- Referral working hardest – constant crisis. ICA's / Case referrals hardest – very personal, very quickly.
- Another found refuge being a "constant conveyor belt" of hearing abuse but one said while it's more intense, it's not constant new disclosures
- For community support, get time between visits or calls so can process cases

Organisation

- Pay – 'terrible' – can't afford self-care – lunch breaks worked
- Some said orgs really supportive – don't fear being 'stabbed in the back' – more support for less trauma
- one said no malice in it, but that they don't feel supported, and it would help deal with the job if they were more supported
- Some think support is lip service
- another how negative culture affects them – how job would be easier if you didn't have to watch your back
- some say some staff behaviour 'mimics perpetrators'. One expects people like that everywhere, but it's the nature of the organisation (supposed to be empowering) which makes it worse when you come across someone like that.

VR

Extremely Rewarding

- Women doing well is the best thing ever
- A fulfilling feeling / feel lucky to be part of their recovery / get a 'buzz' from helping people
- Smile when driving home / Making a difference
- Rewarding – especially if survivor says they want to become a support worker.

View of Own Life

- Appreciate own partner more
- Appreciate support network
- Greater sense of own good fortune
- Puts own issues (e.g. diet) into perspective)

View of Past Events

- One feels lucky that she left her abusive ex.
- Job helped understand her own experience
- Job helped identify and understand husbands previous abusive relationship
- Appreciate parents more, made peace with own experiences and forgave mum for staying with abusive dad

Knowledge and Skills

- 'Ignorance is not bliss' / learnt and seen so much – can help in keeping self and family safe and knowing what the world is really like
- 'Its interesting'
- Learning how to support people and people from different backgrounds. More non-judgemental now.

Empowering

- Despite 2 feeling powerless…
- Many feel more powerful, assertive because of the power they have in helping others and making a difference

Hope

- Some say hopeful – 'eternal optimist' / hope for families and society to change / 'gives me hope – even in the most adverse of circumstances, people can overcome dreadful things'
- But one has less hope as never seen a change in DA rates (if anything they've gone up)

Events

- Christmas, Halloween, spending time with kids in refuge, 'I lap it up'

Love of Job/ A Calling

- A calling. It was drawing me in, not consciously.
- 'I do really, really love my job'
- Own experience 'gave me the want for the work'

Good with the bad

- 'see the worst of humanity, but you also see the best of it'
- The job is 'like wading through mud. But pink, glittery, gorgeous smelling mud'
- Think of the job like exercise – its hard when you do it, but get a good feeling after it.

COPING STRATEGIES

Relationships with Colleagues

- All use their teams for support, 'bonded onslaught'
- Emotional support, case support and encouragement
- Support from team is better than organised/formal support
- Make 'friends for life'

Humour with colleagues

- All use 'gallows humour' to cope with the job. E.g. jokes about colleagues black eye
- 'its like a release', 'you have to or it'll be such a miserable existence'
- Feel like you have to justify it, don't want anyone to think you are laughing at others situations/pain
- But one said gallows humour level was nothing like her previous job in detention facility

Relationships with Family and Friends

- Some share with family/friends to offload (within confidentiality) and that helps. Some find that partners can try and fix issues which is annoying.
- Even if they don't share, relaxing, days out, spending time with friends and family help
- Some have loved ones in similar positions so they understand more.

Pets

- Most have pets (mainly dogs) and they use them as support.
- One cries/offloads to her dog
- Some say stroking them or cwtching helps
- Caring for animals distracts from any stresses in the day, and also gives exercise and fresh air

Exercise

- Walking (with dogs), biking, hiking – helps clear their heads
- Cold water swimming for one – she will think of a bad case, then jumps in the water so the cold rips away the thought of the bad case

Nature

- Exercise outside – link to nature
- Many like being in nature – greenness of Wales, being in the peace and quiet, tending gardens

Relaxing

- People do things to relax and unwinding, like films, books, baking, music.
- Is it a distraction or avoidance? Some think maybe just avoiding thinking of work instead of processing it. One said not sure if it's a good thing, but other said its better than not coping

Substances

- Most do not drink. Some don't as they don't like feeling out of control, one had an alcoholic father who 'was a shit', and a couple said they behaved badly drunk and it frightened them. One says she sees how this job may lead to people drinking more if they do drink.
- One will only drink at home, doesn't want to have hindered inhibitions when out.
- One now drinks more than she used to before starting the job, one says she has a couple after a bad day, but its not a problem for either of them.
- One used to take cocaine (during employment time, but not when working), but has stopped
- One still takes MDMA – goes raving every few months. Looks forward to it, and thinks it helps her having a blow out

Time Off and Holidays

- Many look forward to holidays, keep them going
- Travelling 'refreshes you'
- But a couple struggle to use A/L and toil due to staffing levels

Spirituality

- Some find their spirituality helps in doing the job and coping with it.
- One is influenced by past religion, but no longer practicing
- One sees her job as part of her religious service
- But one has completely abandoned her spirituality since starting the job. She used to believe everyone has an angel on their shoulder guiding them, but its 'hard to marry it with abuse'

Separation

- Keeping work and home lives separate helps.
- Some use the journey home to trigger the switch, process and forget about work (car, bus ride, walk)

- While in her previous prison job, one had this with driving over a cattle grid, but didn't think she needs something like that in this role to physically separate. (In second interview, she is now thinking of leaving – started taking work home with her so work was affecting her home life)

Workstation

- Some keep it empty as they prefer no link to home, others personalise their work station and think it helps

Perspective

- Keep in mind that you can't change the world. Maybe wont ever get rid of domestic abuse, but can help one person and help change their world.

Happy Outcomes/Endings

- Some like seeing happy endings, and think it would help cope with the job if they could see more success stories (especially in refuge, where survivors leave with a lot of work left to do)
- Little wins may be better than bigger outcomes, as can wait so long for big outcomes. Also some people never get them, and so should celebrate little wins instead.
- One moved to managerial, don't see as many journeys, but gets to see survivor feedback forms which is uplifting
- But some don't want to look too far – nice seeing them do well, but don't want to claim every good thing, and its not their success, but the survivors.

Clinical Supervision

Most have clinical supervision in some form or other.

- Some find it helpful
- One personally doesn't find it helpful, but her group supervision helps her understand others in her team
- other's don't feel like they get anything from it, either because they don't 'get' the purpose, they feel it takes time out of their work so adds more pressure to them, or …
- find it piecemeal – only have ½ hour to an hour as a group, not enough time to discuss anything
- group supervision isn't great – wouldn't share anything sensitive in front of others, and think others feel the same, so its all very light and airy and not discussing anything upsetting
- One org – need to request clinical supervision – staff feel like if you requested it, you would be looked down on as cant cope with the job
- One thinks she needs a different supervisor, as she isn't from the same background, so spends ages explaining her job. Feel it would be better if supervisor had more knowledge of her role/ the sector
- One has her group change every time, sometimes including managers, so struggles to gel with them to get use from the group sessions
- Online isn't great – would prefer face to face supervisions

VT Training

- Only some have had it, and they thought it helped.
- Others who haven't had it, would like it. – throughout the interviews many worried I would they think were strange or not normal – in second interviews were happy to find out others the same, think it would help people to know what to expect and its not just them.

Appendix 10 Self Care Check In Questions

Take time to think about each of these questions. Write answers down if it helps.

Work –

How busy is work?

How am I managing it?

Do I have enough time for myself at the moment?

Stress -

What's on the stress list (what are the different things I am stressed about)?

Is there something stressful coming up?

Is there anything I can do about it? If no, how can I make myself feel better about it?

How could I make it easier?

What's my self-care plan around that?

Relationships –

How am I feeling about my relationships?

How am I feeling about my relationships with friends/family/colleagues/insert name?

What am I doing to look after myself?

Mindfulness –

How am I feeling?

How do I want to be feeling?

What can I do about it?