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Title page

Learning to heal from those who know!

The ‘lived’ experience of a peer support program for adult survivors of childhood trauma.

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Cover page

Learning to heal from those who know!

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trauma.**

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Abstract

The legacy of complex childhood traumatic distress viewed through a medical model lens is often one of psychopathology and long-term debilitating psychosocial consequences in adult life. There is also concern that those who therapeutically support survivors of childhood trauma may risk vicarious exposure from listening to trauma narratives. Trauma peer-support programs combine both situations in that they provide a unique phenomenon of care where the facilitators who offer therapeutic support, are themselves survivors of childhood trauma. However, trauma peer support programs are poorly researched. This study explored the dual phenomenon of experiencing a peer-support residential trauma program from the perspective of: 1) a client; and 2) a facilitator. It sought both positive and negative subjective interpretations. Participants were former clients and current facilitators of the program. Data were collected through a focus group, and analysed using Interpretative Phenomenological Analysis. One superordinate theme, *Altruistic Growth*, overarched two subordinate themes. The first, *Modelling through respect*, included subthemes of *respect*, and *hope and empowerment*. The second subordinate theme, *Reciprocal model of care*, encapsulated personal challenges such as *facing the mirror*, *old demons*, and *burnout and breaking points*. Conversely, participants mused on these challenges as opportunities for further healing through opportunities for *self-nurturing and gratitude*. Implications for treatment of adult survivors of childhood trauma include the potential for client-centred approaches that promote empowerment, offer role-modelling, inclusive of therapist use of disclosure for healing. For facilitators, the program was seen as offering further personal reflection and a giving forward that was interpreted as *altruistic growth*.

Keywords: interpretative phenomenological analysis; adult survivors; childhood trauma; vicarious traumatisation; residential peer-support program

Introduction

There is an abundance of research highlighting negative consequences in adult life from experiencing childhood trauma (see van der Kolk, McFarlane, & Weisaeth, 2007).

Unfortunately, evidenced-based trauma therapies for adult survivors of childhood trauma are few with several meta-analyses informing the guidelines of professional bodies that there is a lack of evidence to support superiority of any one psychological intervention (Bradley, Green, Russ, Dutra & Westen, 2005; Cohen, Mannarino & Deblinger, 2012; SAMHSA, 2014; APS 2014; NHS Choices, 2013.) Two therapies, trauma focussed Cognitive Behaviour Therapy (tf-CBT), and Eye Movement Desensitization and Reprocessing (EMDR) alone have sufficient research to justify nomination as gold standard treatment for adult PTSD, and psychological distress resulting from traumatic childhood experiences. As a consequence, non-evidence based practice often becomes daily practice in the treatment of trauma. This does not suggest ineffective practice by therapists but is indicative of the lag in evidence-based research for providing a diverse range of therapeutic paradigms.

Interventions as yet to be evidenced-based include residential peer support trauma programs. Importantly, by the very nature of peer-support programs, the facilitators, or trauma workers within the program, are former participants of the program having personally experienced childhood trauma. As such, they bring their own trauma history to the role while supporting others' trauma narratives in the course of their work.

Whether this dual phenomenon impacts positively or negatively on trauma peer support facilitators is unknown. While negative psychological effects have been highlighted in trauma therapists (Choi, 2011), positive outcomes as a result of vicarious exposure have also been recognised (Linley & Joseph, 2007; McCormack & Adams, 2015). Therefore, this phenomenological study sought to explore the positive and negative aspects of a previously unresearched residential peer-support program for adult survivors of childhood trauma. It sought the perspective of facilitators who had previously participated in the program as clients.

Traumatised and maltreated children are at risk of developing an array of physical and psychological problems in adult life that persist throughout their lifetime (Bisson & Andrew, 2007; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). While several forms of childhood trauma exist (e.g., nonabusive trauma such as invasive medical procedures; critical incident trauma such as exposure to natural disasters), the bulk of research has focused on instances where children were victimised by adults (e.g., physical abuse, sexual abuse, psychological abuse, emotional abuse, neglect), henceforth termed ‘abusive childhood trauma’.

Treatment for adult survivors of abusive childhood trauma has been variable, with a range of modalities investigated in independent studies (e.g., CBT; patient-centred therapy; emotion-focused therapy for adult survivors; prolonged exposure; EMDR; dialectical behaviour therapy). Overall, when the distress of traumatic events in childhood continues to impact psychological wellbeing in adult life (e.g. post-traumatic distress, depression, or anxiety), improvement has occurred regardless of treatment modality (Kimbrough, Magyari, Langenberg, Chesney, & Berman, 2010; Steil, Dyer, Priebe, Kleindienst, & Bohus, 2011; Wright, Woo, Muller, Fernandes, & Kraftcheck, 2003). Crucially, despite minimal to no differences having been found across treatment modalities (Ironson, Freund, Strauss, & Williams, 2002; McDonagh et al., 2005) treatment rather than no treatment was of significant benefit (McDonagh et al., 2005; Paivio & Nieuwenhuis, 2001). Of concern is that associated anger or hostility, quality of life, and need for interdependence were not positively impacted by evidence based therapies for trauma distress when treating adults exposed to abusive childhood trauma (McDonagh et al., 2005; Paivio & Nieuwenhuis, 2001). These findings leave therapist, carer, or trauma workers and their clients with treatment protocols seemingly inadequate and, while treatment appears more helpful than no treatment, details regarding optimal interventions are lacking.

Limited research defining evidence based therapies for the distress of childhood trauma in adult life is complicated by an array of methodological issues. First, sexual and physical

abuses are overrepresented in the childhood trauma literature (Higgins & McCabe, 2001; Mullen et al., 1996). Second, other abusive trauma modes receive little comparative attention even though they are recognised as widespread (Wright, Crawford, & Del Castillo, 2009). Third, the co-occurrence of different types of abusive trauma incidents, despite being common (Briere & Runtz, 1990; Higgins & McCabe, 2001; Wright et al., 2009), are rarely measured, even though co-occurring abuse is associated with greater adjustment problems (Higgins & McCabe, 2001).

Frequently neglected in the literature, abusive trauma experiences rarely occur in a vacuum yet their consequences are reported often without due consideration of other factors including family environment, the attribution of blame, or the presence of perceived betrayal from abuse perpetrated by a figure of trust (Briere & Elliott, 1994; Dong et al., 2004; Feiring, Taska, & Lewis, 2002; Freyd, 1996; Higgins, 2005; Higgins & McCabe, 2001; Wright et al., 2009). Freyd (1996) introduced the concept of betrayal trauma: trauma that is perpetrated by an individual upon whom the child depends and who has significant power within a trusting and close relationship. Freyd (1996) primarily considers such trauma in the context of memory repression positing that this is motivated by the need to retain care from the perpetrator, thus stunting the usual evolutionary betrayal response (i.e., rejection and avoidance of the betrayer). That betrayal trauma might lead to such a powerful mechanism as memory repression for survival highlights the complex aftermath of childhood trauma.

To make sense of betrayal trauma an individual may conceptualise it as an uncontrollable situation promoting learned helplessness, defencelessness, and the world as a dangerous place (Briere & Elliott, 1994; Feiring, Taska, & Lewis, 2002). Further, should the child attribute blame to themselves, this self-judgement may be internalised as 'bad' and shameful (Feiring et al., 2002). Pessimistic attributional styles, feelings of shame at abuse discovery, and the influence of attribution of blame on shame have all been found to be stable predictors of persistent poor adjustment following abusive childhood trauma (Feiring et al.,

2002; Wright et al., 2009). Thus, Wright et al. (2009) note that the mediating role of shame and subjective feelings of being defective (and, relatedly, attributional style) can alert therapists to the need for meaning making interventions that bring understanding to traumatic experiences rather than simply targetting posttraumatic stress symptoms (Lawson, 2009).

Accordingly, Wilson, Becker, & Tinker (1995) observe that posttraumatic stress-targeted treatments tend to have little effect on overall psychological functioning for adult survivors of childhood trauma as the complex presentation of survivors requires comprehensive treatment approaches across a range of psychosocial functioning. As survivors experience a complex presentation of disturbances (Clemans, 2004; Paivio & Nieuwenhuis, 2001) including changes to consciousness, emotional control, self-perception, perception of others, and systems of meaning (Freyd, 1996), cognitive or behavioural treatment approaches are limited (Murphy, 2009). Currently, a void exists both in the literature and therefore in practice concerning treatment options for adult survivors of childhood trauma. By necessity a more global picture across the biopsychosocial spectrum of childhood trauma and their implications for adult mental wellbeing, is needed beyond current cause-and-effect symptom reduction approaches (Putnam, 2003).

Therapists and others exposed to the narratives of adult survivors of childhood trauma can be at risk of personal consequences. Carers have reported reduced compassion or willingness to care, while experiencing existential challenges concerning life, death, and moral issues (Berzof & Kita, 2010). As compassion is essential for discovering one's own vulnerabilities in order to join with a client when making meaning of their suffering, reduced compassion has consequences for the therapeutic alliance (Berzof & Kita, 2010).

Two terms aptly capture this construct, compassion fatigue (previously termed 'secondary traumatic stress'; Figley, 1983, 1995) and vicarious traumatisation (McCann & Pearlman, 1990). Compassion fatigue in carers essentially includes experiencing symptoms that mirror those found in traumatised individuals: re-experiencing the survivor's traumatic

event, avoidance and/or numbing in response to reminders of traumatic events, and hyperarousal (Baird & Jenkins, 2003; Devilly, Wright, & Varker, 2009; Figley, 1995). Conversely, vicarious traumatisation describes the transformation of one's inner experience in response to empathically hearing details about another's trauma, which then permeate one's inner world and relationships (McCann & Pearlman, 1990; Pearlman & Mac Ian, 1995). Thus, being vicariously traumatised is regarded as a more pervasive and chronic experience than compassion fatigue, which is considered a more acute and observable reaction.

Suggested predictors of risk for both reactions in therapists include being less experienced working with trauma, having greater exposure to traumatised individuals, and having one's own personal trauma history (Baird & Jenkins, 2003). The latter is particularly pertinent given the sample explored in this study, as well as the significantly increased tendency for mental health work positions to attract those with trauma histories (Brady, Guy, Poelstra, & Brokaw, 1999; Elliott & Guy, 1993; Follette, Polusny, & Milbeck, 1994; Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995).

Conversely and more recently, positive outcomes from working with trauma have also been investigated, particularly in qualitative research. These accounts have demonstrated that trauma therapists have identified increased sensitivity, empathy, compassion, and tolerance as a result of their work (Arnold, Calhoun, Tedeschi, & Cann, 2005). In addition, this work has been described as increasing one's sense of personal achievement, and therapists have reflected that they enjoy watching their clients grow while feeling honoured to be a part of this process (Schauben & Frazier, 1995). Staff with personal trauma histories consider that their experiences make them more empathic and better able to buffer stigma (Benatar, 2000). Additionally, a therapist's personal history may present a dual opportunity for ongoing psychological growth as they continue to make sense of their own primary exposure to trauma and their vicarious exposure to the trauma narratives of clients (Arnold et al., 2005; Joseph &

Linley, 2005; McCormack & Adams, 2015). These powerful dynamics are as yet not addressed in the empirical literature.

In light of the paucity of treatments for adult survivors of childhood trauma and the emerging literature on posttraumatic growth from primary and vicarious exposure to trauma in therapists (see Joseph, 2012; McCormack & Adams, 2015), this phenomenological interpretative study explored the subjective interpretations of trained peer support facilitators who were previous participants of a novel, residential, peer-support program for adult survivors of childhood trauma. It sought their positive and negative insights of the program and their perceived impact of using trained peers who were former participants. As a poorly researched intervention, peers support facilitators can offer rich insights into their own experience of this dual phenomenon and the dynamics of the program. The program attracts over 350 survivors a year and is run in three location around the world (Heal For Life, 2013), but as yet little research has been conducted into its efficacy.

Method

Participants

Following University Human Research Ethics clearance, participants were recruited through the residential peer-support program for survivors of childhood trauma (Heal for Life/HFL). Subsequent to distribution of the study information, four facilitators consented to participate in a focus group designed to elicit discussion and interpretations of being a peer-support worker on the HFL program. The researchers and potential participants agreed on a time and place for the interview. Three attended. The fourth was unable to attend at the last moment. Each of the participants had worked as facilitators with HFL for a minimum of three years. All facilitators as peer support personnel and thus survivors of childhood trauma had experienced the program personally. As a phenomenological interpretative study, a purposive sampling is key for the analytic approach chosen, whereby homogeneity provides rich, descriptive data of a particular phenomenon.

All data was de-identified, and the pseudonyms Kathryn, Olivia, and Sarah were allocated to the participants who were aged 45, 44, and 43 years old. Respectively they had 6, 5, and 4 years of experience as facilitators following facilitator training. Both Sarah and Olivia had completed university degrees, and Kathryn had completed a non-university tertiary college qualification. Facilitator training comprised: facilitator training (amounting to 50 hours); eight theoretical modules (amounting to 160 hours); and 20 weeks of practical placement (amounting to 100 hours); as well as engaging with ongoing professional development once qualified. Both Kathryn and Olivia rated the usefulness of the facilitator training program at HFL highly (10/10 and 9/10), while Sarah rated it moderate/high but lower than her peers (7/10).

Procedure

The study invitation letter was sent to management requesting that it be distributed amongst current facilitators. It briefly described the study aims including researchers' contact details. Facilitators interested in participating independently contacted the researchers, and were then forwarded more comprehensive information regarding the study outlining what was required of them as participants.

Data collection

On the day prior to the interview, the participants received a demographic questionnaire which included details related to their training and experience as facilitators and the semi-structured interview schedule in line with IPA protocol (Smith, 1996). Consent forms were signed prior to commencing the focus group. The interview lasted approximately 90 minutes drawing to a natural close when sharing of reflections ceased. The interview was audio taped and subsequently transcribed verbatim by the second author.

Analytic strategy

The analytic method, Interpretative Phenomenological Analysis (IPA), was selected due to its appropriateness for collecting interpretations of unique experiences; recognising the participants as experts in providing detailed descriptions of experiencing a particular

phenomenon (Smith, Flowers, & Larkin, 2009). IPA has roots in phenomenology, such that it seeks to collect rich, descriptive and concrete data about how an individual interprets an experience at a particular time (Smith et al., 2009; Smith & Osborn, 2003). Being an idiographic approach, it is concerned with the particular rather than the nomothetic aspects of data, in contrast to quantitative research methods (Smith et al., 2009). Thus, IPA does not seek to verify or negate specific hypotheses, but instead to uncover unique perspectives. It also draws from symbolic interactionism, in considering how individual meanings are constructed within both a personal and a social world (Smith & Osborn, 2003). Thus, an individual's reality is created via the interaction of one's personal reality, and one's personal reality within one's individual social definitions.

IPA is considered a reiterative approach, necessitating the researchers become closely acquainted with the data by reading and rereading transcripts independently. Another important feature of IPA regards the fact that there is conscious effort on the researchers' behalf to remove ('bracket') or at least raise consciousness to biases, prejudices, and presuppositions that may influence data collection and subsequent analysis. IPA posits that priority in interpretation should be given to the 'new' object rather than one's preconceptions (Smith et al., 2009). Thus, each dataset (i.e. interview transcript) is examined in its own right, independent of prior observations and interpretations.

IPA recognises that engaging with important experiences, allows individuals to reflect on the significance and meaning of these experiences. Analysis is thus active throughout the interview seeking to engage with the participants reflections (Smith et al., 2009). A double-hermeneutic is at play in interpretation, that is, a reflexive relationship involving the researcher seeking to make sense of the participant striving to make sense of and understand his/her experience. This allows each participant to individually and reiteratively explore their own meaning making during the interview (Smith et al., 2009). The data sought is rich interpreted

dialogue that is more than story-telling, unearthing instead a subjective exploration of sense-making.

The semi-structured interview provided a rich and nuanced description of this particular ‘lived’ experience. It gleaned both positive and negative interpretations of being a participant of the program and a facilitator of the program. While this schedule was compiled to guide the interview, it was open to modification dependent on participants’ responses and allowed more detailed exploration of interesting narratives that emerged during the focus group (Smith et al., 2009). The interviewer’s presence was understated to allow for a natural exchange of stories, thoughts and feelings between group members. The interview was transcribed verbatim to provide the dataset for the qualitative analysis. The analysis followed the stepped outline described by Smith et al. (2009) and are illustrated in Table 1.

Table 1 about here

Credibility

In order to ensure thematic validity, rigor was addressed throughout the data collection and analysis rather than through a post assessment of worthiness. The researchers independently conducted audits of the transcript. This is recommended practice in order to ascertain authentic thematic representation of the data, along with consciously assessing biases and presuppositions that might need to be bracketed (Smith et al., 2009). In addition, the researchers independently left a detailed ‘audit trail’, consisting of recordings, transcripts, preliminary notes, early interpretations, and maps leading to final decisions of convergent and divergent themes (Smith et al., 2009). These steps assured design quality, including the degree to which the investigators have chosen the most appropriate method and procedures to assure a within-design consistency and analytic competence (Tashakkori & Teddlie, 2009.) Thus, rigor in qualitative research is an adherence to a step by step process that must be transparent. While there are many stories that can emerge from the data, those themes agreed upon by both authors

as being rich and unique subjective interpretations around the phenomenon being investigated are presented in this study.

Results and Analysis

These results reflected a double-hermeneutic interplay between the researchers' and the participants' reflections of their experiences facilitating a residential peer-support program for adult survivors of childhood trauma. The researchers were interested in positive and negative interpretations (see Appendix 1). Although many themes emerged, only those pertinent to the phenomenon and rich in data remained in the final selection of subordinate themes.

The focus group unveiled insights into the program dynamics, the value of a person-centred approach, and the importance of facilitators' own recovery in supporting others' healing. One superordinate theme was identified, *Altruistic Growth*, which overarched two subordinate themes. The first, *Modelling through respect*, drew on the participants' unique insights as facilitators of the underpinnings of the residential peer-support program. It included subthemes of *respect* and *hope and empowerment*. The second subordinate theme, *Reciprocal model of care*, captured the participants' various insights into the use of the residential program in working with trauma. This theme encapsulated subthemes of challenging aspects such as *facing the mirror, old demons* and *burnout and breaking points*. It explored the participants' musings of these challenges as opportunities for further healing through *self-nurturing and gratitude* (see Table 2). These latter themes highlight the participants' sense of their own recovery as influential in supporting others seeking to heal from childhood trauma. Rich data illustrate these themes.

Table 2 about here

Modelling through respect

This subordinate theme represented the participants' interpretation of the residential peer-support program's philosophies and methods of action. It described creating a space made safe

by the use of unquestioned acceptance of the clients. Facilitators conveyed that they continually sought to meet client needs and felt that these efforts facilitated hope.

Respect.

Respect for self and others was central to the participants' interpretations of the program. Unconditional positive regard towards clients was described as primarily setting the boundaries of respect, challenging prior self-conceptions and the determinants of these, and reformulating their experiences by displacing the 'fault'. By doing this, facilitators could foster a sense of authenticity and stability in identity for the new clients:

This program is about reminding all of us that who we are is precious, unique, and valuable. And what we've been told, and what we have been made to believe, is not who we are. So it's not about having to fix myself, or change myself, it's about chipping away the fear-based crap that I was wrapped up in before. (Kathryn)

Their own experiences in learning how to love unconditionally were felt to be a powerful dynamic between them and the new clients. Such expressions of unconditional and consistent love were perceived to evoke risks in the clients to engage in novel and previously unexplored ways of relating:

People can start practicing new ways of being in relationships with others knowing that if they stuff it up, we're still gonna love them! (Olivia)

This was propelled by their recognition of themselves in the journey, "Coz we've... stuffed it up a fucking thousand times!" (Olivia)

They deemed the new clients as experts of their own journeys, and strove to empower clarity of choice by both validating the clients as whole people and respecting them as the best judges of their own needs:

It's not up to me to be telling a guest [*client*] where there're supposed to be at. (Sarah)

I'm not the expert, they are. (Kathryn)

Safety of all was described as paramount, especially when individual needs interrupted the program. Interwoven within that safety, the freedom to choose without reprimand, often non-existent in childhood trauma, was welcomed:

And, that they have the right and the power to choose whether they wanna change it.

And if they don't wanna change it, it's okay coz it's still their choice. If they want to stay in victim, that's okay because that's their choice. (Kathryn)

They held the tenets of individual rights, promoting a safe environment, and remaining non-judgemental and respect as core to their interpretation of the program:

It's the first time that they realise that they've got rights (laughs a little) ... it's like

"It's okay for you to say 'no'. It's okay for you to say 'yes'. And it's safe for you to do that." (Olivia)

Role-modelling self-respect was interpreted as essential to the program. A willingness to be that role-model and to expect nothing more from clients than what one is willing to do for oneself was required. This single standard was interpreted to lead to better identification with the facilitators, paving the way to hope:

This program is different because we lead by example... We cannot ask people to do something if we are not prepared to do it ourselves. (Sarah)

Hope and empowerment.

Seen as a powerful tool for fostering a sense of control over one's own life, hope triggered formative opportunities for clients:

I kind of take the view that... they're like baby birds learning to fly... They...

empower themselves to, to ask for help... make differences and changes... they get this taste and they run with it. (Sarah)

They spoke passionately of providing an opportunity for clients to practice safe, assertive relationships in which their needs could and would be met. This self-empowerment was

witnessed through new clients reformulating their trauma and conceptualising that they could become survivors, a realisation that transformed their understanding of their future trajectories:

People move from that feeling of being a victim to feeling that they, they've survived.

(Olivia)

Reciprocal model of care

This theme captured the unique dynamic of the program, where 'survivor status' was highly influential to work as facilitators, though it concurrently carried challenges of vicarious exposure. This model of care was interpreted to simultaneously propagate clients' healing opportunities while providing ongoing professional and personal growth for facilitators via practiced reflection.

Facing the mirror.

Powerful journeys towards growth inspired the desire to similarly help others as they were helped. 'Survivor statuses' were both inseparable, and indeed, necessary to their roles as healers, as illustrated by Kathryn's simple statement: "*It IS our role here*". The program presented a complex dynamic where everyone is a survivor and exposure is constant:

You can't take it away, it's like, in this job, we can't eliminate that part of ourselves, coz it is who we are. And we're bringing that... Who we are IS the role. It, there's no separation. (Olivia)

However, far from an incessant, gruelling process, the journey of revisiting one's own trauma and associated beliefs was a powerful reminder that confronting self is a potent mechanism of healing itself: "The tunnel is the light" (Kathryn).

Learning and facilitating were seen to promote growth while triggering one's own trauma experiences; these two processes were interpreted as interdependent. Healing could be transferred to clients as an opportunity for ongoing development:

For me, the positive and negative aspect of the program are the same thing... You get to deal with your own shit... Coz, it's like "I wanna do it" but I can't hide from it if I wanna do it (laughs). (Kathryn)

Due to this dynamic - an ardent drive to help others - engaging with a conscious willingness to continue to heal, and thus be triggered indefinitely, was necessary:

And it's constantly, mirrors in our face. Constant. And if you don't want to look at yourself anymore, and heal, you're kind of ... not the right place to do it (laughs). Part of being here is a willingness to keep growing. (Olivia)

Old demons.

Within their discussions, a subtheme that emerged was the tendency for negative messages to reappear, particularly when the load of responsibility was high and tolerance and strength were low, challenging self-worth:

You've got your own stuff coming up and, umm (pause) making that time and, umm, commitment to yourself when that's never been a priority previously... and I do, even now struggle with the fact that I do matter, because I didn't matter before. (Sarah)

Self-care and compassion needs during burnout were particularly powerful catalysts for old messages, which triggered vehement internal arguments against one's need to prioritise self, often promoting feelings of shame:

But as survivors, I too bring all those messages of 'you're not good enough', 'try harder', 'don't be lazy' ... I didn't want to be seen as the weak one, the one who wasn't coping. (Olivia)

Need for approval was particularly difficult to stifle:

Even today, I'm still working on severing the attachment to approval... it's like an umbilical cord, it's hard to freaking sever it, but I want to. (Kathryn)

Burnout and breaking points.

Burnout was a real concern to these participants. Using rich imagery Sarah illustrated the concept of being bogged in a “*mudpool*” where efforts to pull herself out of the mud (i.e., combat the burnout) led to further bogging:

Coz it just seems to stir up so much stuff, it's like there's a massive well, and yet through the water and at the bottom is just, a massive, massive, massive umm almost never-ending mudpool that just keeps getting stirred up. Umm. And the more I deal with the mudpool, I guess trying to sift through the mud and get rid of the sediment so that there's more water, the further down in the mud I seem to get bogged. (Sarah)

The survivor instinct to keep fighting and keep pushing through even when internal stores are depleted was conveyed as counterproductive in this context:

I couldn't actually walk (laughs) ... I felt like a car that had no petrol. But I'd get in the car every day, and I'd crank the key, I'd push the accelerator and nothing would happen. (Olivia)

Breaking, or personally reaching their limit, was depicted as the worse possible outcome. It was at odds with the survivor instinct, so central to their identities. A traumatic experience in its own right, it challenged prior beliefs about the self:

But it was burnout... my biggest fear after that was, I never knew I had a breaking point... With all the things that were done to me, I never broke. I thought. (Kathryn)

Self-nurturing and gratitude.

Despite this devastation, burnout paved the way for growth by clarifying the importance of permitting self-nurture. Triumph against this often resistant concept was established by focusing on the importance of appropriately role-modelling for clients:

Part of the learning process of actually stopping, and not repeating old patterns of just, sucking it up, and, and keeping on going, umm... and losing the negative messages... and showing not only to myself but others that it is okay to actually... allow myself to have the time that I need to heal (Sarah)

Kathryn was grateful to be able to start afresh and know her limits better.

Looking back, that I wouldn't have made a change unless I was completely annihilated. And for me, one of the most helpful and, empowering things about here is that ever since I first came here, I've been gently stretched... I know how not to *[burnout again]*, so I'm not. And I don't care what it takes. (Kathryn)

Discussion

This study provided unique insights into a novel peer-support residential program for adult survivors of childhood trauma. The participants, all peer-support facilitators, had been participants in the program prior to training as facilitators of the residential program for other adult survivors of childhood trauma. A single superordinate theme, *Altruistic Growth*, overarched *Modelling through respect* and *Reciprocal model of care*. These major themes captured the value of peer support for mirroring non-judgemental healing from the distress and psychosocial quagmire experienced by many survivors of childhood trauma well into adult life. Challenging aspects such as *facing the mirror*, *old demons* and *burnout and breaking points* accurately reflect the vulnerability and complexity of adult relationships that often thwarted success, relational stability, and parenting. The participants reflected on their opportunity as facilitators to revisit their own depth of distress from childhood trauma while reinforcing the importance of *self-nurturing and gratitude* (see Table 2).

The facilitators' own experiences of healing through the program as exemplary for new clients on the program, is seen as central to the program's success, leading to a cyclical pattern of ongoing triggering and positive change. The participants' interpretations of the program were that it dynamically facilitated a different way to live life after childhood trauma through role-modelling, promoted a vision of hope for the clients, and granted the facilitators' opportunities to increase sensitivity around survivor needs, all seen as crucial to client healing. Pivotal in facilitating the very processes they had engaged with in their own healing was the opportunity to engage in another layer of personal growth and learning. While providing the opportunity to support others' on the healing journey they were required to manage their own

reactions when faced with past reflections “*in the mirror*”. In particular, they spoke of the healing power of revisiting old patterns by witnessing others grappling with *demon* messages of un-deservedness. Furthermore, this process was a complex display of synergy, with the role of healer modelled to clients as a potential path to further growth.

Considering the extensive range of symptomatology following childhood trauma, the facilitators interpreted these less structured client-centred approaches as helpful for adult survivors. Within the program’s dynamic, themes of respect and unconditional positive regard were both tenets of the program and therefore cultivated as safe ways in which to explore new ways of behaving without fear of reprimand. These perspectives are reminiscent of client-centred therapy approaches, which are traditionally underpinned by six general conditions, of which three core therapist principles arise: unconditional positive regard, congruence, and empathy (Murphy, 2009; Rogers, 1959). Murphy (2009) found that the use of person-centred therapy within an adult male survivor of childhood trauma produced positive outcomes including increased self-worth, increased sense of being respected, ability to engage with employment, and better relationships with friends and family (Murphy, 2009). Given the complexity of childhood trauma healing, therapy that engages these principles would seem important in a residential program to promote the client’s use of inner resources, underpinned by a theory that assumes an accepting environment and promotes motivation towards growth (Murphy, 2009).

Furthermore, a qualitative study capturing reflections on vehicles of change for adult survivors of abusive childhood trauma found experiencing genuine validation and acceptance to be central themes in their narratives (Woodward & Joseph, 2003). Therefore, treatment approaches typified by such principles when working with adult survivors of abusive childhood trauma have some support, although notably this has been limited to qualitative investigations. The program’s accepting environment was a direct contrast to the invalidating experiences of traumatic abuse and what was stated to be experienced by these participants in their efforts at

help-seeking from the medical model. For example, systemic medical model care was viewed as mirroring the authority and power that had kept them at risk during childhood for these survivors of childhood trauma. The residential nature of this program made room for new ways of relating to be practiced safely and consistently, unregulated by authority and allowing healing to flourish.

The residential peer-support program approach was also felt to lead to promotion of self-empowerment in clients, as the experts of their own journeys. The promotion of empowerment and safety has been previously recognised as central to the approaches used in rape-crisis centres (Ullman & Townsend, 2008). Experiences of childhood trauma often strip away subjective sense of control and power over one's own life. Therefore, fostering self-empowerment as an option and accepting what it yields may function to reinstate this violated entitlement. The realisation that such a profound and protracted belief can be reversed was seen to pave the way towards hope for a brighter future. Implicit in this, the explicit nature of facilitators' "*survivor statuses*" allowed for closer and more credible identification for clients, and thus more potent opportunity for role-modelling.

Role-modelling is facilitated through imitative learning, where behaviour has been found to be adopted not when the learner likes it or even approves of it, but when it is witnessed to lead to success (Bandura, Ross, & Ross, 1963). Clients in the residential peer-support program are likely to have viewed facilitators as success stories, which promoted the idea of modelling. Furthermore, observation of successful facilitators demonstrating resilience may have allowed for optimal transfer to clients. Vicarious resilience, a term originally used to describe increases in therapist coping abilities in response to working with traumatised individuals displaying extraordinary amounts of resilience (Hernandez, Gangsei, & Engstrom, 2007), may have been a prominent feature in the peer-support program.

The experience of having been supported in a manner that was helpful and not dismissive within the peer-support program led ex-clients towards the path of facilitating others' healing.

This drive was felt to be motivated by altruism, where the ex-clients were acutely aware of their ability to provide the best care for other survivors despite the fact that this experience meant continuously facing themselves and their own lurking *demons* when working with clients. It is not uncommon for those who have come through challenging experiences to desire to share such knowledge with other sufferers: the most familiar example of this within mental health is Alcoholics Anonymous. Supporting the aforementioned proposed mechanisms of action, both role-modelling and experientially-based advice have been considered important factors towards the generally high success rate for Alcoholics Anonymous programs (Kaskutas, Bond, & Humphreys, 2002). Similarly, the studied program was underpinned by principles found to be most helpful to adult survivors of childhood trauma.

Previous research has readily investigated a variety of consequences of trauma for trauma workers, unveiling effects such as compassion fatigue and vicarious traumatisation, amongst others. The current qualitative study found more detailed references to burnout over the latter reactions. However, it is difficult to tease out these perceptions given the unique situation that these participants were experiencing. Participants made reference to an inevitable and ongoing process of triggering and retriggering of trauma and old messages simultaneous with ongoing reflection and posttraumatic growth experiences. Therefore, while no participants described feeling traumatised by clients' trauma, or feeling that their worldviews had changed as a result of others' trauma, their assertion that their own trauma was omnipresent in their professional identities makes the simple term 'burnout' difficult to ascribe without leaving them feeling inadequate. In fact, recognising the risk that their own trauma history could be triggered conversely allowed participants the opportunity for further growth, taking purpose and meaning to another level.

Only a minority of authors have avoided the focus on negative outcomes for trauma workers, unearthing positive outcomes amongst the so-called negative ones. However, this study detected a close association between traditionally positive and negative outcomes,

finding them to feed off each other in a balanced, symbiotic relationship supportive of theories of growth that recognise the curvilinear relationship between trauma and growth (see Joseph, 2012).

Limitations

As a qualitative study, this research did not seek to explain the phenomenon studied nor provide a generalised summary of this experience. Many of the common perceived pitfalls within quantitative standards are not seen as problematic for this study; conversely, these violations enhance the current qualitative study. Within qualitative research, and specifically, focus groups, one limitation was the relatively small sample size. The aim of this study was to observe the interaction between the various perspectives. Although it revealed rich data, it was limited by the numbers. Furthermore, the relationships between the participants may have affected the subsequent flow of discussion: while not predetermined, two of the participants appeared to have a close relationship, potentially stifling opportunities for disagreement. As a qualitative study, concerned with subjective interpretation of this particular program, it was limited in comparing types of programs, particularly residential program versus outpatient program. Future quantitative studies could include this variable.

Conclusions and Recommendations

The present phenomenological investigation provided previously uncharted insights into a residential peer-support program for adult survivors of childhood trauma, on the background of a notable paucity of adequate treatment options available. It explored both positive and negative aspects of the program from the facilitators' perspective. Future research could investigate the clients' perspective of the residential peer-support program. Primarily, the study uncovered a felt import to the dynamic of own 'survivor status' by these facilitators when contributing to the opportunity for healing in other survivors: this was interpreted to underpin the program, and to be necessary for the healing of others. The omnipresence of this status

against the clear suffering of others led to a pattern of ongoing development in *Altruistic Growth*.

The possibility of trauma intervention therapy being used not only for symptom reduction but also for psychological growth is a new concept and is not the remit of current evidenced based therapies (CBT & EMDR). Similarly, the dual phenomenon of being both prior client and current facilitator has novel implications for working with trauma clients. This research challenges the traditional medical model approach that focuses on symptom reduction in the care of adult survivors of childhood trauma. Rather it supports a less structured person centred approach where a focus on healing, respect and non-judgement is mirrored by those who know. Importantly it suggests that psychological growth is possible for both participants and facilitators through this peer-support trauma program. By offering the opportunity to reduce symptoms and promote psychological growth for both participant and facilitator, this peer support program is worthy of further research attention.

References

- APS (2014). Understanding and managing psychological trauma. *Aps*. Retrieved June 2014, from https://www.psychology.org.au/publications/tip_sheets/trauma/#s6
- Arnold, D., Calhoun, L. G., Tedeschi, R., & Cann, A. (2005). Vicarious posttraumatic growth in psychotherapy. *Journal of Humanistic Psychology, 45*, 239-263. doi: 10.1177/0022167805274729
- Baird, S., & Jenkins, S. R. (2003). Vicarious traumatization, secondary traumatic stress, and burnout in sexual assault and domestic violence agency staff. *Violence & Victims, 18*, 71-86. doi: 10.1891/vivi.2003.18.1.71
- Bandura, A., Ross, D., & Ross, S. A. (1963). Vicarious Reinforcement and Imitative Learning. *Journal of Abnormal Psychology, 67*, 601-607. doi: 10.1037/h0045550
- Benatar, M. (2000). A qualitative study of the effect of a history of childhood sexual abuse on therapists who treat survivors of sexual abuse. *Journal of Trauma and Dissociation, 1*, 9-28. doi: 10.1300/J229v01n03_02
- Berzof, J., & Kita, E. (2010). Compassion fatigue and countertransference: Two different concepts. *Clinical Social Work Journal, 38*, 341-349. doi: 10.1007/s10615-010-0271-8
- Bisson, J., & Andrew, M. (2007). Psychological treatment of post-traumatic stress disorder (PTSD). *Cochrane Database Syst Rev*CD003388. doi: 10.1002/14651858.CD003388.pub3
- Brady, J. L., Guy, J. D., Poelstra, P. L., & Brokaw, B. F. (1999). Vicarious traumatization, spirituality, and the treatment of sexual abuse survivors: A national survey of women psychotherapists. *Professional Psychology: Research and Practice, 30*, 389-393. doi: 10.1037/0735-7028.30.4.386
- Bradley, R., Greene, J., Russ, E., Dutra, L., & Westen, D. (2005). A multidimensional meta-analysis of psychotherapy for PTSD. *American Journal of Psychiatry, 162*(2), 214-227. doi:10.1176/appi.ajp.162.2.214

Briere, J. N., & Elliott, D. M. (1994). Immediate and long-term impacts of child sexual abuse.

The Future of Children, 4, 54-69. doi: 10.2307/1602523

Briere, J., & Runtz, M. (1990). Differential adult symptomatology associated with three types

of child abuse histories. *Child Abuse & Neglect*, 14, 357-364. doi: 10.1016/0145-

2134(90)90007-G

Choi, G. (2011). Secondary traumatic stress of service providers who practice with survivors of

family or sexual violence: A national survey of social workers. *Smith College Studies in*

Social Work, 81, 101-119. doi: 10.1080/00377317.2011.543044

Clemans, S. E. (2004). Life changing: The experience of rape-crisis work. *Affilia*, 19, 146-149.

doi: 10.1177/0886109903262758

Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2012). *Trauma-Focused CBT for Children*

and Adolescents: Treatment Applications - Google Books. New York: Guilford Press.

Devilly, G. J., Wright, R., & Varker, T. (2009). Vicarious trauma, secondary traumatic stress or

simply burnout? Effect of trauma therapy on mental health professionals. *Australian &*

New Zealand Journal of Psychiatry, 43, 373-385. doi: 10.1080/00048670902721079

Dong, M., Anda, R. F., Felitti, V. J., Dube, S. R., Williamson, D. F., Thompson, T. J., . . .

Giles, W. H. (2004). The interrelatedness of multiple forms of childhood abuse, neglect,

and household dysfunction. *Child Abuse & Neglect*, 28, 771-784. doi:

10.1016/j.chiabu.2004.01.008

Elliott, D. M., & Guy, J. D. (1993). Mental health professionals versus non-mental-health

professionals: Childhood trauma and adult functioning. *Professional Psychology:*

Research and Practice, 24, 83-90. doi: 10.1037/0735-7028.24.1.83

Feiring, C., Taska, L., & Lewis, M. (2002). Adjustment following sexual abuse discovery: the

role of shame and attributional style. *Developmental Psychology*, 38, 79-92. doi:

10.1037/0012-1649.38.1.79

- Figley, C. R. (1983). Catastrophes: An overview of family reactions. In C. R. Figley & H. I. McCubbin (Eds.), *Stress and Family: Coping with catastrophe* (Vol. 2, pp. 3-20). New York: Brunner/Mazel.
- Figley, C. R. (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatised*. New York: Routledge.
- Follette, V. M., Polusny, M. M., & Milbeck, K. (1994). Mental health and law enforcement professionals: Trauma history, psychological symptoms, and impact of providing services to child sexual abuse survivors. *Professional Psychology: Research and Practice*, 25, 275-282. doi: 10.1037/0735-7028.25.3.275
- Freyd, J. J. (1996). *Betrayal trauma: The logic of forgetting childhood abuse*. London: Harvard University Press.
- Heal For Life. (2013). Heal For Life Foundation. from <http://www.healforlife.com.au/>
- Hernandez, P., Gangsei, D., & Engstrom, D. (2007). Vicarious resilience: a new concept in work with those who survive trauma. *Family Process*, 46, 229-241. doi: 10.1111/j.1545-5300.2007.00206.x
- Higgins, D. (2005). *Differentiating between child maltreatment experiences*. Paper presented at the Families Matter: 9th Australian Institute of Family Studies Conference, Melbourne.
- Higgins, D., & McCabe, M. P. (2001). Multiple forms of child abuse and neglect: Adult retrospective reports. *Aggression and Violent Behavior*, 6, 547-578. doi: 10.1016/S1359-1789(00)00030-6
- Ironson, G., Freund, B., Strauss, J. L., & Williams, J. (2002). Comparison of two treatments for traumatic stress: a community-based study of EMDR and prolonged exposure. *Journal of Clinical Psychology*, 58, 113-128. doi: 10.1002/jclp.1132
- Joseph, S., & Linley, P. A. (2005). Positive adjustment to threatening events: An organismic valuing theory of growth through adversity. *Review of General Psychology*, 9, 262-280. doi: 10.1037/1089-2680.9.3.262

- Kaskutas, L. A., Bond, J., & Humphreys, K. (2002). Social networks as mediators of the effect of Alcoholics Anonymous. *Addiction*, 97, 891-900. doi: 10.1046/j.1360-0443.2002.00118.x
- Kimbrough, E., Magyari, T., Langenberg, P., Chesney, M., & Berman, B. (2010). Mindfulness intervention for child abuse survivors. *Journal of Clinical Psychology*, 66, 17-33. doi: 10.1002/jclp.20624
- Lawson, D. M. (2009). Understanding and treating children who experience interpersonal maltreatment: Empirical findings. *Journal of Counselling & Development*, 87, 204-215. doi: 10.1002/j.1556-6678.2009.tb00569.x
- Linley, P. A., & Joseph, S. (2007). Therapy work and therapists' positive and negative well-being. *Journal of Social and Clinical Psychology*, 26, 385-403. doi: 10.1521/jscp.2007.26.3.385
- McCann, L., & Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress*, 3, 131-149. doi: 10.1002/jts.2490030110
- McCormack, L. & Adams, E. (2015). Therapists, Complex Trauma, and the Medical Model: Making Meaning of Vicarious Distress from Complex Trauma in the Inpatient Setting. *Traumatology*. <http://psycnet.apa.org/doi/10.1037/trm0000024>
- McDonagh, A., Friedman, M., McHugo, G., Ford, J., Sengupta, A., Mueser, K., . . . Descamps, M. (2005). Randomized trial of cognitive-behavioral therapy for chronic posttraumatic stress disorder in adult female survivors of childhood sexual abuse. *Journal of Consulting & Clinical Psychology*, 73, 515-524. doi: 10.1037/0022-006X.73.3.515
- Murphy, D. (2009). Client-centred therapy for severe childhood abuse: A case study. *Counselling and Psychotherapy Research: Linking research with practice*, 9, 3-10. doi: 10.1080/14733140802655992

NHS Choices. (2013). Post-traumatic stress disorder (PTSD) - NHS Choices. *NHS Choices*.

Department of Health. Retrieved November 2014, from

<http://www.nhs.uk/conditions/Post-traumatic-stress-disorder/Pages/Introduction.aspx>

Paivio, S. C., & Nieuwenhuis, J. A. (2001). Efficacy of emotion focused therapy for adult survivors of child abuse: A preliminary study. *Journal of Traumatic Stress, 14*, 115-133. doi: 10.1023/A:1007891716593

Pearlman, L. A., & Mac Ian, P. S. (1995). Vicarious traumatising: An empirical study of the effects of trauma work on trauma therapists. *Professional Psychology: Research and Practice, 26*, 558-565. doi: 10.1037/0735-7028.26.6.558

Putnam, F. W. (2003). Ten-year research update review: child sexual abuse. *Journal of the American Academy of Child and Adolescent Psychiatry, 42*, 269-278. doi: 10.1097/00004583-200303000-00006

Rogers, C. R. (1959). A theory of therapy, personality, and interpersonal relationships, as developed in the client-centred framework. In S. Koch (Ed.), *Psychology: A study of science. Formulations of the person and the social context* (Vol. 3, pp. 184-256). London: McGraw-Hill Book Company.

SAMHSA (2014). (Substance Abuse and Mental Health Services Administration).

Posttraumatic Stress Disorder. *NREPP (National Registry of Evidence-Based Programs and Practices)*. Retrieved October 2014, from <http://www.nrepp.samhsa.gov/PTSD.aspx>

Schauben, L. J., & Frazier, P. A. (1995). Vicarious trauma: The effects on female counselors of working with sexual violence survivors. *Psychology of Women Quarterly, 19*, 49-64. doi: 10.1111/j.1471-6402.1995.tb00278.x

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, Method, and Research*. London: Sage Publications.

Smith, J. A., & Osborn, M. (2003). Interpretative phenomenological analysis. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to methods*. London: Sage Publications.

- Steil, R., Dyer, A., Priebe, K., Kleindienst, N., & Bohus, M. (2011). Dialectical behavior therapy for posttraumatic stress disorder related to childhood sexual abuse: a pilot study of an intensive residential treatment program. *Journal of Traumatic Stress, 24*, 102-106. doi: 10.1002/jts.20617
- Tashakkori, A., & Teddlie, Ch. (2009). Integrating Qualitative and Quantitative Approaches to Research. In Rog and Bickman (Eds.). *Handbook of Applied Social Research Methods* (2nd Edition). Thousand Oaks, CA: Sage.
- Ullman, S. E., & Townsend, S. M. (2008). What is an empowerment approach to working with sexual assault survivors? *Journal of Community Psychology, 36*, 299-312. doi: 10.1002/jcop.20198
- van der Kolk; B., McFarlane, A., & Weisaeth, L. (2007). *Traumatic Stress: The effects of overwhelming experience of mind, body, and society*. The Guildford Press: New York.
- Wilson, S. A., Becker, L. A., & Tinker, R. H. (1995). Eye movement desensitization and reprocessing (EMDR) treatment for psychologically traumatized individuals. *Journal of Consulting and Clinical Psychology, 63*, 928-937. doi: 10.1037//0022-006X.63.6.928
- Woodward, C., & Joseph, S. (2003). Positive change processes and post-traumatic growth in people who have experienced childhood abuse: understanding vehicles of change. *Psychology and Psychotherapy, 76*, 267-283. doi: 10.1348/147608303322362497
- Wright, D. C., Woo, W. L., Muller, R. T., Fernandes, C. B., & Kraftcheck, E. R. (2003). An investigation of trauma-centered inpatient treatment for adult survivors of abuse. *Child Abuse & Neglect, 27*, 393-406. doi: 10.1016/S0145-2134(03)00026-7
- Wright, M. O., Crawford, E., & Del Castillo, D. (2009). Childhood emotional maltreatment and later psychological distress among college students: the mediating role of maladaptive schemas. *Child Abuse & Neglect, 33*, 59-68. doi: 10.1016/j.chiabu.2008.12.007

Table 1. IPA steps of data analysis (Smith et al., 2009)

<i>Step 1) Listening, reading, and rereading.</i>	
Each step was conducted independently by each researcher prior to collaboratively identifying the emergent themes. First, each listened to the interview recording several times to become fully immersed in this information before transcription. Following this, the recording was transcribed and read several times. At this point, first impressions were recorded.	
<i>Step 2) Initial noting.</i>	
Subsequently, initial notes were recorded on the right-hand margin of the transcript. These included descriptive comments (i.e., focusing on what was said, at face value: highlighting things of importance to the participants); linguistic comments (i.e., focusing on the way things were said, with regards to content and meaning); and conceptual comments (i.e., focusing at a more interrogative and conceptual level, such that the participants' overarching understanding was interpreted).	
<i>Step 3) Developing emergent themes.</i>	
Interaction between description and interpretation was undertaken with the goal of finding emergent themes, such that patterns were drawn from discrete portions of the transcript in order to provide a more concise and cohesive picture of the initial notes. Such themes were recorded on the left-hand margin of the transcript.	
<i>Step 4) Searching for connections across emergent themes.</i>	
Emergent themes were then developed in order to attempt to group related themes. Superordinate themes were identified under which to organise clusters of theme. Divergent and convergent themes emerged. Only those themes that were represented by rich data irrespective of whether they were divergent or convergent, remained in the final selection.	

Table 2. Subordinate themes overarched by superordinate theme: *Altruistic Growth*.

1	Modelling through respect <i>Respect</i> <i>Hope and empowerment</i>
2	Reciprocal Model of Care <i>Facing the mirror</i> <i>Old demons</i> <i>Burnout and breaking points</i> <i>Self-nurturing and gratitude</i>

Transcript extract notation

... Indicates editorial omission of non-relevant material

[] Indicates inclusion from second author to clarify meaning within material

Appendix 1

Semi-structured Interview Guide

Introduction: We are interested in your interpretation of the Heal for Life Program from the position of facilitators of the program. In particular, we are interested in both positive and negative aspects of the program from your perspective: what you feel works/what you feel doesn't work in the program; what positive and negative outcomes there are for both you and the participants of the program; how consistency and validity of the program is maintained across programs; suggestions you may have for changing/improving the program. Finally, what is it about working on this program that impacts either positively or negatively on you.

From the perspective as someone who participated in the program and now facilitates it – with that experience in mind - can you discuss these aspects?

- 1) *In general could you discuss the positive and negative aspects of the program you are involved in?*
- 2) *How would you describe this program as different to other survivor programs?*
- 3) *From your perspective, what works well? (from both points of view)*
- 4) *From your perspective, what works less well? (from both points of view)*
- 5) *In particular, from your experience as a facilitator, how do you perceive benefits **for you** as a facilitator of the program?*
- 6) *In particular, from your experience as a facilitator, how do you perceive benefits **for the participants** of the program?*
- 7) *Could you talk about those situations where a participant has not benefitted from the program? [how do you make sense of this, from your unique experience perspective]*
- 8) *How is validity and consistency maintained across different programs and groups of facilitators?*
(Prompts: how are they designed, evaluated, what evidence based tools are used?)
- 9) *Are you able to talk a little about the effects, both positive and negative on you as facilitators of these programs? (Prompts: Length of time doing this work, self-care tools, breaks, support etc.)*
- 10) *Do you have any suggestions for changing any aspects of the various programs?*