Trauma-Focused Therapists’ Perceptions and Lived Experiences of Evidence-Based Practices (EBPS) when Delivering Sexual Trauma Interventions to Clients

Carlos Eduardo Golhetto

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TRAUMA-FOCUSED THERAPISTS’ PERCEPTIONS AND LIVED EXPERIENCES OF EVIDENCE-BASED PRACTICES (EBPS) WHEN DELIVERING SEXUAL TRAUMA INTERVENTIONS TO CLIENTS

A Dissertation

Submitted to the School of Education

Duquesne University

In partial fulfillment of the requirements for
the degree of Doctor of Philosophy

By
Carlos E. Golfetto, M.S. Ed., NCC, ACS, LPC

August 2017
DUQUESNE UNIVERSITY
SCHOOL OF EDUCATION
Department of Counseling, Psychology and Special Education

Dissertation
Submitted in Partial Fulfillment of the Requirements
For the Degree of Doctor of Philosophy (Ph.D.)

Executive Counselor Education and Supervision Program

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June 6, 2017

TRAUMA-FOCUSED THERAPISTS’ PERCEPTIONS AND LIVED EXPERIENCES OF EVIDENCE-BASED PRACTICES (EBPS) WHEN DELIVERING SEXUAL TRAUMA INTERVENTIONS TO CLIENTS

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ABSTRACT

TRAUMA-FOCUSED THERAPISTS’ PERCEPTIONS AND LIVED EXPERIENCES OF EVIDENCE-BASED PRACTICES (EBPs) WHEN DELIVERING SEXUAL TRAUMA INTERVENTIONS TO CLIENTS

By

Carlos E. Golfitto

May 2017

Dissertation supervised by Dr. Lisa Lopez Levers

The purpose of this study was to explore trauma-focused therapists’ perceptions of and lived experiences with evidence-based practices (EBPs) when delivering sexual trauma interventions to clients. Over the last three decades, new research has shown that the existence of EBPs significantly influences clinicians’ approaches in working with clients. Numerous studies have quantitatively validated EBPs; however, the literature is lacking qualitative studies that explore trauma-focused therapists’ perceptions of and experiences with EBPs, especially when delivering sexual trauma interventions. In order to complement the literature on EBPs and trauma interventions, this research conducted individual semi-structured interviews with 10 trauma-focused therapists who had experience treating survivors of sexual violence. These participants worked in agencies and/or private practices and self-identified as using an evidence-based approach when treating survivors of sexual violence.
This qualitative, phenomenologically-oriented study used van Manen’s life world existentials (lived body, lived space, lived time, and lived relation), Bronfenbrenner’s bi-ecological model (microsystem, mesosystem, exosystem, macrosystem, and chronosystem), and Levers’ ISAT model (clinical relationship, nexus of personal and treatment issues, and broader systemic and cultural influences) to elucidate the data collected. The results of the study identified themes based on trauma-focused therapists’ perceptions of EBPs that are relevant to the development, implementation, dissemination, and sustainability of sexual trauma interventions. Participants expressed positive feelings toward using approaches that have a great deal of research and support. However, they also recommended flexibility for adapting modalities to work with trauma survivors. As EBPs continue to influence clinicians’ decision-making process, this investigation’s findings may contribute to the existing knowledge base with regard to trauma-focused therapists’ perceptions and lived experiences in the trauma field. This study may also contribute to an advanced comprehension of EBPs in treating sexual trauma.
DEDICATION

This dissertation is dedicated to my mother, Creusa Golfetto, and to my father, Antonio Golfetto.

I miss them both every day. Obrigado, Mom and Dad, for your support and unconditional love.
ACKNOWLEDGMENTS

I've learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel. Maya Angelou

What a journey! I have had the privilege of meeting so many wonderful people who have directly and indirectly contributed to the accomplishment of this dream of mine. I would like to take this opportunity to extend my sincere gratitude to my committee chair, Dr. Lisa Levers. Your expertise, support, and guidance helped me remember why I decided to pursue my PhD. I would also like to thank my committee members, Dr. Debra Hyatt-Burkhart and Waganesh Zeleke, for their insights and encouragement along the way. Your kindness and support will always be so greatly appreciated.

I would like to thank my parents back in Brazil. I can feel their love, support, and cheer from afar. It has always helped me in moments that I thought I would not be able to finish it. I also offer my gratitude to my dear brother. My friends have also been fundamental throughout this journey. I would like to highlight two very special people with whom I have had the privilege to share remarkable moments during these past years: thanks, Dr. Mehmet and Dr. Florence. To my co-workers, my deepest gratitude for your continued support and encouragement.

Last but not least: Ryan, you mean so much to me. You have done everything you could to support and encourage me. I appreciate you. I am looking forward to having more time to spend with you so we can have fun without feeling guilt. It is over!
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Chapter I: Introduction

Since the last decade of the 19th century and throughout the 20th century, finding effective psychotherapies has been at the forefront of behavioral health care (Anderson, 2006). In the first decade of the new millennium, researchers in the mental health field pointed out that evidence-based practices (EBPs) were one of the most important professional issues in the scientific and clinical practice world (Addis, Cardemil, Duncan, & Miller, 2006; Anderson, 2006; Gray, Elhai, & Schmidt, 2007; Miller, 2010). Counselors, therapists, social workers, and psychologists have striven to use best practices in helping their clients by using interventions that fall under the umbrella of EBPs. Accordingly, different modalities of therapy have been employed in the trauma field for treating sexual violence related issues. Trauma-focused therapists have provided treatment for victims and survivors of sexual violence using EBPs or empirically supported treatments (ESTs) (Anderson, 2006). These approaches have been developed to treat and define traumatic experiences that result from sexual violence. The literature that has explored treatments for sexual trauma reveals important information regarding trauma-focused treatment outcomes, but it lacks explorations of the perceptions and experiences of trauma-focused therapists who work with victims and survivors of sexual violence.

The trend toward using EBPs has stimulated significant debate within mental health care. Empirical studies in psychological trauma have largely focused on the incidence and symptoms of posttraumatic stress among victims and survivors of sexual violence (Barkham & Mellor-Clark, 2003). In addition, much of the existing research in the literature is based on quantitative methods, using self-assessment scale designs and samples of psychotherapists from various clinical fields (Aarons, 2004; Briere & Spinazzola, 2009; Gray, Elhai, & Schmidt, 2007). The literature provides evidence that indicates a divide between proponents of EBPs and those who
believe that empirically-supported treatments do not reflect real world clinical practice (Norcross, Beutler & Levant, 2006; Silverman, 1996). Since their efficacy was established in the 1970s, psychotherapy practices (Addis, 1997) have been viewed through a scientific lens. Thus, outcomes, specific approaches, disorders, and treatment structure have all been emphasized. To answer questions regarding what practices can be considered as empirically validated, studies have focused more on treatment outcomes than on clinical practice experience. Various studies have addressed important differences between research and practice when examining EBP issues (Aaron, 2004; Addis et al., 2006; Silverman, 1996). However, most of these studies used quantitative methodology to examine aspects of EBPs along with their impact in clinical practice. They have also focused on clinicians’ attitudes rather than their perceptions and experiences. To date, no studies have examined the perceptions and experiences of trauma-focused therapists who use EBPs, especially when delivering sexual trauma interventions to clients. Consequently, there is a strong need for more knowledge on practicing clinicians’ thoughts and feelings about sexual trauma interventions and the role of EBPs in clinical practice.

The Problem

It is undeniable that a traumatic experience, regardless of its nature, can influence a survivor’s view of the world, relationships, and the community (Herman, 1992; Tummala-Narra, Kallivayalil, Singer, & Andreini, 2012). To help survivors cope with the aftermath of traumatic events, many treatments have been developed within the mental health field. However, topics on traumatic experience from sexual violence and, more recently, psychotherapeutic approaches used to treat victims need to be explored from the clinician’s perspective. It is crucial to account for clinicians’ perceptions, given that they have firsthand experience with EBPs.
In the context of clinical practice, EBPs in general may be regarded with resistance by clinicians who do not wish to use standardized interventions (Norcross, Beutler & Levant, 2006). As a result, dissemination and implementation of research-based services in the mental health field have been hindered as clinicians resist supporting EBPs. Research has argued that practice outcomes would be improved if EBPs were used in real-world care (Reed, 2014). However, the research on clinicians’ perceptions of EBPs is currently minimal. More specifically, no research has explored trauma-focused therapists’ perceptions of EBPs when treating survivors of sexual violence. Inquiring about trauma-focused therapists’ perceptions of EBPs in treating sexual trauma survivors may help mental health professionals, policymakers, and crisis centers comprehend and develop services, including rape-recovery interventions, to help victims and survivors of sexual violence as well as improve the assistance they already provide. Hence, an appropriate starting point is an examination of trauma-focused therapists’ perceptions and experiences in using EBPs when delivering sexual trauma interventions to clients.

**Evidence-Based Practices (EBPs)**

Evidence-based practice has become a focus in many types of healthcare, including behavioral and mental health care (Anderson, 2006; Beidas & Kendall, 2014). A range of professionals—such as physicians, nurses, physical therapists, occupational therapists, and speech pathologists—are increasingly interested in the available evidence for supporting such practice (Sandstrom, Borglin, Nilsson, & Willman, 2011). In 1993, the Division 12 Task Force (APA, 1995) created a procedure for disseminating methods to educate professionals and clients about effective psychotherapies. The report of the Division 12 Task Force was the start of discussions within the mental health field that were aimed at implementing changes in the profession regarding evidence-based treatments (Deegar & Lawson, 2003). Bezyak, Kubota, and
Rosenthal (2010) affirmed that EBP is an integration of individual clinical expertise with methodical empirical evidence that evolves through clinical experience and practice. For this reason, evidence or theory-based approaches to promote evidence-based treatments must be further examined (Perkins et al., 2007). As a result of this growing accumulation of evidence, the scientific community endorsed such specific therapies as EBPs, and various agencies have embraced its concepts. For instance, Aarons et al. (2010) mentioned that the California Mental Health Services Act supports EBP implementation; New York State has established an evidence-based treatment dissemination center to support training and yearlong consultation to frontline clinicians; and the Ohio Department of Mental Health has developed Coordinating Centers of Excellence to promote the use of best practices and EBPs.

The focus has been more intense on implementing EBPs in community-based settings, whereas less consideration has been given to providers’ attitudes toward adopting EBPs (Aarons et al., 2010). In attempting to fill the gap regarding providers’ attitudes toward EBPs, Aarons (2004) developed the Evidence-Based Practice Attitude Scale (EBPAS) to assess mental health providers’ attitudes toward adopting innovation and EBPs in mental health services (Aarons, 2004; Aarons et al., 2010). The EBPAS has been “used in a number of studies to better understand how provider attitudes toward EBPs might be influenced and how such attitudes might influence future behaviors” (Aarons et al., 2010, p. 363). Despite efforts to understand EBPs from the providers’ perspective, a need remains to explore qualitatively the perceptions and lived experience of trauma-focused therapists who use EBPs, especially concerning delivering sexual trauma interventions to clients. As verified in the literature, studies have focused on identifying what motivates practitioners to implement and disseminate EBPs—
namely, their attitudes—and less attention has been paid to their experiences and perceptions of using an intervention.

Critics of the EBP approach point out that such forms of evidence as qualitative research and clinical opinion or expertise are underestimated (Beutler, 2004; Messer, 2004). In supporting the importance of considering clinical expertise, Beutler (1999) contended that unlike quantitative methodology, qualitative research can provide explanations of lived experiences, thus integrating science with experience and knowledge. Professionals and researchers alike have stressed the need to involve clinicians’ input in the development and implementation of treatment approaches (Norcross, Beutler & Levant, 2006). Luborsky et al. (1985) argued that “the therapist is not simply the transmitter of a standard therapeutic agent. Rather the therapist is an important, independent agent of change” (as cited in Silverman, 1996, p. 209). Addis and Crasnow (2000) asserted that there is a strong demand in research to explore practitioners’ opinions about empirically supported treatments. Addis and Crasnow also emphasized that practitioners’ attitudes toward manual-based practices are more problematic than researchers have assumed (2000). Betan and Binder’s (2010) discussion about therapist expertise and interventions highlights that “[e]xpert therapists are skilled at putting words to what is often implicit, nonverbal, and nuanced in the patient’s lived experience and in the relational encounter between therapist and patient” (p. 147). Thus, this study used a qualitative method to fill the gap in the literature regarding the perceptions and experiences of trauma-focused therapists.

The literature on EBPs, from a research standpoint, is informative; but the predominant focus on outcome, manualized treatments, diagnosis, and the fact that the studies are conducive to certain treatment practices based on cognitive behavioral approaches limit its relevance.
Therefore, understanding and exploring trauma-focused therapists’ lived experiences are at the heart of finding what resonates in research and practice.

**Trauma-focused Therapists and EBPs**

Trauma-focused therapists have access to a variety of approaches that help clients recover and heal from past or recent sexual traumatic experiences. To follow the movement of best practices, mental health professionals are highly encouraged to choose from a selective list of evidence-based approaches commonly known as Cognitive Behavioral Therapies (CBT; Beidas & Kendall, 2104.) However, trauma-focused therapists regularly use other trauma-oriented approaches that are not considered evidence based (Norcross, Beutler & Levant, 2006). Though these practitioners use both empirically and non-empirically based treatments to help their clients, they report feeling pressured to use only EBP treatment manuals (Borntrager, Chorpita, Higa-McMillan, & Welsz, 2009). Messer (2004) stated that “[f]or the past decade there has been a culture war raging over the value and even ethical imperative of practicing empirically supported treatment (ESTs)” (p. 18). Many researchers and practitioners have argued that protocol-oriented treatments, instead of meeting the clients’ needs, simply fulfill the requirements of the protocol that the therapist has to follow. Reactions of mental health professionals can be understood within a framework that emphasizes the significance of the client’s needs in treating mental health disorders (Aaron, 2005), including posttraumatic stress disorder. Messer (2004) used the term *culture war* to discuss the dilemma of evidence-supported treatments (ESTs) and eloquently presents contrasts that exemplify viewpoints, such as “subjectivism versus objectivism, contextualism versus atomism, hermeneutics versus universalism, idiographic versus nomothetic, and qualitative versus quantitative method” (p. 3).
These viewpoints exemplify the humanistic- versus scientific-approach debate that has been present in the mental health field for a long time (Kimble, 1984).

Treatments are categorized according to their level of effectiveness. Empirically supported therapies (ESTs), evidence-based practices (EBPs), and best practice approaches are common terminologies used to classify treatments. Messer (2004) affirmed that the efficacy of ESTs in treating specific disorders is based on the American Psychiatric Association’s (1994) *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; DSM-IV), in two randomized controlled trials (RCTs) or in a series of single-case design experiments. Aarons et al. (2010) stated that EBPs increase the quality of care and that “mental health service providers’ attitudes toward change and innovation may influence the implementation of EBPs at several stages” (p. 357). The majority of studies regarding EBPs have focused on researching treatments and determining how effective they are at treating specific disorders (Norcross, Beutler, & Levant, 2006). To date, no studies have investigated trauma-focused therapists’ perceptions of evidence-based approaches regard to sexual violence. Therefore, this study was centered on trauma-focused therapists’ perceptions and experiences in using EBPs when delivering sexual trauma interventions to clients.

**Clinical Decision Making**

What is known about the process of clinical decision making in psychotherapy? Such a question is paramount in research and clinical practice as therapists are constantly exposed to an array of treatment approaches. Regardless of a therapist’s expertise, he or she must decide on the course of treatment that bests suits a client’s situation. Higgs, Jones, Loftus, and Christensen (2008) referred to clinical decision making as a complex process, adding that “health professionals are required to make decisions with multiple foci (e.g. diagnosis, intervention
interaction and evaluation) in dynamics contexts” (p. 89).

In light of the complex work of trauma-focused therapists in the mental health field, clinical decision making is a matter that requires comprehensive understanding from researchers and clinicians alike (Norcross, Beutler & Levant, 2006). Garb (2005) discussed judgment and clinical decision making by examining their relationship with the romantic and empiricist traditions. Research on clinical judgment and decision making enforces the empiricist tradition, based on a large body of research that points out the challenges of learning from informal observation (Garb, 2005). However, Garb noted that “[p]sychologists and other mental health professionals, and even individuals involved in public mental health policy, frequently make causal judgments that are not supported by empirical research. Instead, judgments frequently are based on informal observations or clinical lore” (2005, p. 77). Both traditions influence clinical decision making; however, empiricists place a greater emphasis on scientific findings. Garb also affirmed that “[t]he most vigorous area of research on clinical decision making in the past six to seven years has been on the use of evidence-based treatment recommendations” (2005, p. 81).

Critiques of clinical decision making often emphasize that it is possible to improve the quality of treatment outcome if professionals in the mental health field embrace systematic scientific approaches (Welsh & Lyons, 2001). Frequently, aspects of the therapists themselves, clients’ characteristics, culture, and therapeutic relationships qualities are underestimated (Norcross, Beutler & Levant, 2006). Addis and Cardemil (2006) noted that “[a]t stake are much deeper conflicts over professional identity, territory, decision-making power, and access to resources in the increasingly embattled field of clinical practice” (p. 131). Therefore, exploring trauma-focused therapists’ perceptions and lived experiences of EBPs when delivering sexual
trauma interventions to clients may contribute to the body of literature related to clinical decision making.

**Definition of Trauma**

This study uses the *Diagnostic and Statistical Manual of Mental Health Disorders (DSM-5, 2013)* definition of trauma experience. This definition of trauma has been altered over time, as consideration of the scope and impact of trauma has grown (McHugo et al., 2005). In the *DSM-IV*, the idea of trauma was derived from previous editions as meaning the “traumatic event expanded to include experiencing, witnessing, or being confronted with events that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others” (McHugo et al., 2005, p. 114). In the *DSM-5* (APA, 2014), PTSD was removed from its previous category (APA, 2000) as an anxiety disorder. Given the prevalence of and focus on trauma and stress related disorders, the new DSM has provided them a chapter of all their own. Henceforth, the diagnostic criteria for the *DSM-5* identify triggers for PTSD as exposure to actual or threatened death, serious injury, or sexual violence. The exposure must result from an individual’s involvement in one or more of the following scenarios:

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) as it occurred to others.
3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (p. 271).
In this study, the traumatic experiences examined relate to sexual violence. A detailed explanation of trauma and the evolution of PTSD, based on the DSM construct of trauma, is included in the literature review in Chapter 2.

Despite all efforts to define and describe the trauma experience, one cannot categorize such a subjective experience (Herman, 1992). The focus should be on the alarming data and the continuous research efforts to find ways to prevent and treat the post-traumatic reactions of survivors of sexual violence. Understanding how trauma-focused therapists perceive EBP treatments when delivering sexual trauma interventions to clients can contribute to the development and understanding of services for sexual trauma treatment and intervention.

**Sexual Violence**

In the 21st century, there has been broad public and professional mobilization in recognition of sexual violence. The focus has been on public and professional education to increase preventive education, reporting, and specialized treatments for survivors. More than at any other time in history, victims and survivors of sexual violence have been encouraged to seek psychological help to deal with the enduring effects of posttraumatic stress. News headlines have reached millions of people to reveal cases of sexual violence scandals that empower survivors to come out and talk about their abuse. The impact of sexual violence has been well documented, including evidence that it can affect individuals in all aspects of their lives: physical, psychological, and spiritual (Tummala-Narra et al., 2012). Nonetheless, despite comprehensive research in the trauma field, more studies are needed to assist trauma-focused therapists in providing treatments that will help survivors of sexual violence cope and recover from posttraumatic stress.
The terms *sexual violence*, *sexual aggression*, and *sexual abuse* are commonly used to describe unwanted or non-consensual sexual activity. The Pennsylvania Coalition Against Rape (PCAR; 2015, para. 1, Women) defines sexual violence as “any type of unwanted sexual contact, ranging from sexist attitudes and actions to rape and murder. Sexual violence can include words and actions of a sexual nature against a person’s will.” Both men and women can be affected emotionally, physically, and socially by sexual violence. Tjaden and Thoennes (2000) presented data showing that both boys and girls are vulnerable to abuse. The U.S. Department of Justice National Sex Offender Public Website (NSOPW) selected studies on sexual violence to provide facts and statistics to the public in general. The findings on sexual abuse presented by NSOPW showed that 62,939 cases of child sexual abuse were reported in 2012 (US Department of Justice NSOPW, n.d.). The NSOPW stated that approximately one in six boys and one in four girls are sexually abused before the age of 18. Abuse via technology has also grown in the past few years, accounting for approximately one in seven (13%) of youth Internet users who received unwanted sexual solicitations (Mitchell, Jones, Finkelhor, & Wolak, 2011).

From these data, we can project that a high percentage of the U.S. population has experienced sexual violence of some sort. If we narrow down the statistics by state, in 2014 there were 2,485 total sexual injuries to children in Pennsylvania, according to the Department of Human Services *Annual Child Abuse Report 2014*. These statistics for the state of Pennsylvania include rapes, sexual assaults, statutory sexual assaults, and sexually explicit conduct for visual depiction. Data provided by the Center for Disease Control and Prevention (CDC) affirmed that sexual violence is a public health problem that influences millions of people every year in the United States, and the victimization can have a negative impact on survivors’ health (CDC, 2015). The National Intimate Partner and Sexual Violence Survey (NISVS) conducted a large
scale of interviews in 50 states and the District of Columbia in 2011. According to the results of the survey, an estimated 19.3% of women and 1.7% of men have been raped during their lifetimes. The NISVS also estimated that 43.9% of women and 23.4% of men have experienced some other forms of sexual violence, which includes penetration, sexual coercion, unwanted sexual contact, and noncontact unwanted sexual experiences (CDC, 2015).

At some point, survivors of sexual violence may realize that the traumas have affected different aspects of their lives. Trauma-focused therapists commit themselves to working with survivors of sexual violence in different phases of their trauma, from childhood sexual abuse to adult rape and sexual assault. The growing body of empirical, clinical, and theoretical observation available from the sexual abuse and psychological trauma literature offers a variety of treatments ranging from the least to the most frequently used in the treatment of PTSD (Messer, 2004). Regardless of the traumatic nature, practitioners and scholars alike have argued for EBP in treating clients with the intent that all mental health professionals should agree that EBP is always the right choice (Messer, 2004). For instance, the Department of Veterans Affairs (VA) “instituted national initiatives to provide training and consultation in two evidence-based treatments (EBTs) for posttraumatic stress disorder (PTSD)” (Cook, Dinnen, Simiola, Thompson, & Schnurr, 2014, p. 136). To analyze the impact of EBPs in the mental health field, Jensen-Doss, Cusack, and de Arellano (2008) stated that “Federal funding agencies are prioritizing research efforts to disseminate evidence-based treatments (EBTs) to real-world clinical settings. Arguably, one of the most important components of these efforts is training the therapists who deliver the interventions to implement them effectively” (p. 228). Other health profession fields have noticed the impact of EBPs as well. Sandström, Borglin, Nilsson, and Willman (2011) stated that “the presence and the characteristics of nurse leaders and their
influence on EBP implementation have recently attracted a great deal of attention” (p. 213). In the field of occupational therapy Thomas, Saroyan, and Lajoie (2012) emphasized that advances in the health care system and clients’ expectations regarding quality of care have pressured professionals in their field to work within an EBP context.

**Trauma Intervention**

According to the literature, two approaches have helped researchers and clinical specialists in the quest to find the best treatments for psychological trauma. Deegar and Lawson (2003) noted that the first approach is based on arguments supporting the use of EBPs that include managed health care and requirements for reimbursements, objectivity over clinical judgment, the importance of professional status, and compliance to the medical model. The second approach is more therapeutic and relationship focused, with less emphasis on treatment protocols and constraints imposed by managed health care. As Deegar and Lawson (2003) wrote, “What is seen as a strength by one group (e.g., adherence to the medical model) may be viewed as a weakness by another group, although both groups agree that evidence-based psychotherapies are critical for accountability and effectiveness” (p. 3). Hansen (2006) suggested that within the counseling profession, EBPs seem to be used out of fear of becoming less competitive with other professions in the mental health services.

Although researchers and clinicians in the field of trauma have criticized both approaches, only a few studies have focused on trauma-focused therapists’ perceptions of EBPs in the mental health field. The majority of studies has proposed a quantitative methodology and has concentrated on the effectiveness and efficiency of treatments. Seidler and Wagner (2006) performed a systematic review of the literature dating from 1989 to 2005 on two EBPs used in treating PTSD, EMDR, and CBT. The authors indicated the need for randomized controlled trials
and suggested that “future research should not restrict its focus to issues related to the effectiveness and efficiency of these therapy methods but should also attempt to establish which clients are more likely to benefit from one method or the other” (p. 1521). Both clients’ and clinicians’ perceptions and experiences of treatment are fundamental for improving services offered for posttraumatic stress disorders from sexual violence. Some researchers have attempted to identify clinicians’ motives for not using EBPs, listing the top five reasons:

(a) the research base is not convincing, (b) they are difficult to implement, (c) they require too much change, (d) they are incomplete given the problems we face, and (e) the infrastructure for implementation does not exist or is not supported. (Fixen, Wallace, & Naoon, 2005, as cited in Amaya-Jackson & DeRosa, 2007, p. 381)

An examination of clinicians’ experiences when using EBPs for treating survivors of sexual violence constitutes a gap in the literature. Therefore, this study explores trauma-focused therapists’ perceptions of and experiences with EBPs when delivering sexual trauma interventions to clients.

Statement of the Problem

Effectively addressing sexual violence and its negative impact on survivors is an overdue issue in our society. The U.S. Department of Justice’s National Crime Victimizations Survey (NCVS) estimates that a sexual assault occurs every 107 seconds, yet systems in the community lack the resources needed to help survivors of sexual violence recover from the traumatic experience. Over the past four decades, society has begun to recognize sexual violence as a significant problem (van der Kolk, 2014). Professionals in the mental and behavioral health field have put a great deal of effort into seeking ways to treat, prevent, and eliminate sexual violence (Snyder, 2000). Various treatments have been developed to address the psychological
consequences of posttraumatic stress. Trauma-focused therapists have been presented with a
variety of treatment approaches, some falling under the criteria of empirically validated
treatments and others considered non-empirically validated (Messer, 2004). However, adopting
empirically validated treatments or EBPs is emphasized, and counselors feel pressured to use
them (Aarons, 2005; Gray et al., 2007). Thus, the lived experiences of trauma-focused therapists
need to be explored, as well as their perceptions of EBPs when delivering sexual trauma
interventions to clients. To date, there is a limited amount of research on therapists’ thoughts and
feelings about EBPs, especially in relation to trauma and sexual violence. Therefore, the goal of
this study is to explore, describe, and understand the experiences of trauma-focused therapists
with EBPs when working with survivors of sexual violence. Having therapists explain the
essence of their experiences provides an opportunity for the field of trauma and counseling
interventions to gain a better understanding of this phenomenon.

The dependence on producing quantitative outcomes has overshadowed opportunities for
qualitative explorations of more effective approaches and appropriate interventions (Hansen,
2006). Barkham and Mellor-Clark (2003) elaborated on the importance of exploring practitioners
in the field of mental health:

The utility of large datasets derived from practice research networks can be used to
address one key component, which has often been raised in terms of RCTs [Randomized
Clinical Trials] in the psychological therapies and relates to the unit of analysis. Power
has primarily been calculated on the basis of clients, thereby assuming that all clients are,
statistically, independent. Many researchers have long argued for the need to consider
therapists as the unit of analysis. However, in focusing on therapists, the research
endeavor can become threatening in terms of confidence and professional standing. It is
interesting that while traditional research paradigms have employed the *client* as the unit of analysis and the evidence-based culture focuses on empirically-supported *treatments*, there is a scarcity of established research utilizing the *therapist* as the unit of analysis. (p. 322)

Studies have suggested a need to improve the services offered to victims and survivors of sexual aggression (Borntrager, et al., 2009). For the past three decades, EBP treatments have meant that the counseling services provided to victims of sexual violence have relied strictly on cognitive behavioral modalities (Norcross, Beutler & Levant, 2006). Regardless of appropriateness or efficacy, approaches under the umbrella of CBT have contributed to the need to quantify and categorize the psychological issues experienced by survivors of sexual violence.

A large body of literature surrounds survivors’ reactions to their trauma and, consequently, to the effects of available treatments on posttraumatic stress disorder, depression, anxiety, and any other disorders resulting from a traumatic experience (Tummala-Narra et al. 2012). However, the literature on therapists’ perceptions of and experiences with EBP treatments of sexual violence survivors is insufficient (Briere & Spinazzola, 2009). To date, most investigations have been dedicated to finding EBPs that will support trauma-focused treatment, but not specifically sexual trauma. Aarons (2005) noted that “the building momentum in the United States for the dissemination and adoption of EBP in both private and public mental health services settings is bringing pressure on providers to adopt EBP, ready or not” (p. 1). Although data on important aspects of trauma-related treatment approaches have increased, less focus has been given to how trauma-focused therapists perceive evidence-based trauma therapy, especially in the treatment of victims and survivors of sexual violence. Gray, Elhai, and Schmidt (2007) stated that it is essential to know about the attitudes of trauma mental health professionals who
use EBPs. It stands to reason that a treatment’s effectiveness depends on how much the clinician believes in it, whether empirically supported or not.

Finally, as more cases of sexual violence, including childhood sexual abuse, occur within society, so does the need to explore trauma-focused therapists’ perceptions and experiences of interventions being used to help survivors (Briere & Spinazzola, 2009; Carlson, 2005). Hundreds of rape and crisis centers, crisis hotlines, sexual victims units, and survivors support groups have emerged with the rise of sexual violence (Carlson, 2005). Trauma-focused therapists who work in agencies or private practice would benefit from a comprehensive exploration of trauma-focused therapists’ perceptions of EBP when delivering sexual trauma interventions to clients.

**Purpose of the Study**

The purpose of this study is to explore trauma-focused therapists’ perceptions of and experiences with EBPs when delivering sexual trauma interventions to clients. This study examines pertinent elements and themes that surface from individual interviews with participating trauma-focused therapists. The interpretation of data may help in acquiring an understanding and a strong description of the trauma-focused therapist’s perceptions and lived experiences in using EBPs when delivering sexual trauma interventions.

A qualitative study guided by a phenomenologically oriented approach has been used to gain an understanding of the essential “truths” of the lived experience of therapists who use EBPs. The use of a phenomenological approach supports “the researcher’s focus on describing what all participants have in common as they experience a phenomenon” (Creswell, 2013, p. 76). Further, a person’s meaning and experience is essential to the interpretation of the data. This study thus investigated the themes that shape trauma-focused therapists’ perceptions of and experience with EBPs when delivering sexual trauma interventions.
This inquiry focused especially on trauma-focused therapists’ perceptions and lived experiences rather than on those of clients. Trauma-focused treatments related to EBPs were highlighted from the therapists’ experiences and were considered evidence based if they contained treatment protocols and were recognized as empirically supported. For a treatment to be considered as empirically supported, it must be revealed as efficacious in a controlled clinical research setting, which means that there is a manual or protocol with guidelines for using it (Norcross, Beutler & Levant, 2006). Addis and Cardemil (2005) noted that the purpose of treating according to a manual is to “describe an intervention in sufficient detail such that a test of treatment integrity can be performed to document whether the independent variable (i.e., the treatment under consideration) was successfully manipulated” (p. 132). Although criticized by professionals and researchers alike, in the past few decades, treatment manuals have become a part of trauma-focused therapists’ practice as the EBP approach has become more predominant (Beidas & Kendall, 2014). Nevertheless, clinical practitioners have recognized that staying flexible and adjusting their approaches to meet clients’ needs is rather beneficial (Prochaska & Norcross 2007). For example, Kendall, Chu, Gifford, Hayes, and Nauta (1998) suggested that manuals should be used as a guide, thus allowing therapists to be flexible and creative in using his or her clinical skills.

To further understand therapists’ perspectives, this qualitative study explored trauma-focused therapists’ perceptions of and experiences with EBPs by using semi-structured qualitative interviews. The investigation may contribute to the existing knowledge base with regard to trauma-focused therapists’ perceptions and lived experiences in the field of trauma. It also may contribute to an advanced comprehension of EBPs in treating sexual trauma. Finally, the aim of this study was to gather in-depth information concerning the lived experience of
trauma-focused therapists in terms of how they perceive EBPs when delivering trauma-focused interventions.

**Research Questions**

This study sought to answer the following research question: How do trauma-focused therapists perceive evidence-based practices in treating sexual trauma? The following subsidiary questions were employed to assist in answering the guiding question:

1. What EBPs do trauma-focused therapists use when delivering sexual trauma interventions to clients?

2. What are the lived existentials, according to van Manen (1990, lived time, person, space, and relationship), of trauma-focused therapists who use EBPs when delivering sexual trauma interventions to clients?

3. What risk and protective factors affect decision making by trauma-focused therapists who use EBPs when delivering sexual trauma interventions to clients?

4. How do trauma-focused therapists understand their experiences of using EBPs, within the context of Bronfenbrenner bio-ecological model (1979) and Levers’ (2012) ISAT model, particularly relating to issues of context and systems?

**Statement of Potential Significance**

The results from this study may contribute to a better understanding of trauma-focused therapists’ perceptions of EBPs and their lived experiences in delivering sexual trauma intervention to clients. The current study used relevant information from previous research based on trauma-focused therapists’ perceptions of, experiences with, and attitudes toward EBPs. Awareness of trauma-focused therapists’ perceptions of treatments for the use of EBPs is relevant to both treatment development and the facilitation of treatment dissemination,
implementation, and sustainability when delivering sexual trauma interventions to clients. For instance, leaders, supervisors, administrators, policymakers, and mental health professionals could benefit from such awareness and thereby improve the services provided to their clients. This study is important because it qualitatively expands our ability to examine specific personal and professional experiences with EBPs for sexual trauma interventions.

One important issue regarding EBP concerns the extent to which it has been explored from a trauma-focused therapist’s perspective. Based on the limited research, it appears that it is much more usual for studies exploring the perceptions and experiences of therapists to use a quantitative approach. The few studies that have been conducted on EBPs are primarily concerned with treatment effectiveness (Aarons, 2005). More recent studies, however, indicate that EBP must be explored from both client and provider perspectives (Jensen-Doss, Cusack, & de Arellano, 2008). Qualitative research design provides the ideal process for eliciting the perceptions and lived experiences of trauma-focused therapists in their use of EBPs when delivering sexual trauma interventions to clients. Therefore, this qualitative investigation employed semi-structured individual interviews with trauma-focused therapists to explore their perceptions of and lived experiences with EBPs when delivering sexual trauma interventions to clients.

The Study

This study aimed to explore trauma-focused therapists’ perceptions of and experiences with EBPs when delivering sexual trauma interventions to clients. The study was conducted with data gathered from trauma-focused therapists who work either in private practice or in trauma-focused centers and agencies. These mental health professionals were required to be counseling survivors of sexual violence—adults or children, males or females—who had sought treatment
for posttraumatic stress issues—including posttraumatic stress disorder, acute stress disorder, anxiety, and depression—and who use or have used at least one type of EBP. The trauma-focused therapists were asked to participate in individual interviews regarding their experience.

**Data Collection**

Interviews were conducted in the spring of 2017. According to van Manen (2007), subject interviews from a hermeneutic phenomenological perspective serve the purpose of “gathering experiential narrative material that may serve as a resource for developing a richer and deeper understanding of a human phenomenon” (p. 66). Ten participants were recruited from counseling centers, agencies, and/or private practice. Recruitment continued until the data reached saturation. This purposive sampling method allowed the researcher to select participants with characteristics that suit the study design and purpose. The participants had an average of six years of experience working in agencies or self-identified as using an evidence-based approach. Participant characteristics for this study included therapists’ level of education, counseling specialty, and length of work experience. These criteria allowed the researcher to focus on professionals who were most likely to be involved, know about, and have insights and experience into the research topic.

All interviews were audio recorded and varied in length from 42 minutes to 1 hour and 20 minutes. The interviews were semi-structured with open-ended questions and were carried out in a conversational style. Handwritten field notes were collected during the individual interviews and expanded to achieve a thorough interpretation and description of the data. These field notes were also expanded into rich descriptions after the interviews for a better exploration of the phenomenon being studied. All of the audio-recorded interviews and notes taken during the interviews were entered into computer files. The researcher used *NVivo 11*, a software program
that uses a coding system organized around different topics and themes. Connections between categories and themes were used to improve the understanding of trauma-focused therapists’ perceptions of and experiences with EBPs when delivering sexual trauma interventions to clients.

**Theoretical Foundation**

This qualitative, phenomenologically oriented study explores the perceptions and experiences of trauma-focused therapists as they use EBPs when delivering sexual trauma interventions to clients. This qualitative design is grounded in the bio-ecological model of human development (Bronfenbrenner, 1979, 1997, 2005) and van Manen’s (1990) four lived existentials of lived space, body, time, and human relation.

Van Manen (1990) explained phenomenology as “the study of the Lifeworld—the world as we immediately experience it pre-reflectively rather than as we conceptualize, categorize, or reflect on it. Phenomenology aims at gaining an understanding of the nature and meaning of everyday experiences” (p. 8). Existing research related to EBPs has been primarily quantitative and lacking in the understanding that could be provided by a qualitative design, which is designed to explore the reality or “lifeworld” of trauma-focused therapists when delivering sexual trauma intervention to clients. For capturing the lived experience of trauma-focused therapists, van Manen’s concept of lifeworld provides a framework in understanding a therapist’s lived experiences with EBPs. The four existential themes that guide this inquiry are lived space, lived body, lived time, and lived relation (van Manen, 1990). Lived space is not just the physical space where people reside; rather, it refers to how people experience their place or space in the day-to-day activities of their lives. Lived body is people’s understanding of their physical presence in the world. Lived time is people’s biography: it is the past influencing the present and
future, as well as the relationship of the present or future to the past. Lived other refers to interactions with others or relationships that share space in people’s lives (van Manen, 1990). These four reflection guides have been used to capture therapists’ lived experiences with EBPs when delivering trauma-focused therapy to survivors of sexual violence.

Bronfenbrenner’s bio-ecological model (1979) was used to assist in understanding how trauma-focused therapists’ development is affected by their environment. The bio-ecological model approach is applicable in this study not only for understanding trauma-focused therapists’ development, but also to understand the treatment approaches they routinely use. This model, overall, has helped the researcher explore the interconnected characteristic of trauma-focused therapists’ experiences in working with EBP approaches, as well as the influence of EBPs when delivering sexual trauma to clients. Bronfenbrenner’s (1979) theory was implemented to help the researcher explore the perceptions and experiences of trauma-focused therapists within the context in which they use EBPs when delivering sexual trauma interventions to clients. In his theory, Bronfenbrenner (1979) described the complex “layers” of the environment, each of which have an effect on changes that the therapist experiences. The bio-ecological model suggests that any change or divergence within one layer will influence other layers. For example, to study trauma-focused therapists’ perceptions and experiences in using EBPs, it is essential to contemplate some of the subsequent dynamics that affect a therapist’s ability to use EBP approaches: the relationship that the therapist has with the client, his or her supervisor, the agency (if the therapist works for an agency), and the therapist’s competency to work with survivors of sexual violence. To understand therapists’ perceptions of EBPs when working with survivors of sexual violence, one must consider not only their understanding of trauma-focused approaches but also how other systems have influenced their experiences with EBPs when
delivering sexual trauma interventions to clients. Bronfenbrenner (1979) discussed five interconnected layers or systems: the microsystem, mesosystem, exosystem, macrosystem, and chronosystem. These systems will be used in this study to explore trauma-focused therapists’ perceptions and experiences when delivering sexual trauma intervention to clients. Bronfenbrenner’s theory will also be used here to investigate the risk factors and protective factors associated with trauma-focused therapists perceptions of EBPs. Henggeler and Schoenwald (2002) have noticed that researchers often ignore critical components related to EBPs, and they have indicated that

variables influencing treatment fidelity, including the quality of the treatment manual, can be conceptualized from a social ecological framework. Practitioners are embedded in quality assurance systems (e.g., manuals, supervision), which are embedded within organizations, which are embedded within community contexts. Variables at each level of analysis influence practitioner behavior and, in many cases, can undermine the intents of the best conceived treatment manual. (p. 419)

An examination of lived experiences from an ecological systems perspective can be valuable in deriving a picture of the risk and protective factors and processes functioning within trauma-focused therapists’ environments.

Parallel to Bronfenbrenner’s bio-ecological model (1979), the Levers ISAT model contributed to a holistic understanding of trauma-focused therapists’ systems and the contexts in which they practice counseling. The ISAT integrates three interconnected elements: clinical relationship, nexus of personal treatment issues, and broader systemic and cultural influences. Levers’ emerging ecological model offered a holistic base for exploring the pertinent variables
that impact trauma-focused therapists perceptions of and lived experiences with EBPs when treating survivors of sexual violence.

**Explication of Data**

Once the interviews were transcribed, the transcripts and field notes were explored. Through this inquiry, an emerging understanding of trauma therapists’ perceptions of and lived experiences with EBPs was developed, especially as they relate to providing sexual trauma interventions to clients. Future lines of inquiry are also explored in the hope that may serve to enhance trauma work and the lived experiences of trauma-focused therapists who work with survivors of sexual violence.

**Operational Definitions**

Evidence-based practices (EBPs): The APA Presidential Task Force on Evidence-based Practice defined EBP as the "integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (APA, 2006, p. 273). In the literature, the terms “evidence-based practices” and “evidence-based interventions” are often used interchangeably.

Manualized treatment: “Treatment manuals are written documents intended to aid in the evaluation, dissemination, and implementation of some evidence-based treatments (Addis, 1997)” (as cited in Addis and Cardemil, 2005, 134).

Sexual violence: The Pennsylvania Coalition Against Rape (PCAR, 2015, Women, para. 1) defines sexual violence as “any type of unwanted sexual contact, ranging from sexist attitudes and actions to rape and murder. Sexual violence can include words and actions of a sexual nature against a person’s will.”
Trauma-focused therapists: Professionals in the mental health field who offer trauma-informed care services to children and adults who are victims and survivors of physical, psychological, and social trauma. For this study, the focus is on trauma-focused therapists who work with survivors of sexual violence.

Trauma-focused treatments: Treatments or interventions based on psychotherapy that address the psychological aftermath of posttraumatic stress issues. In the context of this study, trauma-focused treatments or interventions are related to sexual violence trauma.

Intervention: In this study, “intervention” refers to all direct services rendered by health care professionals “including assessment, diagnosis, prevention, treatment, psychotherapy, and consultation” (APA, 2006, p. 273).

Summary

In the past decades, studies on trauma-focused issues as well as EBP treatments for sexual trauma survivors have progressed remarkably. Various professions consider EBPs to be the most important indication of efficacy when one seeks treatment. Referring to the impact of EBPs in mental health care, Miller (2010) mentioned what “Prochaska and Norcross (2007) considered to be one of the most important professional issues of the decade: the development of evidence-based practice in mental health” (p. 425). Whether evidence-based or non evidence-based, several forms of treatment, intervention, and diagnosis have delineated the way clinicians help their clients during the healing process. However, to date, there has been a lack of studies that use a qualitative design to explore trauma-focused therapists’ perceptions of and experiences with EBPs, especially when delivering sexual trauma interventions to clients.

As more empirical evidence is collected regarding therapists’ perspectives on EBPs, questions remain about how trauma-focused therapists perceive EBPs, what their lived
experiences are, and what motivates their clinical choices when delivering sexual trauma interventions to clients. Much empirical research has been conducted that validates evidence-based approaches; most of these studies have assessed clients’ experiences, as opposed to those of the therapists, and the methodologies have been predominantly quantitative. In developing this study, the researcher hoped that researching the perceptions and experiences of trauma-focused therapists from their clinical experience might provide insight into factors that motivate them in choosing an approach, whether EBP or not.

A qualitative research approach, informed by a phenomenological perspective, was proposed for this study. Using a phenomenological approach supported the researcher’s “focus on describing what all participants have in common as they experience a phenomenon” (Creswell, 2013, p. 76). Furthermore, a person’s perception and experience is essential for interpreting the text data from the interviews. Research paradigms, whether empirically oriented or not, tend to be equally efficacious. This study did not restrict its focus to the efficacy, effectiveness, and efficiency of empirically oriented methods; instead, it attempted to explore the perceptions and experiences of trauma-focused therapists.

**Organization of the Dissertation**

This study is organized into five chapters. In Chapter 1, I have provided an overview of the study, describing the elements pertinent to the research. I have also presented the research design, significance of the study, and data collection methods for guiding the examination of trauma-focused therapists’ perceptions and lived experiences with EBPs when delivering sexual trauma interventions to clients. The literature review is presented in Chapter 2, which comprises a discussion of trauma history, the evolution of the definition of PTSD in the DSM, and current perspectives on EBPs, trauma-focused therapists, and sexual violence interventions. Chapter 2
also reviews the theoretical foundation for this study, which includes van Manen’s (1990) Lifeworld Existentials, Bronfenbrenner’s (1979) Bio-ecological model, and Levers’ (2012) ISAT model.

Chapter 3 describes the qualitative methodology I used for this study. I present the theoretical framework, research design, participants and sampling, and methods and procedures. Finally, I describe my instruments, data collection, ethical consideration, limitations, and summary. Chapter 4 presents the results of analyzing the data collected from participants. Chapter 5, finally, explicates the results from data analysis and discusses the limitations of the study, implications for the field of sexual trauma interventions, evidence-based practices, clinical practice, and suggestions for future research.
Chapter II: Review of the Literature

The purpose of Chapter 2 is to present an overview of the literature regarding trauma-focused therapists' perceptions and lived experiences of evidence-based practices (EBPs) when delivering sexual trauma intervention to clients. This literature review serves as an evaluative report of information related to the definition, classification, and treatments associated with EBPs. The nature of traumatic experience is also reviewed, with a focus on the trauma that results from sexual violence. As Boote and Beile (2005) noted, “a researcher cannot perform significant research without first understanding the literature in the field” (p. 3). Therefore, this literature review is intended to explore, summarize, and strengthen the knowledge that contributes to the research questions for this qualitative study, which may complement the literature in the field of trauma interventions and sexual trauma-related studies.

The literature review is compiled with the purpose of understanding the field of trauma counseling and, more specifically, that relating to sexual violence. To supplement the effort to understand EBP from clients’ and institutions’ perspectives, I have explored trauma-focused therapists’ perceptions and lived experiences of EBPs when delivering sexual trauma interventions to clients. Hence, studies have been reviewed and examined that have narrowed sources and facilitated exploration of the research interest. Boote and Beile’s (2005) adaptation of Hart’s (1999) criteria has been used to assure content quality. According to Boote and Beile, “Hart suggests a much more central role for the literature review in doctoral dissertations” (2005, p. 6). The five categories adapted by Boote and Beile (2005) have entailed coverage, synthesis, methodology, significance, and rhetoric.

These five categories have been implemented as a framework from which the reviewed literature has been analyzed according to the context of the study. With respect to coverage,
inclusion and exclusion of psychological trauma-related treatment, diagnosis, and approaches have been evaluated, including the history and development of PTSD. For achieving synthesis, studies have been reviewed that rely on fundamental information and uncover the possibility of improving research in the field of trauma intervention and sexual violence. The criteria for methodology include identification of both qualitative and quantitative studies carried out in the field of trauma and psychotherapy treatment. For instance, one of the major studies reviewed used the Evidence-Based Practice Attitude Scale (EBPAS; Aarons, 2004, 2005). The significance of the research included relates to a consideration of its qualitative understanding of practitioners’ perceptions toward the application and the implementation, maintenance, and policymaking development. This study may contribute to the literature in the field of mental health and related trauma studies. Finally, the rhetoric category is intended to ensure that the literature review is clear and coherent in its analysis and structure.

Over the past three decades clinical and scientific research has empirically substantiated the effectiveness of various sexual trauma-related treatments (Koss & Harvey, 1991). The demand for approaches that help survivors of sexual violence cope with the aftermath of a traumatic experience is undeniable. As noted by Levers, “[t]he experience of trauma is a long-lived human dilemma, and in spite of everything that we have learned over the millennia, we continue to deal with the overwhelming consequences of trauma” (2012, p. 23). Clinicians and researchers alike have made great efforts to develop as well as discover if treatments, whether labeled or not labeled as evidence-based, are understood by professionals and clients alike (Amaya-Jackson & DeRosa, 2007). Discussions have drawn from research and clinical wisdom to increase knowledge about the effects of trauma on psychological, biological, and social systems (van der Kolk, McFarlane, & Weisaeth, 1996). Trauma clinicians in the community and
researchers into psychological trauma have debated the issues around EBPs as they apply to clients who have developed posttraumatic stress difficulties (Amaya-Jackson & DeRosa, 2007; Cook, Dinnen, Simiola, Thompson, & Schnurr, 2014). Some authors have articulated the use of EBPs in addressing mental and behavioral health based on the argument that empirically supported practices or treatments offer firm scientific support and should be disseminated and implemented in the mental health field (Amaya-Jackson & DeRosa, 2007; Anderson, 2006; Sanderson, 2003). Other authors have shown interest in the potentially negative effects of focusing solely on EBP treatments (Hansen, 2006; Hensberger, 2007; Messer 2004; Thomason, 2010), including Carl Rogers (1957) who questioned “whether the evidence-based practice paradigm is a necessary and sufficient condition to support routine practice settings” (as cited in Barkham & Mellor-Clark, 2003, p. 320).

In order to address the relevant topics in the literature, this review is organized sequentially, starting with the history and progression of psychological trauma, followed by PTSD evolution based on the DSM construct of trauma experience. Aspects of trauma interventions used especially for treating survivors of sexual violence were reviewed, and their use was examined for a better understanding of the lived experience of trauma-focused therapists. This chapter has reviewed other research findings that have explored trauma-focused therapists’ attitudes about EBPs, trauma, and interventions that address sexual violence, along with the theoretical foundations that inform this study. Finally, this chapter has included an extensive review of van Manen’s existentials (1990) as an instrument for exploring the lived experience of trauma-focused therapists who work with survivors of sexual violence, and Bronfenbrenner’s bio-ecological model (1979) as a means for understanding the systemic context of therapists’ perceptions and lived experiences.
Trauma History

The word “trauma” has a dense connotation and a long developmental history. Often, being confronted with trauma is just a matter of glancing at a daily newspaper, turning on the TV, or navigating the Internet. Even if trauma is not observable in any type of media or if it occurs out of public view, the thoughts of trauma, independent of its nature, are likely to evoke disturbing images or memories (van der Kolk, 2014). Even as traumatic events make headlines very rapidly, mental health care practitioners and scientists in the field strive to understand trauma’s emotional, mental, physical, and social implications. The Center for Disease Control and Prevention (CDC, 2014) states that sexual violence and childhood sexual abuse are public health problems and that they influence millions of persons every year in the United States. For this study, it is fundamental to review traumatic stress from a historical perspective as well as its current state of knowledge, both of which have guided scientific research and practice.

In the last century, copious amounts of research have emerged on psychological trauma, contributing to its historical development. Thanks to the research on trauma, attachment, and brain science, we have never known more about how to work with survivors and victims of psychological trauma (van der Kolk, 2014). Though we do not know it all, we have never had more information and more hope about what to do in accessing help and healing trauma. A great part of this accomplishment in the field of traumatology is possible because of the studies of modern psychiatry on the mind (Hyatt-Burkhart & Levers, 2012; Wilson, 1995). Thus, it is impossible to contribute to the study of psychological trauma without revisiting and acknowledging the roots of traumatic stress.

Historically, psychological trauma has always been a part of society. Early descriptive accounts of stress-related disorders are often linked to the history of warfare (Andreasen, 2010).
The literature on psychological trauma provides abundant examples of reactions to psychological stress regardless of its nature. Echterling, Field, and Stewart (2015) elaborated on the evolution of PTSD, indicating that both the psychological and somatic movements offered a distinct conceptualization of traumatic stress. Toward the end of the eighteenth century, the emphasis in the psychological movement was predominantly mental, covering consciousness and amnesia, which was later known as dissociation (Echterling et al., 2015). The somatic movement began in England during the nineteenth century. The focus during that time, when railroad accident were prevalent, was on physical trauma, thus explaining the origin of the label “Railway Spine.” At the same time in the United States, physicians suggested that traumatized Civil War combat veterans were experiencing a cardiac condition, which they labeled “Soldier Heart” or “Da Costa’s Syndrome” (Echterling et al., 2015). The different conceptualizations of trauma stemming from these two movements narrowed down to the emerging diagnosis of “hysteria,” setting the stage for what we now know to be PTSD (Echterling et al., 2015). Micale (2001) noted that Western Europe and North American psychiatry focused its attention on psychological trauma toward the middle of the nineteenth century and pointed out that the first medical attempt to describe, label, and treat traumatic stress emerged in the seventeenth century. At the time, army physicians “[t]ypically regarded the cases as an organic disease of unknown nature, cowardice, or malingering” (Micale, 2001, p. 115).

Most of the foundations for the existing knowledge of psychological trauma and its potential long-term effects are rooted in the late nineteenth century (Herman, 1992; Hyatt-Burkhart & Levers, 2012; Micale, 2001). The Parisian neuropsychiatrist Jean-Martin Charcot’s work on posttraumatic pathology and his consideration of “traumatic neurosis” have been cited extensively in the literature along with the work of his well-known students Sigmund Freud,
Joseph Breuer, and Pierre Janet (Micale, 2001). In the past century, their work in psychological trauma, viewed from a historical perspective, reflects the beginning of a pervasive interest in posttraumatic stress by the medical and behavioral sciences. As noted by Wilson (1995), the twentieth century faced the reality of wars, civil violence, genocide, and man-made and natural disasters, along with a growing awareness of domestic and sexual violence and childhood sexual abuse. Consequently, the literature on posttraumatic stress and its effects on victims has increased exponentially over the last century. Interest in the topic of trauma reflects increased practice with an increased awareness of the challenges of treating adults and children who have been exposed to sexual violence.

Charcot’s investigations into the idea of posttraumatic pathology inspired the observation and theorization of psychological trauma in modern psychiatry, psychology, and psychotherapy (Micale, 2001). Charcot’s case studies on traumatic neuroses identified what we currently know as posttraumatic stress disorder (PTSD), but at the time it was called “névrose traumatique,” “hystérie traumatique,” “hystéro-traumatisme,” or “hystéro-neurasthénie traumatique” (Micale, 2001, p. 116). The Parisian neuropsychiatrists’ observations of traumatic neuroses captured public and scientific attention, and during his ‘Tuesday Lecture,’ Charcot revealed his findings on hysteria by live demonstrations, wherein he exposed young traumatized women (Herman, 1992). Thereafter, observations and examinations of psychological trauma became more prominent, and in 1895, Freud and Breuer published Studies in Hysteria. Freud’s perspective of psychological trauma turned its focus to intrapsychic mechanisms rather than the posttraumatic paradigm of neurosis (Wilson, 1995). Later on, Freud shifted his belief that sexual trauma always lies at the root of psychological problems, and instead began to focus on the role that sexual instincts play in the developmental process. Freud’s contributions had great importance for
European and American thinking in the field of psychological trauma. His exploration of trauma-related issues influenced the mental health profession from about 1895 to the end of the Vietnam War era in the United States (Wilson, 1995). Freud’s shift from his original view of neurosis led him to reevaluate intrapsychic conflicts related to posttraumatic stress experiences and to expand his definition of psychological trauma. In *The Introductory Lectures on Psychoanalysis* (1917, 1966), Freud wrote as follows:

The closest analogy to this behavior of our neurotics is afforded by illnesses which are being produced with special frequency precisely at the present time by the war—what are described as traumatic neuroses. Similar cases, of course, appeared before the war as well, after railway collisions and other alarming accidents involving fatal risks. Traumatic neuroses are not in essence the same thing as the spontaneous neuroses which we are in the habit of investigating and treating by analysis; nor have we yet succeeded in bringing them into harmony with our views, and I hope I shall be able at some time to explain to you the reason for this limitation. But in one respect we may insist that there is a complete agreement between them. The traumatic neuroses give a clear indication that a fixation to the traumatic accident lives at their root. (as cited in Wilson, 1995).

Freud’s expanded definition of psychological trauma would contribute to the later framework and categorization of trauma-related disorders within APA’s DSMs (Wilson, 1995).

The interest in posttraumatic reactions motivated the psychiatric field to work further toward conceptualizing trauma and its consequences on victims. The intense effects of WWI and the increase of emotionally disturbed soldiers led to the concept of “shell shock” (Andreasen, 2010), which is mentioned later, in the evolution of PSTD in the DSM section. Attention to posttraumatic issues, and consequently shellshock, vanished as WWI ended. However, the dawn
of World War II resuscitated the matter of psychological trauma, and such mental health professionals as Charles Myers studied the impacts of combat-related disturbance on soldiers (Herman, 1992). Although the activity subsided somewhat after two major wars, the study of traumatic exposure did remain of interest to a few professionals within the field of psychology, which contributed to the development of later conceptualizations of posttraumatic stress (Herman, 1992).

**Evolution of PTSD in the DSM**

Since 1980, a formal diagnosis of trauma-related disorders has been included in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*. Since its introduction in the *DSM-III*, the evolving diagnosis of PTSD has generated changes and controversies. Sexual violence was not even originally under the diagnoses of posttraumatic stress disorder in the *DSM*, but the PTSD criteria and the field of traumatology in general have progressed over time. Although strides have been made over the past decades in the DSM regarding posttraumatic stress difficulties related to sexual violence, Foa, Keane, Friedman, and Cohen (2009) noted that the PTSD diagnostic framework remains inherently limiting. Foa et al. (2009) emphasized that the limitation relates especially to survivors of early childhood sexual and physical abuse or domestic violence because little is known about successful treatments for these populations, and clinical consensus points toward integrative interventions. Therefore, it is fundamental to understand early conceptualizations of psychological trauma and PTSD as they relate to trauma-focused therapists’ perceptions about using EBPs for sexual trauma interventions.

During over 50 years of arguments related to definition, classification, and treatment, PTSD diagnostic history has had an impact on the field of mental health care. Levers (2012) pointed out that although PTSD first appeared in 1980, the concept of the disorder has a very
long history. Even before its inclusion in the DSM III, PTSD was portrayed in Hollywood films (Levers, 2001). A stress-related diagnosis first appeared in the official nomenclature when the *Diagnostic and Statistical Manual of Mental Disorders (DSM-I)* was published in 1952. Within the manual, stress-related disorders were placed under the heading of “Transient Situational Personality Disturbance” (APA, 1952) along with the diagnosis of gross stress reaction (Levers, 2012). Stress related disorders were omitted, however, in the second edition of the manual in 1968. Conversely, when the *DSM-III* was developed in the mid-1980s, the struggles of returning soldiers from the Vietnam War as well as a recognition of the trauma-inducing aspects of rape provoked a more thorough examination of the disorder. Posttraumatic stress disorder was finally defined as a stress disorder, which occurs as a consequence of many different types of stressors, including combat and civilian stress (Andreasen, 2010).

Major events in the 20th century contributed to significant changes in the conceptualization of PTSD in the *DSM*. Wilson (1995) noted that traumatic neurosis was essentially rewritten into the *DSM* (APA, 1952) diagnostic criteria for gross stress reaction, the earliest diagnostic category for what was later codified as PTSD in the *DSM-III-R* (APA, 1987). The First World War showed evidence of the psychological aftermath of combat, and by 1918, the British Royal Army Medical Corps had treated 80,000 cases of “shell shock” (Echterling et. al., 2015). Although there was a better understanding of stress-related disorders within the field of psychiatry during WWI, peaceful times led to the neglect of psychological trauma. The advent of World War II renewed attention to the issue of traumatic stress, and the condition was then conceptualized as combat stress and combat fatigue (Andreasen, 2010). After WWII, there was another period of neglect until the early conceptualization of the *DSM-I* (1952). The concept of traumatic stress was elaborated upon under “gross stress reaction diagnosis,” which categorized
traumatic stress essentially as a short-lived reaction to combat or catastrophe. In the revision for the *DSM II*, published in 1968, the diagnosis of gross stress reaction was absent. Andreasen (2010) suggested that the omission of “gross stress reaction” in the *DSM II* happened because it was written in a peaceful era, and she emphasizes that between 1968 and 1980 no official diagnoses for stress disorders were available. During this time, the Vietnam War brought to light many questions regarding post-combat psychological issues. Andreasen (2010) noted that the health care system was challenged because of its lack of adequate treatment for those who had psychiatric symptoms post-combat.

The emergence of *DSM-III* in 1980 established the urgency to include stress disorders in the manual. Several types of major traumatic events identified during that period provided abundant evidence indicating that stress disorders were common and followed by symptoms that could stem from different types of stressors arising from “combat, death camps, industrial accidents, natural disasters, mass catastrophes, and violent act against individuals” (Andreasen, 2010, p. 69). Thus, posttraumatic stress disorder (PTSD) was created to describe symptoms based on three general categories: re-experiencing, numbing, and cognitive or autonomic symptoms (Andreasen, 2010). The *DSM-III* edition was revisited, and seven years later, the *DSM-III-R* was released with modifications to some of its diagnostic criteria, including a broadened definition of stressors under PTSD. Minor modifications were made on *DSM-IV*, which was completed in 1994. However, as Wilson (1995) stressed, a significant change concerned the definition of the traumatic event, “which has a two-pronged criteria indicating that the person must have experienced or witnessed a life-threatening event and responded to it with fear, horror, or hopelessness” (p. 23). The traumatic event was broadened to threat experience or witness. In 2000, the American Psychiatric Association released the *DSM IV-TR*. There were no
substantive changes to the diagnostic criteria related to trauma in this edition. However, a full revision occurred with the DSM-5 released in 2013, in which changes were made to the PTSD diagnosis. Friedman (2014) pointed out some of the major modifications regarding PTSD in the most recent DSM edition. He noted that the 17 DSM-IV PTSD criteria were retained, but modified in some cases, and emphasized the three foremost modifications:

1. Establishing a new DSM-5 diagnostic category, “Trauma and Stressor-Related Disorders” for PTSD (and acute stress disorder, adjustment disorders, and others) so that PTSD is no longer classified as an anxiety disorder,

2. Reconceptualizing PTSD broadly to include posttraumatic anhedonic/dysphoric, externalizing and dissociative clinical presentations along with the original fear-based anxiety disorder.

3. Establishment of preschool and dissociative subtypes. (p. 1)

The most recent changes accounted for important factors that were previously ignored in terms of PTSD. The development of recent DSM trauma-related criteria has influenced trauma-focused therapists in favor of EBPs when delivering sexual trauma interventions to clients. The fact that sexual violence is under the categorization of PTSD, which was originally ignored, has an impact on clinicians’ decision-making processes regarding which approach to use based on criteria and symptoms described in the manual.

**Current Perspectives on Evidence-Based Practices (EBPs)**

The use of EBPs has increased considerably over the last three decades, and as a result, much more is known about the efficacy of treatments for mental health issues, including PTSD from sexual violence. Evidence-based practice is not a new concept in the field of mental and behavioral health. Anderson (2006) reiterated the first conceptions of applied psychology and
highlighted that EBPs have been in the forefront of patient care since the beginning of the 20th century. “Early practitioners such as Frederick C. Thorne (1947) articulated the methods by which psychological practitioners integrate science into their practice by ‘increasing application of the experimental approach to the individual case and to the clinician’s own experience’” (Anderson, 2006, p. 271). Evidence or empirical-based practice is, nonetheless, a subject related to researchers, clinicians, and providers involved directly or indirectly with client survivors of sexual violence; thus, EBPs require an overview in this chapter.

There are certain landmarks in the medical development of EBPs (see Figure 1): the first is the Flexner Report, the second was the first randomized clinical trial, and the third was the establishment of the Food and Drug Administration (FDA; Norcross, Beutler & Levant, 2006). The history of EBPs in mental health, though, is rather brief, going back only to the 1990s and originally in Great Britain. In the United States, it was the American Psychological Association Society of Clinical Psychology (Division 12) Task Force that initiated efforts to identify promote and disseminate evidence-supported treatments (Norcross, Beutler, & Levant, 2006). Scholars initially disagreed over the definition and purpose of EBPs, which changed over time until a consensus was reached to use the terms $EBP$ and $EBT$ for specific treatments (Norcross, Beutler & Levant, 2006).
The Institute of Medicine Committee on Quality of Health Care in America (2001) defined EPBs as “the integration of best-researched evidence and clinical expertise with patient values” (p. 147). It was decided that in order to be classified as an EBP, an intervention must reveal consistent scientific evidence that it improves client outcomes. The Agency for Healthcare Research and Quality identified three levels of scientific evidence in the 1990s:

- **Level A**: good research-based evidence, with some expert opinion
- **Level B**: fair research-based evidence, with substantial expert opinion to support the recommendation
- **Level C**: a recommendation based primarily on expert opinion, with minimal research-based evidence (Institute of Medicine Committee on Quality of Health Care in America, 2001).
The American Psychiatric Association (APA) also released guidelines based on a combination of expert consensus and research, but it has set the highest standard for research as a meta-analysis of randomized clinical trials, comparing the practice to alternative practices or no intervention (Solomon & Stanhope, 2004). The APA (2006) re-defined evidence-based practice as incorporating research evidence, clinical expertise, and client context. This APA definition of evidence-based practice could be considered pragmatic, as it accounts for client context when making best-practice decisions (Field, 2012). Similarly, the Code of Ethics of the American Counseling Association (2014) mandates that “[c]ounselors use techniques/procedures/modalities that are grounded in theory and/or have an empirical or scientific foundation” (p. 10).

To be consistent with current requirements, research into counseling and psychotherapy has sought to identify the most effective approaches and to delineate EBPs based upon various findings. The Council for the Accreditation of Counseling and Related Educational Programs (CACREP) now requires that trainee counselors in addictions counseling, clinical mental health counseling, and marriage, couple, and family counseling demonstrate knowledge of “evidence-based treatments” (CACREP, 2009, Standard I.3, p. 21).

There are different perspectives on exactly what it takes for a treatment to be considered evidence-based (Anderson, 2006). In general, the scientific community looks at the number of research studies, the quality of those studies, and whether experts agree that the treatment works (APA, 2006). Evidence-based treatments have been tested in multiple research studies. One study is not enough to prove whether a treatment really works. Confidence grows when studies are repeated, and researchers find the same outcome. This is especially true when treatments have been studied by different researchers in different settings, reporting similar results (Cook et al., 2014). The quality of those studies is important as well. In high-quality studies, the subjects
in the study are in the category of people who would use the treatment being tested. In addition, the treatment being tested is compared to another treatment or to no treatment, and participants are randomly assigned to the treatment groups. That way, researchers know that the groups are the same at the start, and that improvement during the study stems from the treatment (APA, 2006). Another characteristic of evidence-based treatments is expert agreement on the effectiveness of the treatment. If a study is published in a scientific journal, it means reviewers examined the study and agreed with the conclusions (APA, 2006). There are also organizations, such as the Institute of Medicine, American Psychiatric Association, and Department of Veteran Affairs, that review studies and publish recommendations identifying evidence-based treatments. The stronger the recommendations that a treatment is effective, the more confidence one can have that the treatment has good outcomes. For instance, the Substance Abuse and Mental Health Service Administration (SAMHSA, 2016) has created a National Registry of Evidence-based Programs and Practices (NREPP) for program developers and researchers interested in disseminating their findings. There four minimum requirements for submissions:

- The intervention has produced one or more positive behavioral outcomes (p ≤ .05) in mental health or substance abuse misuse among individuals, communities, or populations.
- Evidence of these outcomes has been demonstrated in at least one study using an experimental or quasi-experimental design.
- Results of these studies have been published in a peer-reviewed journal or other professional publication such as a book volume, or documented in a comprehensive evaluation report.
- Implementation materials, training and support resources, and quality assurance
procedures have been developed and are ready for use by the public. (National Registry, 2016, para. 14)

According to Messer (2004), not every trauma-focused therapist provides services neatly on one or the other side of EBPs. In addition, alternatives now available for practitioners to draw on for an empirically oriented practice are studies on empirically supported relationships, or ESRs (Norcross, 2002). The ESR literature focuses on people, not disorders—namely, the roles of the therapist and the client, and their interaction in contrast to the ESTs’ emphasis on techniques and treatment packages. For example, three general elements of the therapeutic relationship that have been shown to correlate with therapy outcome are the quality of the therapeutic alliance, therapist empathy, and agreement and collaboration around goals (Messer, 2004).

Evidence-based Practice and Sexual Violence Interventions

Many researchers have shown interest in EBPs in psychotherapy. The emergence of EBPs regarding treatment effectiveness, training, supervision, and best practices in general is a given in the mental health field (Aarons et al., 2010; Anderson, 2006; Messer 2004, Solomon & Stanhope, 2004). However, specific areas in the mental health field, including sexual violence treatments, lack data with regard to trauma-focused therapists’ perceptions of EBPs (Gray et al., 2007). “At the present, little is known about trauma therapists’ attitudes regarding EBPs, and it would be particularly interesting to examine this issue among trauma practitioners” (Gray et al., 2007, p. 735).

Messer (2004) posed a timely question concerning the controversy that surrounds EBPs in psychotherapy: “Must the clinician choose between a practice that is strictly objective and data based and one that is purely subjective and experience based?” (p. 580). Levers (2012) noted that
the subject of trauma treatment raises several questions that lead to the answer “it depends.” She emphasized that “so many factors influence a decision concerning trauma survivors and how to go about choosing a treatment” (p. 1). Without disregarding the benefits of both practices, the discussion surrounding EBPs is still a dilemma in the mental health field (Gray et al., 2007; Solomon & Stanhope, 2004). Researchers and clinicians interested in improving mental and behavioral services struggle to decide whether or not to use a specific approach to counsel their clients (Messer, 2004).

Although research shows that cognitive behavioral therapies are mostly used when treating survivors and victims of sexual violence (Seidler & Wagner, 2006), little is known about trauma therapists’ perceptions and lived experiences when delivering EBPs interventions to survivors of sexual violence. Some researchers suggest that there may be considerable variability among trauma professionals’ attitudes regarding EBPs (Aarons, 2005; Gray et al., 2007). Okiiski, Lambert, Nielsen and Ogles (2003) stated that “research about effective treatments generally assumes that the individual therapist is a relatively unimportant part of the outcome equation, rather than the central figure that facilitates patient improvement” (p. 361).

The implementation and dissemination of EBPs have been a part of the effort to promote them to many professionals in the mental health field. For instance, several American Psychological Association (APA) divisions including Division 12 (Clinical Psychology), Division 29 (Psychotherapy), and Division 17 (Society of Counseling Psychology) have offered additional frameworks for integrating EBPs on regular practice (Anderson, 2006). However, since the Task Force on Promotion and Dissemination of Psychological Procedures (1995), professionals in the mental health field, including trauma-focused therapists, have expressed concerns regarding the structure of EBPs, which are usually brief, and protocol oriented or
manualized. Clinicians and researchers alike stated that factors such as therapeutic relationship, comorbidity, race, ethnicity, and culture raised questions regarding EBPs and instead suggest that studies on empirically supported relationships (ESRs) would be valuable (Anderson, 2006; Messer, 2004; Norcross 2004). Okiiski et al. (2003) supported researchers and clinicians in improving patient outcomes through studies that explore the treatment response of clients as a function of the therapist, discussing a move towards empirically-supported therapists. In light of this ongoing discussion regarding EBPs and the lack of data with regard to trauma-focused therapists’ perceptions of EBPs, this research is interested in exploring the lived experiences of trauma-focused therapists as a means to understand their perceptions regarding EBPs when delivering sexual trauma interventions.

Although we have made great strides in the past decades toward better understanding posttraumatic stress reactions, we need to redouble our efforts to examine the processes involved in treating survivors of sexual violence. Such comprehension is essential to developing and refining interventions, regardless of empirical evidence criteria.

**Trauma-focused Therapists**

Trauma-focused therapists or therapist commit themselves to working with survivors of sexual violence in different phases of their trauma, from rape and sexual assault to childhood sexual abuse. These clinical experts’ competency and skills accounts for a great part of the treatment (Johnsen & Friborg, 2015). Trauma-focused therapists work directly with those individuals who have experienced a traumatic event (Cook et al., 2014). The increase in the number of sexual assaults reported by the CDC illustrates the need for specialized intervention to address a very serious issue (2014). It is important to mention that the numbers from the CDC account for reported sexual assaults only; many people who have been victimized have never
sought legal and/or mental health services because of shame and the fear of not being believed. In the United States, every 2.5 minutes a person is sexually assaulted (CDC, 2014). The need to improve services offered for victims and survivors of sexual violence is based on the statistics, which show an increase in these incidents; people have a responsibility to respond and help survivors reclaim their power (Herman, 1992). Similarly, developing trauma-focused treatments is necessary for survivors to process trauma and decrease symptoms related to their posttraumatic stress difficulties.

As more cases of sexual violence and childhood sexual abuse occur within society, so does the need for counseling services to assist individuals in need. Thousands of rape and crisis centers, crisis hotlines, sexual victims units, and survivors support groups have emerged in light of the rise of sexual violence. Many efforts have been made to increase awareness of sexual violence issues from local groups to national campaigns, such as No more, which was launched in 2013 by the U.S. Department of Justice along with several non-profit organizations. A unique aspect of campaigns to increase public awareness has been to encourage survivors to seek mental health help. The immediate and long-term assistance usually comes from trauma-focused therapists who work in agencies or private practice, delivering sexual trauma interventions to victims and survivors of sexual violence. Therefore, qualitatively exploring trauma-focused therapists’ perceptions and lived experiences of EBPs when delivering sexual trauma interventions to clients can contribute to a better understanding of posttraumatic stress from sexual violence. No studies to date have examined trauma-focused therapists’ perceptions and lived experiences of EPBs specifically in the field of sexual violence. Given that the emergence of EBPs has been discussed as an essential aspect of psychotherapy, it seems crucial that an exploration be completed on trauma-focused therapists’ lived experiences when delivering
sexual violence interventions to clients. Okiishi et al. (2003) pointed out that “there is an urgent need to take account of the effectiveness of the individual therapist, and it is time for clinicians to welcome such research” (p. 372). Not only might such information provide some insight into the degree of their lived experiences in practicing trauma-focused counseling, but it may also increase the likelihood that studies on future approaches will be adopted by clinicians. Courtois and Ford articulated a common question in the trauma field: “How can the profession remain true to strength-based counseling theory and practice in a medical model world that demands diagnosis and labeling of clients? (2009, p. 45).

The personal aspect of the therapist is an important and sometimes overlooked factor as well. Clinicians and researchers alike have argued against the medical model and have emphasized that who the psychotherapist is directly relates to his or her ability to establish and maintain effective therapy relationship with clients (Hansen 2006; Messer, 2004). Abundant research has indicated the centrality of the person of the therapist as a primary factor in successful therapy (Norcross & Lambert, 2011; Norcross & Wampold, 2011). Clients value the personality of the therapist more than the specific techniques used (Lambert, 2011). Norcross and Lambert (2011) elaborated on considerable evidence indicating that “the person of the psychotherapist is inextricably intertwined with the outcome of psychotherapy” (p. 18).

The Department of Veteran Affairs (VA) completed qualitative interviews with 198 providers from 38 VA residential posttraumatic stress disorder treatment programs across the United States from 2008 to 2010 (Cook, Dinnen, Simiola, Thompson, & Schnurr, 2014). The investigation of the VA study was not focused on sexual violence interventions; however, it sought answers regarding implementation of two evidence-based treatments. Both considered trauma-focused treatments: Prolonged Exposure (PE) and Cognitive Processing Therapy (CPT).
Trauma-focused providers were asked how they decided which patients are appropriate for these treatments (Cook et al., 2014). Findings indicated that many providers did not perceive any patient factors that discouraged them from using EBPs. However, three broad categories surfaced in terms of reasons that clients were perceived to be less suitable candidates for certain treatments: the presence of psychiatric comorbidities, and low levels of patient motivation (Cook et al., 2014, p. 136). According to Cook et al., theirs was the first study to report on provider perceptions regarding the use of EBTs in a national sample of VA residential treatment programs. Gray et al. (2007) used Aarons’ (2005) Evidence-Based Practice Attitude Scale (EBPAS) to evaluate attitudes toward and use of EBPs among mental health professionals specializing in trauma. The findings showed that an overwhelming majority of the 461 trauma professionals who completed the survey supported the use of EBPs. However, the authors emphasized that although a “favorable disposition toward EBPs does not necessarily connote that one actually uses such interventions regularly in practice, it is arguably the case that unfavorable opinions about EBPs preclude their usage in practice” (Gray et al., 2007, p. 734). Although not trauma specific, Cook, Schnurr, Biyanova, and Coyne (2009), measured the influences on psychotherapists’ adoption and sustained use of new therapies. The study investigated 2,607 U.S. and Canadian psychotherapists via a web-based survey in which they rated factors that influenced their clinical practice. According to their findings “empirical evidence had little influence on the practice of mental health providers” (p. 673). Evidence from surveys assessing providers’ perceptions of EBPs is not often examined; thus, more studies are needed to explore the divide among trauma-focused clinicians concerning whether or not they adopt EBPs (Aarons, 2010; Cook et al., 2009; Cook et al., 2014; Messer, 2004).
Every therapeutic approach comes with limitations, whether or not empirically supported; thus, even though clinicians in general support EBPs, many believe that they undermine the therapeutic relationship (Field, 2012). Clinicians and researchers alike have pointed out that the rapport created throughout the therapeutic process is imperative to the client's progress, and is in no sense insufficient (Norcross & Lambert, 2011). They also believe that structured inventories can be excessive and ineffective, as some clients could become discouraged or assessed falsely. The therapeutic alliance is thus germane, as the therapist must understand the client fully in order to treat their condition effectively without the limitations of protocols.

**Sexual Violence**

It has been almost half a century since studies on sexual violence have emerged (Carlson, 2005). Since it started, a large body of literature has examined how trauma affects survivors of sexual violence. Several forms of treatment, interventions, and diagnosis have delineated the way clinicians help their clients during the healing process. Many survivors of sexual violence eventually develop mental health problems, most frequently PTSD, which is strongly related to sexual trauma (Carlson, 2005; Briere & Spinazzola, 2009). The impact of sexual violence, which has been well documented, can affect an individual in all aspects of his or her life: physically, psychologically, and spiritually (Tummala-Narra et al., 2012).

Tjaden and Thoennes (2000) presented data showing that both boys and girls are vulnerable to sexual abuse. Their report showed that one in four girls and one in six boys are sexually abused before they reach the age of 18. According to Snyder (2000), sexual assaults are most often perpetrated by someone who has a very close relationship with the victim, such as a father, husband, or boyfriend, with 93% of victims knowing their perpetrator (Snyder, 2000). Of those who sexually abuse children, approximately 77% are adults and 23% are juveniles. From
this data, we can project that a high percentage of the U.S. population has experienced sexual violence of some sort. For instance, according to the Pennsylvania online annual crime reports, there were 3,828 rape offenses reported by Pennsylvania police agencies in 2014, an average of 10 each day, or one every 2 hours and 17 minutes. This is an increase of 1.1 percent from the 3,787 offenses reported the previous year. Rape offenses comprised 1.3 percent of the crime index and 9.5 percent of the violent crime index. (Pennsylvania Uniform Crime Reporting System, 2016, para. 1, Summary)

Traumatic events, such as rape and physical assault, have been associated with posttraumatic stress, anxiety, and depression (Briere & Spinazzola, 2009). In addition, interpersonal issues can cause survivors to retreat into the self and become isolated from others. Among many issues, lack of trust, guilt, and self-blame hinder the person from developing a fulfilling and meaningful life. Sexual violence trauma can alter survivors’ experiences and the meaning of their lives. Herman (1992), who has written eloquently about trauma and recovery, spoke of the fundamental stages of recovery: (1) the establishment of safety; (2) remembrance, integration, and mourning or the in-depth exploration of the traumatic experience; (3) reconnection or the establishment of mutually satisfying and non-exploitative relationships. She described the recovery process as “running a marathon,” wherein a survivor recognizes that recovery is a “test of endurance, requiring long and repetitive practice” (p. 174). The complexity and subjectivity of sexual violence trauma makes the diagnosing and treating of posttraumatic stress a challenge for trauma-focused therapists who work with this population.

Despite comprehensive research in the trauma field, more studies are needed to assist trauma-focused therapists in providing treatment that will help survivors cope and recover from posttraumatic stress difficulties. Considering key factors involved in trauma-focused therapists’
perceptions of their approach to sexual trauma interventions may offer new insight into meaningful counseling for survivors of sexual violence. Research has shown that a high number of the population has experienced sexual abuse; this fact calls for more studies in the field of trauma interventions. Because trauma-focused therapists are a fundamental part in the healing process, examining their perceptions could provide new ways of exploring sexual trauma interventions. Therefore, using a qualitative inquiry to examine trauma-focused therapists’ perceptions of and lived experiences with using EBPs in sexual trauma interventions may facilitate access to appropriate and informed trauma-focused care for survivors.

**Interventions for Sexual Violence**

Studies have examined different approaches in an attempt to find the most efficient way for treating symptoms developed after sexual trauma. Cognitive, behavioral, and humanistic approaches have been used to help victims of sexual violence in the recovery process to cope with posttraumatic stress difficulties. D’Andrea and Pole (2012) examined the relationship between trauma-focused processes, and although the findings were limited by not knowing the validity of the therapy process measured, the study was fundamental as it observed different approaches when treating survivors experiencing PTSD symptoms. The authors found that therapy highlighting “relaxation, relationships, affect, and meaning-making appeared to be more helpful than therapy that emphasized exposure to trauma reminders” (p. 444). In addition, D’Andrea and Pole (2012) mentioned numerous studies done over the last three decades regarding psychotherapeutic processes and PTSD symptom reduction from various traumatic occurrences, including sexual violence. They mentioned psychodynamic therapy as the earliest therapy for trauma issues. Other therapies, such as cognitive–behavioral therapies (CBT), were widely studied, and prolonged exposure (PE) therapy was considered the first-line treatment for
posttraumatic stress disorder. Along with CBT, eye movement desensitization and reprocessing (EMDR) has been in the forefront of evidence-based therapies. Francine Shapiro (2001), the originator and developer of EMDR, stated the “rape victims constitute the largest population of PTSD sufferers and [are] the only homogeneous group besides combat veterans that has been the focus of controlled clinical outcome research” (p. 24).

**EBPs and Cultural Factors**

It is important to consider that limitations have been pointed out regarding cultural factors in EBPs (Foa et al., 2009). Solomon and Stanhope (2004) stated that taking account of cultural differences is not an EBP premise, thus, EBPs have not shown effectiveness in interventions for racial, ethnic, and cultural minorities. Thus racial or ethnic minorities have often not been included in research for evaluating interventions. Since empirically based treatments are usually protocol based, cultural factors are dismissed. A 2006 report from APA recognized that social factors and cultural differences necessitate different forms of approaches. The APA Presidential Task Force on Evidence-Based Practice report attempted to include cultural factors, stating that “evidence-based practice in psychology (EBPP) is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences” (2006, p. 273). However, the inclusion of culture is an important aspect of trauma-focused counseling (Levers, 2012). Carlson (2005), for example, emphasized that culture matters when trauma is concerned. In working toward an exploration of the lived experiences of trauma-focused therapists, the current study is challenged to capture social factors and cultural implications related to clinical work. A contribution to the field of mental health and trauma work can be meaningful only if researchers and clinicians pay attention to the contexts in which therapeutic performance occurs (Betan & Binder, 2010). Therefore, an approach that cannot be
made relevant to survivors suffering, and to their unique needs based on their cultural
differences, is not helpful.

Theoretical Perspectives

Over the last few decades studies have defined the consequences of trauma and the
literature associated with treatment approaches to posttraumatic stress disorders regardless of its
nature. The research on PTSD is primarily quantitative and lacks a qualitative study of the lived
experience of trauma-focused therapists and their perceptions of EBPs when delivering sexual
trauma interventions to clients. This qualitative phenomenologically oriented study has used van
Manen’s (1990) lifeworld existential as a theoretical basis to capture the lived experience of
trauma-focused therapists with EBPs when delivering sexual trauma interventions to clients. The
lens of Bronfenbrenner’s (1997) ecological models of human development has helped to frame
the complex system that affects trauma-focused therapists as they use EBPs to treat survivors of
sexual violence.

Max van Manen’s Lived Existentials

This study, a qualitative, exploratory inquiry, is guided by a phenomenological approach.
In capturing the lived experience of trauma-focused therapists, Max van Manen’s concept of
hermeneutic phenomenology has been used to support the methods and procedures that answer
the research questions. The four existential themes that have guided the inquiry are “lived space,
lived body, lived time and lived relation” (van Manen, 1990). They have been applied in the
context of the lived experiences of trauma-focused therapists. Lived space is not only the
physical space in which trauma-focused therapists practice but also how they experience their
day-to-day activities as a clinician. Lived body is trauma-focused therapists’ understanding of
their physical presence in the world as practitioners. Lived time refers to a trauma-focused
therapist’s biography, in which the past influences the present and future, and the present or future, in turn, influences perceptions of the past. Lived relation is trauma-focused therapists’ interactions with others or relationships that share space in their lives. According to van Manen (1990), “These four existentials of lived body, lived space, lived time, and lived relation to the other can be differentiated but not separated. They all form an intricate unity which we call the lifeworld or our lived world” (p. 105). In order to conceptualize the large amount of data that often is produced with qualitative designs, these existentials are essential in understanding and framing the lived experiences of trauma-focused therapists as they express their experiences of using EBPs to deliver sexual trauma interventions to clients.

Van Manen (1990) believed that phenomenological research always emphasizes the meaning of the lived experience and that it is essential “to look for related notions in phenomenological sources to find relevant material” (van Manen, 1990, p. 75). He also discussed the use of personal experience as a logical starting point for phenomenological research, on the grounds that others may also experience what one person has experienced. This aspect was, in fact, the motivation for this research study. The researcher has observed that many trauma-focused therapists working with victims of sexual violence seem resistant toward implementing EBPs. Hence, the aim of this study is to explore trauma-focused therapists’ perceptions of this phenomenon and to determine whether research and practice are still struggling to find common ground in clinical work with clients who have experienced sexual violence.

**Phenomenology**

In phenomenology, the researcher tries to understand and reflect on the essential meaning of life experiences at a deep level (van Manen, 1990). The researcher elicits rich and descriptive data in order to approach a lived experience with a sense of purpose. Creswell (2013) affirmed
that “a phenomenological study describes the common meaning for several individuals of their lived experiences of a concept or a phenomenon” (p. 76). Exploring trauma-focused therapists’ perceptions of EBPs when delivering sexual trauma interventions taps into an experience not previously studied or shared within the field of psychological trauma. By using a phenomenological approach, the researcher has been able to identify certain themes among the individual experiences. These themes, in turn, have served as “the experiential structures that make up that experience” (van Manen, 1990, p. 79).

Phenomenology, being the study of lived experience, what people experience, and how they experience it (Moustaka, 1994), offers its audience a “deeper understanding of the nature or meaning of our everyday experiences” (van Manen, 1990, p. 9). Phenomenology can be divided into descriptive phenomenology, which was created by Husserl, and interpretive-hermeneutic phenomenology, as created by Heidegger (Moustaka, 1994). The descriptive and interpretative nature of these phenomenology approaches contrasts with quantitative approaches. Therefore, a phenomenological approach does not seek to explain or control events; instead, it attends to the potential array of plausible insights that might bring one closer to the truth of an individual’s reality (Valle, 1998). This truth provides a deeper understanding of the world we live in and perhaps guides us toward taking actions that might bring about improvement. Employing a phenomenological framework, this study inquires into trauma-focused therapists’ lived experience of EBPs when delivering sexual trauma interventions to clients. The themes that emerge as trauma-focused therapists express their perceptions and lived experiences may lead to a better understanding of how these clinicians perceive EBPs and perhaps suggest what might be done more effectively to illuminate changes in the field of posttraumatic stress and sexual violence.
Hermeneutic Phenomenology

In order to understand the experience of trauma-focused therapists, this study employs hermeneutic phenomenology as a method for obtaining detail and description as well as meaning from engaging with trauma-focused therapists. Through a phenomenological lens, this research focuses on what is essential to being and what we expect to continue exploring in the counseling profession, especially in the field of sexual violence.

The methodological process of hermeneutic phenomenology seeks the descriptive as well as the interpretive. The methodology focuses on the descriptive (phenomenology) and the interpretive (hermeneutic) components of each reflection because they are an inseparable process that is necessary to reconstruct the lived experience (van Manen, 1990; Moustaka, 1994; Creswell, 2013). Hermeneutic phenomenology aims not only at comprehending the phenomena but also understanding it from the inside and then writing descriptions to identify the themes and meanings that emerge (van Manen, 1990). The hermeneutic methodology allows for a deeper description as well as interpretation of the lived experience. It also encourages a reflection on the experience and the meaning behind it. The hermeneutic process aims at extracting meaningful data about the lived experience as it really happens, not as people conceptualize it. The methodology has provided the structure for an evocative exploration of the lived experiences of trauma-focused therapists.

Bioecological Model of Human Development

Bronfenbrenner’s bio-ecological model (1979) has been extensively used in studies to aim at understanding how an individual’s development is affected by the environment. The bio-ecological model is adaptable in this study not only for understanding trauma-focused therapists development but also in comprehending their perception of EBPs in everyday practice. This
model, overall, has helped the researcher to explore the interconnected characteristic of trauma-focused therapists’ experiences, their perceptions in working with EBP approaches, and the impact of EBP systems on their attitudes toward treating survivors of sexual violence.

Bronfenbrenner’s (1979) theory has been implemented to help the researcher to explore the perceptions of trauma-focused therapists within the context in which they use EBPs. Bronfenbrenner’s (1979) theory describes complex “layers” of the environment, each having an effect on the therapists’ change. The bio-ecological model suggests that any change or divergence within one layer will influence other layers. To study trauma-focused therapists’ perceptions of EBPs, it is essential to contemplate some of the subsequent dynamics that affect the therapist’s ability to use EBP approaches: the relationship that therapists have with their clients, their supervisors, their agencies (if applicable), the therapists’ competency to work with survivors of sexual violence, and their theoretical approaches to counseling. To understand therapists’ perceptions of EBPs when working with survivors of sexual violence, one must consider not only his or her perceptions of trauma-focused approaches but also how other systems have influenced the decision to use EBPs. Bronfenbrenner (1979) discussed five layers or systems that are interconnected. These systems are the microsystem, mesosystem, exosystem, macrosystem, and chronosystem. In the context of this study, these systems have been used to explore trauma-focused therapists’ relationships and connections that have influenced their experience when delivering sexual trauma interventions to clients.

**Integrative Systemic Approach to Trauma (ISAT)**

Levers’ (2012) integrative systemic approach to trauma is an emerging model used to understand the multifaceted effects of trauma. The ISAT model takes into consideration multimodal systemic and integrative approaches to helping survivors of trauma (Levers, 2012.)
The ISAT conceptual framework relates to the bioecological structure, which considers all connections amongst individuals and their respective systems. The ISAT integrates three interconnected elements: clinical relationship, nexus of personal treatment issues, and broader systemic and cultural influences. The clinical relationship comprises the client-clinician dyad, as well as other relationships contributing to a client’s healing process. The nexus of personal and treatment issues incorporates matters associated with all of the individuals involved in trauma treatment, from both ends—clients and the professional counselor (Levers, 2012.) The broader system and cultural influences take into consideration the overall treatment systems that affect the process and consequently the outcome of care. Levers (2012) stated that these “elements represent an ecological perspective of counseling survivors of trauma” (p. 580). In the context of this study, these elements offered a conceptual framework for understanding multiple levels that have influenced trauma-focused therapists’ experience when treating survivors of sexual violence.

**Risk and Protective Factors Related to EBPs**

The constructs of risk and protective factors are essential and often examined within the framework of the bio-ecological model of human development (Bronfenbrenner, 1979, 2005). Lynch and Levers (2007) have discussed the role of protective and risk factors, noting that an essential characteristic of Bronfenbrenner’s model is the rich framework it provides for clinicians in assessing risks and protective factors in the lives of clients and in constructing interventions that can minimize or eliminate risks, mediate risks, or foster or enhance protective factors. This provides a vast horizon for creative applications, both theoretically and clinically. (p. 590)
In the last 20 years there has been a growing understanding of EBPs and the presence of risk and protective factors upon clinical acceptance. Since the efforts of the American Psychological Association Division 12 Task Force on Promotion and Dissemination of Psychological Procedures (Task Force, 1995), mental health providers have been highly encouraged to use best practice guidelines. Therefore, the potential risks for not using empirically-based treatments have increased. Hansen (2006) pointed out that within the counseling profession, EBPs may be used out of fear of becoming less competitive with other professions in the mental health services. He also stated that treatment manuals usually outline session-by-session activities for the therapist. To deviate from the protocol could alter the outcome and consequently the efficacy of treatment delivery increasing dropout rates and decrease symptoms. APA (2005) informed about the risk that best practices guidelines might be used inappropriately by commercial health care organizations that are unfamiliar with the scientific basis of practice to direct particular forms of treatment and control client care. For example, Sanderson (2003) cited the wording from the Agency for Health Care Policy and Research (1993) guidelines for depression, which states that when psychotherapy is to be selected as the sole treatment,

[t]he psychotherapy should generally be time limited, focused on current problems, and aimed at symptom resolution rather than personality change as the initial target. Since it has not been established that all forms of psychotherapy are equally effective in major depressive disorder, if one is chosen as the sole treatment, it should have been studied in randomized controlled trials. (p. 292)

As clinical guidelines and EBPs continue to emerge for various psychological and emotional issues, including posttraumatic stress difficulties, they will have a significant impact
on the way trauma-focused therapists deliver sexual trauma interventions. According to Sanderson (2003), “in effect, these documents set standards of care, which if ignored, leave the clinician both ethically and legally vulnerable” (p. 293). Sanderson (2003) even reiterated that “the implications are clear: Failure to provide an empirically supported treatment from these guidelines, when one exists, may constitute malpractice in the eyes of the payer” (p. 294). Some authors have argued that a rigorous dependence on EBPs, meaning manualized treatment protocols, might influence clinicians’ abilities to address “the novel and unpredictable circumstances” (Betan & Binder, p. 146).

**Summary**

Extensive research has been conducted on the phenomenon of trauma and its effect on individuals after a traumatic event. As more empirical data is collected to validate posttraumatic issues, questions remain concerning how treatment is perceived, what motivates trauma-focused therapists, and how trauma-related variables are explored. Much empirical research has been conducted validating evidence-based approaches, wherein trauma-focused therapies are usually assessed using clients’ experiences, and the methodology used is predominantly quantitative. No studies in the professional literature so far have used a qualitative methodology to examine clinicians’ perspectives on using EBPs to treat sexual trauma. Researching the lived experiences of trauma-focused therapists may give insight into the motivating aspects involved in practicing trauma-focused counseling, whether EBP or not.

This study is a qualitative examination of the perceptions and lived experiences of trauma-focused therapists with regard to employing EBPs when delivering sexual trauma interventions to clients. The study seeks to illuminate the phenomenon of EBPs in treating survivors of sexual violence. This study may provide a richer understanding of trauma-focused
therapists’ perceptions in using specific approaches along with insights in counseling interventions for trauma survivors of sexual violence.
Chapter III: Methods

Introduction

Dissemination and implementation of EBPs have been the source of ongoing discussion since their introduction into mental and behavioral health (Messer, 2004). Studies related to EBPs have been conducted using quantitative methods to provide measurement and data on particular outcomes and interventions, most often focused on clients’ perspective (Barkham & Mellor-Clark, 2003). Even though researchers have continued to demonstrate interest in as well as demand knowledge from therapists providing trauma-related care, only a few studies have directly examined providers’ attitudes toward EBPs (Aaron, 2004, 2010; Gray et al., 2007). To date, no studies have explored trauma-focused therapists’ perceptions of EBPs in treating sexual trauma. This study used qualitative methods in attempting to expand understanding of trauma-focused therapists’ experiences with and perceptions of EBPs when delivering sexual trauma interventions to clients. Thus, this exploration was intended to add to the scarce literature regarding the perceptions of trauma-focused therapists concerning the use of EBPs, especially in relation to sexual trauma. This chapter details the theoretical framework, research methodology, purpose of the study, research design, data collection and analysis, and study limitations.

Theoretical Framework

In order to shape the process of investigating trauma therapists’ lived experiences, this study used a hermeneutic phenomenology approach. According to van Manen (1990), phenomenology is the study of the dynamic meaning-making process of lived experiences. In other words, it is the study of the life world in the context of the phenomenon being investigated. Fischer (1998) defined phenomenology as that which
addresses how human “consciousness” forms what we understand of the world. It is the study of (“ology”) what appear to us (“phenomena,” [as opposed to “noumena”- things in themselves]). In this context, phenomenology as a philosophical foundation for psychological inquiry is distinct from the North American use of the term in which phenomenology refers simply to taking experience seriously, or in medical contexts to identifying similar patterns of symptoms with diverse etiology. Instead, phenomenology, as a philosophy of being and knowledge, grounds the empirical psychological study of meaning as they occur in and across situations. (p. 114)

Phenomenological underpinnings enable researchers to explore the essential meaning of a person’s experience and to understand how humans transform experience into consciousness. A rigorous methodology is required to describe, carefully and thoroughly, and capture well the lived experience of a phenomenon (Patton, 2002). From a phenomenological perspective, the understanding of consciousness and of how individuals make meaning of an experience is more important than the pragmatic facts that describe the experience.

Hermeneutics is another theoretical approach that informs qualitative inquiry. The hermeneutic perspective is essential for comprehending and elucidating the meaning of a text (Moustakas, 1994). Hermeneutics offers a perspective for interpretation and unfolds the elusive meaning of the phenomenon. McCall (1983) gives this definition: “Hermeneutic (from the Greek for ‘interpretive’) is a standard term in Biblical theology… It conveys the idea of clarification of the meaning present” (p. 63). Hermeneutics, however, emphasizes that an interpretation is one perspective which cannot be viewed as absolutely true or correct (Ashworth & Chung, 2006). Although there are distinct philosophical differences between hermeneutics and phenomenology, van Manen (1990) attempts to incorporate the two methodologies. According to van Manen
(1990), “phenomenology (as pure description of lived experience) and hermeneutics (as interpretation of experience via some ‘text’ or via some symbolic form) are essential approaches in the search of lived experiences” (p. 24). Thus, the use of the phenomenological approach is fundamental for this study, as it was employed in the hope of gaining a deeper understanding of trauma-focused therapists’ perceptions and lived experiences of EBPs when delivering sexual trauma interventions to clients. For interpreting and analyzing the lived experiences in this research, van Manen’s (1990) four life world existentials were used as guides to reflection: lived space, lived body, lived time, and lived human relation.

Bronfenbrenner’s (2005) bio-ecological model of human development was also employed as another method of reflecting on the dynamic relationship between individuals and their environments. To clearly understand the perceptions and experiences of trauma-focused therapists, it is essential to consider the lens of the ecological model of human development to foster a better comprehension of their systems. Bronfenbrenner (1979) defined the ecology of human development as follows:

The ecology of human development involves the scientific study of the progressive, mutual accommodation between an active, growing human being and the changing properties of the immediate settings in which the developing person lives, as this process is affected by relations between these settings, and by the larger contexts in which the setting are embedded. (p. 21)

In an effort to understand the perceptions and lived experiences of trauma-focused therapists, the data have been interpreted according to the various systems in the bio-ecological model. Bronfenbrenner’s (1979, 2005) ecological systems consist of the microsystem, mesosystem, exosystem, macrosystem, and chronosystem (p. 80). In this study, the microsystem is that which
is closest to trauma-focused therapists. It is a direct, face-to-face system, and it has the most influence when delivering sexual trauma interventions to clients. At this level the relations between therapist and client happen in two ways. Therapists in a microsystem influence the clients’ treatment and understanding of the counseling process, but clients can also influence the therapists’ perceptions and processes in delivering an intervention. Bronfenbrenner (1979, 2005) called this phenomenon “bi-directional influence” and points out that such relationship exist on all environmental levels. This inner system is also influenced by outer levels, which mean that changes in the exosystem can affect clients.

The mesosystem is the next layer; this can include the therapeutic relationship, working environment, coworkers, and peers. This layer produces the connections between the structures of therapists’ microsystems. A good example in this study is the connection between therapists and their peers and supervisors. Next is the exosystem, which is the linkage process that occurs between two or more settings (Bronfenbrenner, 1979, 2005). It includes the larger systems that might affect therapists’ decisions to use a specific intervention(s) when treating sexual trauma survivors. Community, mental health agencies, crisis centers, society, and culture can all be part of this layer. In the context of this study, the therapists’ exosystem can be the agency or private practice policy, counseling system, and administrative decision. The next layer is the macrosystem, which is the overarching pattern of micro, meso, and exosystems that exist at the level of subculture, the culture as a whole (Bronfenbrenner, 1979, 2005). Legal mandates, values, rules, and laws can be included in this layer. It is critical in delivering interventions to sexual trauma clients because trauma-focused therapists are influenced by ethical professional guidelines. For example, the pressure in the mental health system to only use EBPs as referred to earlier falls into this layer. The last layer is the chronosystem, which encompasses the dimension
of time as it relates not only to the characteristics of the individual, but also to the environment in which that individual lives. The chronosystem models may be either short or long term (Bronfenbrenner, 2005). This layer is related to existential or lived time (van Manen, 1990), and it can relate to any major transition in a therapist’s life. A good example can be therapists’ own experiences with trauma, including loss or separation of a loved one, which can influence the way they perceive traumatic experiences overall.

Finally, the use of the ecological theory of human development for this study facilitated an exploration of the environment, including the complex interactions occurring in the lived experiences of trauma-focused therapists. The ecological developmental lens also contributed to examining the risk and protective factors involved in the processes related to the phenomenon.

**Purpose of the Study**

The purpose of the study was to illuminate trauma-focused therapists’ perceptions and lived experiences of EBPs when delivering sexual trauma interventions to clients. According to Barkham and Mellor-Clark (2003), there is a gap between practice and research in the literature. A better understanding of this phenomenon may allow clinicians and researchers in the mental health field to proceed from a more informed perspective in terms of the implementation and dissemination of EBPs in treating sexual trauma. In seeking to explore this phenomenon, the study addressed this question: (1) How do trauma-focused therapists perceive evidence-based practices in treating sexual trauma?

In this phenomenologically oriented study, description and interpretations relied upon methods, instruments, and data explication that are traditional to qualitative inquiry. Investigations have been done in the mental health field regarding EBPs, providers’ attitudes, and sexual trauma interventions, but an insufficient amount of literature has been produced on
how trauma-focused therapists perceive empirically supported approaches. Because little is known about the experiences of clinicians in the field of trauma, this study used a qualitative design to examine trauma-focused therapists’ lived experiences. The qualitative lens in this study provided an opportunity to capture more than just a description of text of the lived experience; it also generated interpretations of the real lived experience (Moustakas, 1994).

**Research Design**

A qualitative research design was used for this study, oriented by a phenomenological approach. Merriam and Tisdell (2015) stated that “[e]ngaging in systematic inquiry about your practice—doing research—involves choosing a study design that corresponds with your question; you should also consider whether the design is a comfortable match with your worldview, personality, and skills” (p. 2). Using a phenomenological approach supports the researcher’s “focus on describing what all participants have in common as they experience a phenomenon” (Creswell, 2013, p. 76). Further, a person’s meaning and experience are essential to interpreting the data. The aim of the study was to describe comprehensively the essence of trauma-focused therapists’ lived experiences that relate to their perceptions of EBPs in treating survivors of sexual violence. van Manen (1990) stated that

> [u]nlike any other kind of research, phenomenological research makes a distinction between appearance and essence, between the things of our experience and that which grounds the things of our experience. In other words, phenomenological research consists of reflectively bringing into nearness that which tends to be obscure, that which tends to evade the intelligibility of our natural attitude of everyday life. (p. 32)

This study examined pertinent elements and themes that surfaced from individual interviews with trauma-focused therapists. An interpretation of texts was then used to acquire an
understanding and a robust description of the trauma-focused therapists’ perceptions and experiences in using EBPs when delivering sexual trauma interventions.

**Qualitative Investigation**

The qualitative method was chosen for the design of this study because it is grounded in an essentially constructivist philosophical position, instead of a quantitative or logical positivism approach (Merriam & Tisdell, 2015). This study follows the principles inherent in qualitative research, which strives to understand how the complexities of the sociocultural world are experienced. As cited in Bloomberg and Volpe (2012), “The intent of qualitative research is to examine a social situation or interaction by allowing the researcher to enter the world of others and attempt to achieve a holistic rather than a reductionist understanding” (p. 118).

Several investigations have been done using a quantitative design on EBPs, providers’ attitudes, and sexual trauma interventions, but an insufficient amount of literature has been produced on how trauma-focused therapists perceive empirically supported approaches. Because little is known about the experiences of trauma-focused therapists, this study used a qualitative design to examine trauma-focused therapists’ lived experiences. The lack of exploratory studies that illumine the perceptions and lived experiences of the clinicians under investigation calls for a qualitative inquiry. According to Creswell (2014),

> One of the chief reasons for conducting a qualitative study is that the study is exploratory. This usually means that not much has been written about the topic or the population being studied, and the researcher seeks to listen to participants and build an understanding based on what is heard. (p. 29)
This study provided an opportunity for uncovering valuable insights about the unique lived experiences of trauma-focused therapists perceptions’ of EBPs when delivering sexual trauma interventions to clients.

Sample

Although in many other research designs sampling can be randomized, participants for this qualitative study were selected specifically because they represented individuals who had lived experiences as trauma-focused therapists who have used EBPs. Sampling is fundamental to qualitative research, and it also enhances the understanding of the participants selected for the study (Bloomberg & Volpe 2012). The sample indicated for this study met the conditions necessary to be a source of rich, meaningful experiences with the phenomenon under examination. Pinnegar and Daynes (2007) affirmed that the intent in qualitative research is not to generalize the information but to elucidate the particular, the specific (as cited in Creswell, 2013, p. 157). Therefore, to understand trauma-focused therapists’ perceptions of EBPs, I used purposeful selection for this qualitative inquiry.

Purposeful selection. Various qualitative sampling techniques were considered for this investigation. Bloomberg and Volpe (2012) stated that qualitative research is purposeful. Purposeful sampling—or judgment sampling, as some researchers refer to it (Merriam & Tisdell, 2015)—was employed in this inquiry to obtain participants who represent the phenomenon under investigation. Unlike quantitative research, which is based on a random sampling procedure, this type of sampling “is based on the assumption that the investigator wants to discover, understand, and gain insight and therefore must select a sample from which the most can be learned” (Merriam & Tisdell, 2015, p. 96). My aim was to select individuals whose experience fulfilled the requirements for this qualitative exploration.
**Participant selection.** Ten participants were recruited from counseling centers, agencies, and private practice. Recruitment was continued until the data reached saturation. This purposive sampling method allows the researcher to select participants with characteristics that suit the study design and purpose. The participants were required to have over one year of experience working in agencies or to self-identify as using an evidence-based approach. Participant characteristics for this study included therapists’ level of education, counseling specialty, and length of work experience. These criteria allowed the researcher to focus on professionals that would be most likely to be involved, know about, or have insights and experience into the research topic.

**Data Collection and Explication**

In a hermeneutic phenomenology, data collection involves gathering the reflections and experiences of the participants in a study that captures vital aspects of the phenomena under investigation (van Manen, 1990). In a qualitative inquiry, in-depth interviews take the place of the statistical data used for a quantitative inquiry. The following methods were employed to gather data for this qualitative study.

**Individual Semi-Structured Interviews**

One method used to collect data for a qualitative study is in-depth interviews of the participants. Merriam and Tisdell (2015) suggested that the type of interview should be based on the amount of structure anticipated by the researcher. Because hermeneutic phenomenology is focused on capturing the lived experience of the participants, a semi-structured interview format has been used. A semi-structured interview format provides interviewers with more flexibility because they “must develop, adapt, and generate questions and follow-up probes appropriate to each given situation and the central purpose of the investigation” (Berg, 2007, p. 106). Merriam
and Tisdell (2015) pointed out that the semi-structured interview is in the middle between structured and unstructured interview formats, offering a mix of more or less structured questions. I believe that the semi-structured interview format for this study provided a prime opportunity to elicit the participants’ perceptions of and experiences with EBPs when delivering interventions to sexually traumatized clients.

A semi-structured interview, however, contains some specific questions and other open-ended questions that can be followed up with probes (Merriam & Tidell, 2015). Patton (2002) recommends that the qualitative researcher examine the questions to ensure they are truly open-ended. The opened-ended question “allows the person being interviewed to select from among that person’s full repertoire of possible responses those that are most salient” (p. 354). Likewise, probes or follow-up questions after open-ended questions can be simple, follow-up questions, expressions, and even silences, which cannot be planned ahead of time in the interview schedule (Merriam & Tidell, 2015). The semi-structured format employed for this study allowed the participants the freedom to elaborate on their experiences. Thus, the research began with open-ended questions such as the following: “What has it been like to be a trauma-focused therapist?”; “What is your lived-experience?”; “What approaches have you used in counseling trauma survivors?”; “How do you perceive EBPs and non-EBPs in treating survivors of sexual violence?”; “How have you dealt with challenges (e.g., adapting protocol, screening clients, integrating other approaches and etc.)?”. The descriptions and interpretations derived from these questions then afforded the contextual and structural data essential for the shared experiences of the participants (Creswell, 2013). Therefore, based on the sub questions, the study goals were as follows:
• To develop a deeper understanding of therapists’ perceptions of their experiences with EBPs.

• To learn about the lived experiences of trauma-focused therapists in using evidence-based approaches to sexual trauma.

• To discover the processes therapists use in order to manage the issues and challenges involved in using EBPs.

Data collection began with audio-taped and semi-structured face-to-face, phone, or internet-based interview with the participants. Merriam and Tisdell (2015) stated that “[i]n education, if not in most applied fields, interviewing is probably the most common form of data collection” (p. 106). The interviews varied in length from 60 to 90 minutes. Having an interest in and inquiring about one’s practice with the intent to improve one’s practice “leads to asking researchable questions, some of which are best approached through qualitative research design” (Merriam & Tisdell, 2015, p. 1).

Once the semi-structured interviews were completed, TranscribeMe!, a transcription service, was used to transcribe the interviews. The data analysis was an iterative process that began with open-ended qualitative interviews about trauma-focused therapists’ current practices and their perceptions and experiences in using EBPs. All of the taped interviews and field notes were entered into computer files. The researcher used NVivo 11, a software program that employs a coding system organized around different topics and themes. Connections between categories and themes were used to improve understanding in studying the trauma-focused therapists’ perceptions of EBP approaches when delivering sexual trauma interventions to clients.
The content of the data was then explored within the framework of van Manen’s existentials. Once the statements were framed with van Manen’s existentials of lived time, lived space, relation, and lived body, meanings were formulated. The bio-ecological model (Bronfenbrenner, 1979) was used to reflect on the dynamic relationship between trauma-focused therapists and their environments. The five levels proposed by Bronfenbrenner to conceptualize contexts of development (1979) are microsystem, mesosystem, exosystem, macrosystem, and chronosystem. These levels were used in this study to examine the dynamics that affect the trauma-focused therapists in their context.

**Instrumentation**

The researcher was the main instrument in this hermeneutic phenomenological study. According to Merriam and Tisdell (2015), researchers are the principal instrument for data gathering and analysis in most qualitative research. Observation and interviewing were used to collect data. From the data transcript and analysis, the researcher extracted the themes, descriptions, and meaning that emerged from the engagement with the participants. Field notes and audio-recordings of individual interviews were used as instruments to collect robust and clear descriptions of the data for this study. It was anticipated that the analysis would uncover the perceptions of the participants and how they have experienced EBPs when delivering sexual trauma intervention to clients. Because I as the researcher conducted the individual interviews, provided field notes, and interpreted the data, it is reasonable to detail my qualifications, experience, and interest in the inquiry.

**Researcher as Instrument**

I have worked in the mental health field since 2006 when I started an internship at an outpatient mental health agency. At the time, as an intern student for my psychology
undergraduate program, I gravitated toward existential/humanistic theoretical approaches to counseling clients. After graduation, I continued to work as a psychosocial rehabilitation specialist at the agency until I finished my Master’s degree in marriage and family therapy from Duquesne University. My experience in counseling clients recovering from severe mental illness helped me understand a variety of interventions developed to treat specific psychopathologies. My interest, however, was always geared toward trauma-focused counseling and sexual trauma issues. The opportunity to complete my master’s degree internship at a rape crisis center confirmed my passion in working in the field of trauma counseling. My experience in working with survivors of sexual violence inspired me to attain my PhD with the intention to focus on and contribute to the research field in trauma counseling and intervention. During my 10 years of experience, I became a national certified counselor (NCC), licensed professional counselor (LPC), and approved clinical supervisor (ACS), and obtained training and supervision to practice cognitive processing therapy (CPT) and eye movement desensitization and reprocessing (EMDR).

For the last five years of working with survivors of sexual violence, my objective has been to improve my skills to better understand the needs of my clients. Through my experience, I became aware of debates in the field of trauma-focused counseling regarding approaches to treating sexual trauma. I have also become acquainted with the impact of best-practice approaches and of how it has influenced me as a trauma-focused therapist. My own experience as a therapist who has been practicing EBPs as well as unsupported approaches has piqued my interest in exploring other trauma-focused therapists perceptions and experiences on this topic. From my own perspective, an integrative approach is more suited to delivering trauma-focused intervention to clients. Therefore, my inquiry in this study is aligned with my long-term interest
in the trauma field.

I am cognizant that my own involvement with the topic created the potential for bias while I am conducting this study. However, following the methodology chosen for this study, along with consultation with my dissertation chair and committee, helped to mitigate the possibility of a biased view. Indeed, I hope that my involvement contributed to this inquiry, as my lived experience was employed to add richness and depth to the phenomenon being explored.

**Data Analysis**

The goal of data analysis is to manage and analyze the material gathered from the interviews. According to Merriam and Tisdell (2015), “in qualitative research, the process of data analysis and collection is recursive and dynamic” (p. 195). Data analysis may begin while collecting the data is still being collected, as both the collection and analysis processes are fluid (Patton, 2002). Flick (2014) described the process of data analysis as “the classification and interpretation of linguistic (or visual) material to make statements of meaning-making in the material and what is represented in it” (as cited in Merriam & Tisdell, 2015, p. 196).

Marshall and Rossman (2011) have suggested seven phases typically used in analytic procedure for qualitative research. The following recommended phases were adopted to analyze the collected data:

1) Organizing the data. The first analysis step was organizing the data. The data collected from individual interviews and field notes was organized in folders (hard copy and electronic).

2) Immersion in the data by reading. In this phase, through reading and writing, I worked toward an exhaustive exploration of the data by interpretation and understanding.
3) Generating categories and themes. In this phase, which is linked with the next phase, I focused my attention on the data to identify themes, recurring ideas, categories, and patterns.

4) Coding the data. In this phase, I applied a code scheme to the categories and themes. I managed themes and categories identified in the data using different colors as codes.

5) Offering interpretations. In this phase, I provided integrative explanations of what I had learned to illuminate the themes, patterns, and categories.

6) Searching for alternative understanding. In this step, I identified and described alternative explanations and demonstrated how my elucidation is the most conceivable.

7) Writing the report for presenting the study. Here, I was engaged in the interpretive act, giving shape and form meaning to the raw data. It is a step of reporting the research (Marshall & Rossman, 2011, p. 209).

As mentioned earlier, each interview was audio recorded and transcribed by through a professional transcription company. The minutes were completed immediately after each interview. Other notes were completed throughout the analytic process to explore how the participants’ experiences related to one another. During the analytic process, I looked for patterns that might become themes and categories. The ongoing analysis allowed for continued reflection on the data generated from each interview, as well as ongoing consideration of how the interviews were related to each other.

**Examining Trauma-Focused Therapists Experiences**

This study was committed to exploring trauma-focused therapists’ perceptions of and lived experiences with EBPs when delivering sexual trauma interventions to clients. Therefore, the data was interpreted and analyzed through the lens of van Manen’s phenomenologically
oriented method, Bronfenbrenner’s bioecological theory of human development, and Levers’ integrative systemic approach to trauma (ISAT) model.

Van Manen’s four lifeworld existentials of lived space, lived body, lived time, and lived human relation (1990) helped to delineate the structure of the lived experience of the trauma-focused therapists. According to van Manen (1990), these four existentials can be differentiated but not separated in the lived world of experience. To examine human experiences, van Manen referred to existential lived space as “felt space,” alluding to the space a person occupies at a conceptual level (1990, p. 102). The lived body “refers to the phenomenological fact that we are always bodily in the world” (p. 103). This existential indicates what one feels in one’s physical body. Lived time “is subjective time as opposed to clock time” (p. 104). It is our temporal existence in the world, and as described by van Manen (1990), “it is the time that speeds up when we enjoy ourselves and slows down when we are bored or anxious” (p. 104). Lived time is the experience of time in the context of lived experience. The lived other concerns “the lived relation we maintain with others in the interpersonal space that we share with them” (p. 104). This last existential has the potential to take on considerable significance in understanding trauma-focused therapists’ experiences with and perceptions of EBPs when delivering sexual trauma interventions to clients. In this inquiry, the four lived existentials were considered as the researcher analyzed the data for emergent essential themes.

Bronfenbrenner’s (1979, 2005) bioecological theory of human development facilitated an exploration of the complexities of the pertinent interactions that have affected the lived experiences of trauma-focused therapists. This bioecological theory includes five interrelated systems: microsystem, mesosystem, exosystem, macrosystem, and chronosystem. The
bioecological theory lens offered insight and understanding of the risk and protective factors that affect trauma-focused therapists’ environments as well as development.

This study used Levers’ (2012) integrative systemic approach to trauma (ISAT), as well. The ISAT model underpinning in the bioecological and systemic approach, combined with attention to the lived experience perspective in trauma intervention, contributed to the data analysis. The ISAT integrates three interconnected elements: clinical relationship, nexus of personal treatment issues, and broader systemic and cultural influences. Levers’ emerging ecological model offered a holistic lens for examining the relevant variables that influence trauma-focused therapists perceptions of and lived experiences with EBPs when delivering sexual trauma interventions to clients. In addition to searching for themes related to the life worlds, bioecological model, and ISAT model, this study remained open to other units of meaning that might be derived from the interviews.

**Ethical Considerations**

This study was submitted to the Institutional Review Board at Duquesne University for review. In preparation for IRB and in order to ground the study in an ethical framework, I reviewed my knowledge of the American Counseling Association Code of Ethics and familiarized myself with proper ethical conduct in qualitative research (Patton, 2002). A number of pertinent ethical issues were considered and attended to as the study progressed. Of import were the treatment of subject participants, confidentiality, data storage and retention, and the reporting of findings.

**Limitations**

This study is not concerned with generalizability, because such is not the goal of qualitative research (Bloomberg & Volpe, 2012); rather, transferability is emphasized.
In this qualitative inquiry, it was assumed that the small number of participants might affect the findings, as the researcher cannot generalize these findings to all contexts or settings of trauma-focused therapists who deliver sexual trauma intervention to clients. The researcher’s personal biases and experiences are another limitation of this study (Merriam & Tisdell, 2015). As a practicing trauma-focused therapist who is interested in the process and phenomenon, I might have affected the data collection and analysis. Thus, a self-reminding of personal biases and interests is an important consideration during data collection and data analysis to prevent any uninformed bias (Patton, 2002).

**Trustworthiness of the Data and the Role of the Researcher**

Qualitative research methods have been well known for controversy in terms of questions about reliability and validity. However, many scholars have highlighted the possibility of objectively studying a subject. Lincoln and Guba outlined credibility, transferability, dependability, and conformability as the assumptions of trustworthy qualitative research (as cited in Bloomberg & Volpe, 2012). These criteria were followed in this study to ensure that the information collected would be credible, transferable, dependable, and confirmable.

To address credibility, the researcher invested significant time into learning about trauma-focused therapists, as well as in building rapport with participants, persistent observations through the interview, and peer debriefing. In terms of transferability, the researcher provided the results and their interpretation for future research studies on the subject. Guba and Lincoln (1985) suggested that “[d]ependability and confirmability are primarily achieved through the use of audit trails” (as cited in Joniak, 2003, p. 10). These criteria were used as a guide to achieving reliability and validity in the research study.
The fundamental strengths of this research study are the understanding and perceptions of trauma-focused therapists with regard to EBPs. Other elements contributed to the results, the first of which is the experience of the investigator, who has worked as a trauma-focused therapist for the past five years. The participants were aware that the investigator is a trauma-focused therapist. To minimize potential problems, constant review and self-examination were carried out during the entire data collection and analysis process.

**Summary**

In the past decades, studies on trauma-focused issues and EBP treatments for sexual trauma survivors have progressed remarkably. Clinicians and researchers alike consider EBPs to be the most important indication of efficacy when one seeks treatment (Cook et al., 2014). Whether evidence-based or non-evidence-based, several forms of treatment, intervention, and diagnosis have delineated the way clinicians help their clients during the healing process. However, no studies have as yet explored trauma-focused therapists’ perceptions of and lived experiences with EBPs, especially when delivering sexual trauma interventions to clients.

The aim of this study was to examine trauma-focused therapists’ perceptions of and experiences with EBPs when delivering sexual trauma interventions to clients. A qualitative research design, with its emphasis on trauma-focused therapists’ lived experiences, was an appropriate method for this study. The methodological framework of this study is phenomenologically oriented, which is suited to the purpose of this inquiry. Thus, in order to build understanding of trauma-focused therapists’ lived experiences, it is important to use the theoretical framework of the bio-ecological development of human development (Bronfenbrenner, 1979, 2005), as well as van Manen’s (1990) lived existentials.
As more empirical data is collected to validate EBPs and sexual traumatic experiences, questions remain about how trauma-focused therapists perceive EBPs and what motivates them when delivering sexual trauma interventions to clients. Much empirical research has been conducted to validate EBPs and trauma-focused therapies, using predominantly quantitative methodology. However, the professional literature lacks studies on EBPs from a qualitative perspective. Researching the perceptions and experiences of trauma-focused therapists based on their clinical experience may give insight into what motivates therapists to adopt certain approaches in treating sexual trauma.
Chapter IV: Research Findings

Introduction

The purpose of this study was to explore trauma-focused therapists’ perceptions of and experiences with EBPs when delivering sexual trauma interventions to clients. I believed that a better understanding of this phenomenon would allow researchers and practitioners in the mental health field to proceed from a more informed perspective in terms of implementing and disseminating EBPs in treating sexual trauma. This chapter presents the major findings derived from 10 in-depth interviews with trauma-focused therapists. The data analysis process and demographic data are presented in this chapter, followed by an analysis of interviews and a case-by-case analyses for each of the 10 individual interviews that were conducted for this study. The chapter concludes with a cross-case analysis, the application of lifeworld existentials and ecological factors, common themes, and a summary; an in-depth analysis, interpretation, and synthesis of findings and themes appear in Chapter 5.

The research results presented in this chapter reflect van Manen’s (1990) theoretical framework, Bronfenbrenner’s bio-ecological model (1979), and Levers’ (2012) ISAT model, as discussed in the previous chapter. In this process, I sought an understanding of trauma-focused therapists’ experiences by identifying themes emerging from the interviews and determining how these themes relate to the guiding questions of this study.

Data Analysis Process

Marshall and Rossman (2011) have suggested seven phases typically used in analytic procedure for qualitative research. The following recommended phases have been adopted in order to analyze the collected data:
1) Organizing the data. In this first step of analysis, the data collected from individual interviews and field notes are organized in folders (hard copy and electronic).

2) Immersing in the data. In this phase, through reading and writing, I worked toward an exhaustive exploration of the data by interpretation and understanding.

3) Generating categories and themes. In this phase, which is linked with the next phase, I focused my attention on the data to identify themes, recurring ideas, categories, and patterns.

4) Coding the data. In this phase, I used an NVivo software coding system to organize data into categories and themes.

5) Offering interpretations. In this phase, I provided integrative explanations of what I have learned to illuminate the themes, patterns, and categories.

6) Searching for alternative understanding. In this step, I identified and described alternative explanations and demonstrated how my elucidation is the most conceivable.

7) Writing the report for presenting the study. Here, I engaged in the interpretive act, giving shape and form meaning to the raw data. This step also consists of reporting the research (Marshall & Rossman, 2011, p. 209).

Demographic Information

A total of 10 trauma-focused therapists participated in one individual interview for this qualitative inquiry. The participants for this study have been working in the mental health field for at least 6 years and have provided EBPs when delivering sexual trauma interventions to clients. The participants had experience working in different settings including hospitals, clinics, agencies (for-profit and non-profit), health centers, schools, universities, and group and private practice.
In order to protect the confidentiality of the participants in this study, each therapist was assigned a number, and any identifiable information was omitted. The therapists are identified by this number throughout the discussion of the findings. There were eight female and two male therapists, ranging in age from 30–66 (with an average age of 41.5). Seven of the 10 participants identified as Caucasian/White, two as Black and African-American, and one as Latina. Five of them had master’s degrees and five, doctoral degrees. Seven of the 10 therapists were licensed by the state in which they have been practicing counseling. The years of experience ranged from 6 to 23 years (with an average of 13.9 years). On the demographic information survey, participants were asked about their name, age, gender, race, occupational position, current employer, professional credentials, whether or not they had worked with victims and/or survivors of sexual violence, if they had attended training on evidence-based practices, and how many years of experience they had in the mental health field. All participants said they had been trained in an evidence-based treatment modality. They all had experience in working with trauma survivors as well; however, their caseloads were not limited to survivors of sexual violence. Though they all reported having victims and or survivors of sexual violence on their caseloads, just four out of the 10 participants have worked exclusively with survivors of sexual violence.
Table 1

Participant Demographic Information

<table>
<thead>
<tr>
<th>Participant</th>
<th>Age</th>
<th>Gender</th>
<th>Race</th>
<th>Credentials</th>
<th>Years of Experience</th>
<th>Training in EBPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Th1</td>
<td>30</td>
<td>Female</td>
<td>Caucasian</td>
<td>PhD; LPCC</td>
<td>7 years</td>
<td>CBT, TF-CBT</td>
</tr>
<tr>
<td>Th2</td>
<td>30</td>
<td>Female</td>
<td>Caucasian</td>
<td>PhD; LPC, NCC</td>
<td>6 years</td>
<td>CBT, SFBT</td>
</tr>
<tr>
<td>Th3</td>
<td>38</td>
<td>Female</td>
<td>Caucasian</td>
<td>PhD</td>
<td>14 years</td>
<td>CBT, DBT, MI</td>
</tr>
<tr>
<td>Th4</td>
<td>50</td>
<td>Female</td>
<td>Latina</td>
<td>LPC</td>
<td>23 years</td>
<td>CBT, DBT</td>
</tr>
<tr>
<td>Th5</td>
<td>33</td>
<td>Female</td>
<td>African-American</td>
<td>MA</td>
<td>8 years</td>
<td>CBT, DBT</td>
</tr>
<tr>
<td>Th6</td>
<td>32</td>
<td>Female</td>
<td>Black</td>
<td>PhD, NCC, ACS</td>
<td>13 years</td>
<td>CBT</td>
</tr>
<tr>
<td>Th7</td>
<td>39</td>
<td>Female</td>
<td>Caucasian</td>
<td>LICSW</td>
<td>8 years</td>
<td>CBT, CPT, EMDR</td>
</tr>
<tr>
<td>Th8</td>
<td>66</td>
<td>Female</td>
<td>Caucasian</td>
<td>MA</td>
<td>20 years</td>
<td>EMDR</td>
</tr>
<tr>
<td>Th9</td>
<td>47</td>
<td>Male</td>
<td>Caucasian</td>
<td>M.S. Ed., NCC, LPC, CCBT</td>
<td>20 years</td>
<td>CBT</td>
</tr>
<tr>
<td>Th10</td>
<td>50</td>
<td>Male</td>
<td>Caucasian</td>
<td>PhD, LPC</td>
<td>20 years</td>
<td>CBT, MI</td>
</tr>
</tbody>
</table>

Organization of the Data

For the data transcription, I used TranscribeMe!, a service that employs an infrastructure and network security in the delivery of transcription services. To ensure confidentiality, the company has a custom micro-tasking algorithm that splits complex content into simple, bite-sized microtasks. In addition, TranscribeMe! is NVivo-compatible. As I uploaded the interviews into NVivo, read the transcriptions, and listened to the audio recordings of the interviews, I started to identify common themes. For this process, I used NVivo software, which has been developed for qualitative research. The structure of NVivo allowed me to explore the data from the interviews and to use specific tools to analyze interview text in conjunction with my field notes. During the analysis, themes were identified and later classified into analytical categories. The structure of the analysis of the collected data was developed through reflection on van...
Manen’s (1990) four lived existentials, including lived time, lived body, lived space, and lived human relations; Bronfenbrenner’s (1979) bio-ecological model; and Levers’ ISAT.

Exploring the collected data allowed me to immerse myself in the subjective experiences of participants. I was mindful of the risk of researcher bias because I am a trauma-focused therapist who uses EBPs when delivering sexual-trauma interventions to clients. All participants were aware of my professional background and appeared to be comfortable sharing their experience working as trauma-focused therapists. After the interviews, an email was sent to each participant with a copy of his or her respective transcription for review and feedback on accuracy.

**The Interview Process**

The interviews for this inquiry were conducted at a private location that was convenient for participants. Two interviews were done through the Internet via Facetime. A mutually agreed-upon time was arranged via email to set up the interview. A semi-structured interview guide, shown below, was used to facilitate the individual interviews. Prior to each interview, the participant was asked to sign a consent form that presented all of the important information about the participant’s consent to participate in the study. Such information consisted of the title of the study, the investigator’s name and contact details, the advisor of the co-investigator, the rationale for conducting this study, the purpose of this study, the risks and benefits, the lack of compensation, the confidentiality, the right to withdraw, the summary of results, and the meaning of the voluntary consent. Last, I asked if participants had any questions or concerns that they wanted to discuss before we started the interview. The range of the duration of the interviews was from 42 minutes to 1 hour and 20 minutes.
The following semi-structured protocol questions were used in the study to elicit information about the perceptions and lived experiences of trauma-focused therapists.

1. What has been your experience working as a trauma-focused therapist?
2. What has it been like for you to treat survivors of sexual violence?
3. What approaches have you used in counseling trauma survivors of sexual violence?
4. How have you used sexual trauma interventions, or how do you currently use sexual trauma interventions?
5. How were you trained to provide evidence-based practices (EBPs) to treat clients’ survivors of sexual violence?
6. How do you perceive EBP and non-EBP approaches when delivering sexual trauma interventions to your clients?
7. Have you dealt with any challenges using EBPs? If yes, can you elaborate on how you dealt with these challenges?
8. Explain, in as much detail as possible, your lived experience of using EBPs to treat clients’ survivors of sexual violence.
9. How has your environment affected your clinical decision to use EBPs with your clients?
10. What are the benefits of using EBPs?
11. What are the risks of not using EBPS?
12. Overall, how do you feel about your experience using EBPs when delivering sexual trauma interventions to your clients?
13. Are there other questions I have not asked that would enhance my understanding of your perceptions and lived experience of EBPs when delivering sexual trauma interventions to clients?
Analysis of Interviews

After each interview was finished, the audio recording was transcribed through *TranscribeMe!* and uploaded into *NVivo* software. This process allowed me to listen and read the interview narrative several times, which facilitated accuracy to advance description and interpretation of the raw data. Per Merriam and Tisdell (2015), “in qualitative research, the process of data analysis and collection is recursive and dynamic” (p. 195). When I had finished transferring the transcriptions into *NVivo* and reviewing the interviews, I began to expound the data collected using the conceptual framework of the life worlds, bioecological model, and ISAT model. I used features of *NVivo* software to accomplish the explication of the data into themes. First, I used Nodes, which assisted me in gathering related material into one place so that I could look for emerging patterns and themes. I then coded the data and placed the quotes in their appropriate analytical category. Finally, I extricated common and distinctive themes that sustained the findings of this study.

Throughout the process of deriving units of information, I highlighted significant quotations related to the research questions. Because of the large amount of data that originated from the transcripts, I had to reduce content by separating units of information that did not fit any of my existing descriptors. All these excluded materials were saved in an *NVivo* folder and revisited to ensure a possible connection with current or new emergent themes.

As patterns and themes became more prominent during the analysis, I noticed that the identified units of information complemented the research questions for the study. Van Manen (1990) noted that in the process of analyzing lived-experience descriptions we become aware of themes that begin to emerge. The emerged themes were then categorized within van Manen’s life world existentials, Bronfenbrenner’s bio-ecological model, and Levers’ ISAT model. These
conceptual frameworks served as a guide to understand trauma-focused therapists’ perceptions of and lived experiences with EBPs when delivering sexual trauma interventions to clients. The following are the major six analytical categories used in the study:

1. Van Manen life world existentials
2. Bio-ecological framework
3. ISAT
4. Protective factors
5. Risk factors
6. Common themes

The objective of data analysis is to manage and evaluate the material gathered from the interviews, which was accomplished throughout this inquiry. Saturation in this study was reached with the final interview. Van Manen (1990) emphasized that as themes recur as commonalities “[t]he task is to hold on to those themes by lifting appropriate phrases or by capturing in singular statements the main thrust of the meaning of the theme” (p. 93). The following case-by-case analyses embrace this concept. Significant quotations derived from participants’ narratives were identified and placed next to their corresponding analytical category.

**Findings: Case-by-Case Analyses**

The interviews began with questions regarding participants’ demographic information pertinent to the subject being explored in this study. As stated earlier, this information included age, gender, race, occupational position, current employer professional credential, experience working with victims and/or survivors of sexual violence, evidence-based practices training attendance, and years of experience working in the mental health field. This section provides a
thorough description of the 10 participants’ perceptions and experiences of trauma-focused therapists about EBPs when delivering sexual trauma intervention to clients. In addition to searching for themes related to the life worlds, bioecological model, and ISAT model, I remained open to additional units of meaning. I could begin to identify their appearance and reemergence almost immediately, so using an iterative and recursive process, I began to construct what would become the common themes here, right from the first interview onward.

**Th1 Interview**

The first interview was conducted with a 30-year-old Caucasian female who has been working in the mental health field for 7 years. We began with the demographic questions by which I gathered information to proceed with my inquiry. This counselor is currently working for a behavioral health center and teaching at a university. She has a PhD and is a licensed professional counselor who has delivered sexual trauma interventions to victims and/or survivors of sexual violence. She has also attended trainings on evidence-based practices. She was fully aware of the nature of the study and seemed excited to talk about her perceptions and experiences with EBPs when treating survivors of sexual violence. She mentioned that the agency she is currently working for is a health center. She emphasized that her agency is medically focused and that she sees fewer patients than the medical doctors who work at health centers. We met in a room at her private residence where she felt comfortable in sharing her experiences. I reviewed confidentiality concerns with her and told her how the information she shared would be protected. I reviewed the purpose of the study, emphasizing that participation in this study was voluntary and that she could leave at any time. She agreed to participate, and we both signed the informed consent.
Th1 started describing her work even before we started audio recording the interview. She was enthusiastic about sharing her experiences and seemed passionate about her profession. I prompted her to talk about her background working in the mental health field, for which she offered this description:

I had practiced out-patient care to (state of practice) to continue with schooling and work with kids with autism, which is much different than my experiences working in out-patient mental health, where I saw everything including work with trauma and sexual abuse. And then I moved back to (city) to finish my schooling, and I started working again in outpatient mental health care. So I had probably about 5 years of experience working with sexual trauma, and I see anywhere from age 5, as probably my youngest that I've worked with, to early 70s, who have experienced any kind of sexual trauma. Additionally, she explained that working with survivors of sexual trauma was difficult in the beginning and that she would bring it home, especially the work with children. She stated, “The kids job is much harder at the beginning but as…with time and experience it’s been a little bit easier.” I also shared with her that I had experienced that myself when I began working in the mental health field so that she would understand that I valued her work with trauma survivors. I prompted her to speak about her experience in working with survivors. She explained that she had no experience at the beginning of her career and that she has never been certified in any specific trauma intervention, theory, or approach. She mentioned that 80 to 90% of the population she sees is in poverty and that probably more than 50% of her clients have some issue with sexual trauma.

Th1 expressed feeling a definite need to educate herself further and become specialized in approaches that work with not only sexual abuse but also trauma in general “because trauma is
so common in the work that I do.” I inquired about approaches she has used in counseling traumas survivors of sexual violence. She reflected and explained:

I definitely pull from more of a cognitive behavioral approach. I just use that a lot, because a lot of people I see is very short term. I might see them for four or five sessions, and then they disappear. That's extremely common for a lot of the people I work with. So I always, in my head, feel like I need to use more brief therapy approaches in case they are going to be leaving or drop off at any point. But I pull a lot from trauma-focused CBT. I know it's more specific towards children, but I use a lot of them with adults as well.

She explained that at her current job, there is no specific protocol; she can use any approach to treat her clients. She noted that she does not have opportunity to consult or receive much supervision because she is not required to be an independently licensed clinician. Without further prompt, she started to talk about supervision and the fact that at her center “[y]ou’re just kind of thrown into the job and you do what you do. So I think there’s still a lot that I need to do. That is my responsibility.” I felt a little concerned when she talked about her lack of opportunity to obtain supervision in her agency. As a trauma-focused therapist, I believe it would be difficult for me not to have constant supervision for my cases. She also seemed concerned, as she said, “So in my office, I’m the only one, which I think is definitely a limitation and probably not a good thing that I don’t really get the opportunity to consult a whole lot, or receive supervision a whole lot.”

We segued into a discussion about using sexual trauma interventions with clients. She stated that her center offers long and short-term therapy, but they see a great deal of drop off. She noted that she has seen some of her clients for a couple of years. However, she also does brief
therapy around 10-12 sessions because “[i]t depends on the client as well.” She went on to explain the interventions she uses:

So first, it depends, I guess, on the age of the person. So children, adolescents, and adults, my first approach is I start with a lot of psychoeducation. So I've read a book that changed my life as a clinician: The Boy Who Was Raised As a Dog by Dr. Bruce Perry; that totally changed my work with trauma-informed care. And I pull a lot of his interventions.

She emphasized that at her center they allow clinicians to employ any type of approach they feel comfortable in using with clients, as long as the approach is evidence based. She continued to detail her approach to counseling her clients:

So the first thing is obviously rapport, right? Getting whomever it is to feel comfortable with me, and then we really start on psychoeducation. So I really try to help whether it's kids at their appropriate level, adolescents, their parents or adults, just learning how trauma can affect people… And then from there, I always talk about the risks and the benefits of trauma care... I really leave the person making the decision whether they want to do and hope from therapy and all of that, because I think it's so important there are risks with that as well. So I always have that conversation with them no matter what kind of trauma they've been through.

She seemed very comfortable explaining her intervention and going over the process she uses to implement it. She also noted that being on her own and having freedom to choose an intervention can be “good and not good.” When I followed up with a question about what she thought was good about it, she said that she knows agencies that have to use specific treatment approaches, which would not make her feel comfortable or confident. “[B]eing able to decide what approach
works for me and what works for my clients is nice.” She believes that the bad part of it is being on her own, not having “the opportunity to consult with other people who are giving the same kind of intervention or kind of approach.” She concluded by stating that she does not get specialized in specific areas.

I inquired about her training to provide EBPs to treat clients’ survivors of sexual violence. She reiterated that she had no specialized treatment approach to working with her clients. She talked about using TF-CBT, though she has not been formally trained in this approach and emphasized her efforts to attend conferences and specific workshops on trauma and sexual violence. She talked about using Dialectical Behavioral Therapy (DBT): “I used a lot of DBT stuff…. So I kind of pull from DBT, which I feel like is kind of under the umbrella of CBT in so many ways.” I prompted her to talk about continuing education and if she finds it helpful. “Yes, not only helpful and it's helping me feel educated, but I think it helps with burnout. And kind of staying motivated a little bit. It kind of gives me an extra push. Because this field, we're so likely to have burnout, especially when we work with trauma.”

Staying on the topic of EBP use, I asked the question about how she perceives EBPs and non-EBPs when delivering sexual trauma intervention to clients. She stated that she does not perceive EBPs as structured:

My experiences are like here's the interventions, here's what you do kind of thing. But it's never like in the first session you do this and then in the second session you do this. It's never been that kind of structure, which I would wonder if I would like because I'm very much a black-and-white thinker. And sometimes I feel not competent at times when I'm doing what I'm doing because of that lack of structure. Because it's just the way that kind of flows with my clients. So, I don't know. I think structure might be a good thing for me.
She paused and reflected after answering this last question and then began to speak about the importance of delivering evidence-based approaches. She stated that “as a clinician it’s my responsibility to become familiar with the evidence-based practices—what works for certain populations, for example, sexual trauma.” With regard to using non-EBPs, she mentioned that not every approach works with every single person. So she modifies her approach to meet the clients where they are. She went on to talk about using components of EBPs, but staying within the evidence-based framework:

So, for example, with the narrative part of trauma-focused CBT, not everybody is comfortable doing that. People have started to maybe talk about their experiences, and then will stop and say, ‘I'm not comfortable here. I don't want to go backwards, I want to move forward.’”

She noted again that her current job allows her to integrate different approaches to treat her clients. She stated, “Nobody looks at my notes. Nobody supervises me. It’s really what I want to do, which is crazy.” However, she emphasized that there are expectations from her agency, which includes always using evidence-based practices to treat clients.

When inquired about her lived experiences with EBPs, the participant described that she feels it is important to explain to survivors of sexual violence about the approach she uses: “it kind of helps me with my own experiences as a counselor to be able to educate them why I'm using what I'm using, and kind of help them understand, here's the research on why we're using TF-CBT or CBT, or whatever approach that I use.” She mentioned burnout as part of her lived-experience. “There are some days that I do feel burnout hearing just trauma after trauma after trauma, and a lot of sexual trauma with the work that I do. So there are definitely some days that I just feel kind of burnt out.” When she paused here and became reflective, it seemed like a good
moment to segue into exploring further her lived experience in working with survivors of sexual violence. She talked about her agency again not being supportive of supervision or consultation.

In further discussing her experience using EBPs, she even described having to be careful using EBPs because she does not “want to leave them in this open wound here.” There is a high rate of dropout at her health center, so she is aware of teaching clients coping mechanisms for dealing with everyday stressors before using a structured protocol. When I attempted to inquire further into the benefits and risks of using EBPs, she stated that one of the benefits is that the research is out there to show that the intervention works,

So, I'm not just pulling this out of nowhere and thinking, “That technique sounds cool. I'm just going to try that and use that.” There's research out there that shows that it can be effective for this population or this trauma. So that kind of helps me as a clinician feel like I'm doing the right thing and helping my client, which is what I should be doing. It's a priority. So, I definitely think that's the benefits of it. The research just shows it's effective.

She also mentioned that they are required to document evidence-based treatments in her notes: “So I don’t want to just be documenting it. I want to be ethically using them as well.”

With regard to risks, the participant reiterated that using practices that have not been studied could be harmful to the client: “Are we going to leave them feeling worse than better? You know what I mean? That is part of our ethical obligation, … to do no harm.” As we discussed her challenges in using EBPs, she noted that she needs to learn more evidence-based treatments for sexual trauma as well as increase her knowledge and competence in trauma interventions.
As we were concluding the interview, I asked Th1 how she felt, overall, about her experience using EBPs when delivering sexual trauma intervention to clients. She reflected on the question and explained that she felt like she had experienced a great deal of good results with it. I asked her to give me an example of a good outcome.

So a good example of a good outcome would be I have a client—I haven't seen her for probably a couple months now—but she started to do the counseling. She had a lot of sexual trauma, history. Like multiple events by multiple people. Just a really hard life. And it started when she was very young. And then stopped. And then she had like another random event. And then like later on in life. I mean, this has just been her life. So we did a lot of CBT, TF-CBT. And she wasn't working at the time. She was in a domestic violent relationship. Just trying to survive. She now is working. She's away from the one guy. She's in a new healthy relationship. She's not drinking anymore. So she really just got her life back on track, and is able to be a mom and care for her kids.

The interview concluded when I asked the participant if there were other questions that I had not asked that would enhance my understanding of her perceptions and lived experiences of EBPs when treating survivors of sexual violence. She stated that talking about sexual trauma interventions made her feel as if she wanted to get more specialization in this field of counseling. I thanked the participant for her time and reiterated that I would be emailing her a copy of the transcription of the interview to her for verification of accuracy and feedback.

After I left her residence, I started to reflect on the interview. A few hours later when I arrived home, I listened to the audio recording while going over my field notes. As I processed the interview, I noticed that we had talked about EBPs and trauma courses while she was in graduate school. She stated that her master’s program offered a trauma course, but it wasn't
required. She went on to say that she didn't take the course because it conflicted with another class that she was taking. However, she also said,

I think we all need to be educated whether a counselor or teacher, or any kind of helping profession, because we know and the research shows, anytime people have been through trauma we can be impacted and then it can affect every part of our life into our adulthood if in some situations. So I think there needs to just be more about educational part of it for any helping profession.

She noted that while getting her PhD, she had decided to study trauma although it was not required and there were no specific courses on the subject. This last discussion prompted me to ask her about possible emphasis on EBPs during her time in graduate school. She mentioned learning theories and classes on the foundations of being a counselor. However, the use of EBPs was not emphasized. Because this was my first interview, I thought it would be important to ask participants about their graduate education with regard to trauma interventions and EBPs.

The interview with Th1 provided a number of statements of significance that were explicitly related to analytical categories. The following table organizes these statements based on the theoretical framework guiding the study.

Table 2

Summary of the Interview with Th1

<table>
<thead>
<tr>
<th>Analytical Categories</th>
<th>Quotations of Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. VAN MANEN LIFE WORLD EXISTENTIALS</td>
<td></td>
</tr>
<tr>
<td>Lived body</td>
<td>So I always, in my head, feel like I need to use more brief therapy approaches…and always keep that in the back of my head.</td>
</tr>
<tr>
<td></td>
<td>So I'm always very aware of that in the back of my head, knowing though that not every approach works with every single person.</td>
</tr>
</tbody>
</table>
I don't want to leave them in this open wound here.

Lived space

I would like because I'm very much a black-and-white thinker.

…and there are some days that I do feel burnout hearing just trauma after trauma after trauma…

All right. I feel so alone in the world.

So, I'm kind of feeling stuck at that moment of, well, this isn't effective for this patient.

Lived time

…I started to take little bit of things home with me

I will tell you this is definitely harder in the beginning…

So I've read a book that changed my life as a clinician… that totally changed my work with trauma-informed care.

Lived relationship

So there's kind of like this disconnect from me to them that I've had to gain in order to keep my own sanity right.

You're very much on your own. I have nobody else in my building that does counseling.

I have some people that I've worked with for a year or over a year. I even have some that I've worked for a couple of years with and become tricky, because then they just kind of, I think become dependent on the counseling.

So a lot of our practice is working towards them, becoming less dependent on counseling, and then being in their own world.

So it kind of helps me with my own experiences as a counselor to be able to educate them why I'm using what I'm using, and kind of help them understand it.

People have started to maybe talk about their experiences, and then will stop and say, "I'm not comfortable here. I don't want to go backwards; I want to move forward."

2. BIO-ECOLOGICAL FRAMEWORK

Microsystem

So did we start something and open it and never had them leave with coping mechanisms or just an ability to deal with everyday stressors based on their trauma. So I'm
always thinking about that because of the environment I work in.

…it depends on the client as well.

So, I guess, being able to decide what approach works for me and what works for my clients is nice.

So there's kind of like this disconnect from me to them that I've had to gain in order to keep my own sanity right.

Mesosystem

I don't really get the opportunity to consult a whole lot, or receive supervision a whole lot now that I'm not required to as an independently licensed clinician.

So for me, when I reach out for consultation, it's usually through email because our director is extremely busy, and I get very extremely minimal responses from her.

We're kind of on our own and have freedom there, which is good and not good.

Nobody supervises me. It's really what I want to do.

Exosystem

So we're very much medically focused, and that is the priority there.

I feel like sometimes, we're just not as important as the medical. So you don't really get the opportunities.

Macrosystem

… but it's just become like almost the norm in my practice to see it and to hear it.

The population I see is probably—this is just a random guess—I would say 80 to 90% poverty…I might see them for four or five sessions, and then they disappear.

I want to be ethically using them as well. We know manage care, I use that a lot of the time.

Cronosystem

… anytime people have been through trauma we can be impacted and then it can affect every part of our life into our adulthood if in some situations.

3. ISAT

Clinical relationship

… it depends on the client as well.

So, I guess, being able to decide what approach works for me and what works for my clients is nice.
Nexus of personal and treatment issues

... I need to use more brief therapy approaches in case they are going to be leaving or drop off at any point.

... knowing though that not every approach works with every single person.

I know a lot of agencies and you have to use specific treatment approaches

So we kind of did some substance abuse treatment outside of our agency. And she, with the interventions—I feel like with support just in general for her, too

Broader systemic and cultural influences

I mean, there is poverty. Many people can't even get there sometimes, transportation.

I don't really get the opportunity to consult a whole lot or receive supervision a whole lot now that I'm not required to as an independently licensed clinician.

So we don't have any protocol. You're just kind of thrown into the job and you do what you do.

I feel like sometimes, we're just not as important as the medical. So you don't really get the opportunities.

I want to be ethically using them as well. We know manage care, I use that a lot of the time.

### 4. PROTECTIVE FACTORS

“I’m not pulling this out of nowhere”

...there’s research out there that shows that this works. So I'm not just pulling this out of nowhere and thinking.

“It can be effective”

...EBPs can be effective for this population or this trauma.

“I’m doing the right thing”

I'm doing the right thing and helping my client, which is what I should be doing.

That's part of our ethical obligation is to do no harm and to not cause harm.

We're required to. I mean, we're required to document it in our notes. So I don't want to just be documenting it. I want to be ethically using them as well. We know manage care, I use that a lot of the time.

First and foremost, I'm always making sure I'm delivering evidence-based approaches. So I feel that as a clinician it's
my responsibility to become familiar with the evidence-based practices with what works with certain populations and certain scenarios.

5. RISK FACTORS

Being careful

I just feel like I have to be careful with evidence-based treatment that I use.

I'm always concerned, so for example, if TF-CBT is did we open something and then not give then the skills they need to be able to deal.

So I'm kind of feeling stuck at that moment of, well, this isn't effective for this patient. I don't know other techniques or other interventions or theories that work for sexual trauma, then I feel very incompetent and feel like I'm not helping the person…

Lack of preparation for trauma – graduate school

I think that's a really good question because in my master’s program, we were offered a trauma course, but it wasn't required… I didn't take it because it clashed with another class that I was taking.

I very much had very minimal education on working with trauma.

Lack of preparation for EBPs – graduate school

So we talk about ethics. Yes, that's important. And we have a class on multiculturalism. Yes, that's so important. But when it actually that came to really doing things in real life, sometimes I felt like, "Okay, what do I do?" Because it was this lack of training in that area I felt.

6. COMMON THEMES

Multimodal approaches

I'm sure a lot of cognitive behavioral therapy and kind of pull from trauma-focused CBT a little bit.

I need to use more brief therapy approaches in case they are going to be leaving or drop off at any point.

I feel like a lot of approaches can be used with trauma intervention. So, cognitive behavioral therapy or we could do dialectical behavioral therapy or motivational interviewing.

Structure/rigid

We give a lot of homework out on educating themselves, and I give them reading materials.

Flexibility/adaptation

We're kind of on our own and have freedom there, which is good and not good.
I guess, being able to decide what approach works for me and what works for my clients is nice

<table>
<thead>
<tr>
<th>Rewarding experience</th>
<th>N/A</th>
</tr>
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<tbody>
<tr>
<td>Being a woman</td>
<td>N/A</td>
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</table>

**Th2 Interview**

The second interview was conducted with a 30-year-old Caucasian female who has been working in the mental health field for 6 years. We started with the demographic questions by which I gathered information to proceed with my inquiry. Th2, who is currently in private practice within a group practice, has a PhD and is a licensed professional counselor who has delivered sexual trauma interventions to victims and/or survivors of sexual violence. She has also attended training on evidence-based practices. She stated that she is interested in the field of sexuality and is working toward her certification in sex therapy. We met in my residence office where she felt comfortable in sharing her experiences. I reviewed confidentiality and how the information she shared would be protected. I also reviewed the purpose of the study and emphasized that participation in this study was voluntary and that she could leave at any time. She agreed to participate and we both signed the informed consent.

She appeared to be comfortable talking about her experience, as she stated in the beginning that she had experience working with survivors of sexual violence. I asked her to talk about her work in the mental health field. She stated that her experience as a trauma-focused therapist is most likely to be in three different settings: outpatient therapist, school-based therapist, and through an agency. She explained that in her private practice, not very many clients come specifically for sexual violence issues and that she usually works with survivors of sexual violence after they have been to another treatment program. She went on to talk about
working at a university where she had experience counseling clients who struggled with posttraumatic stress issues, noting that “through my department, I did a lot of sexual violence stuff.” After discussing her experience working with survivors of sexual violence, she said, “Overall I feel like it’s good work, not too hard for me to emotionally deal with as people think that it might be.” She seemed confident expressing her experience in working with her clients. She noted that in her current practice she sees teenagers and adults. She treats many clients who have some sort of sex/relationship issues and often “… through work with them, there will be a history of sexual violence or even just negative dating experiences.”

I followed up with the question about her approach to treating survivors of sexual violence. She replied that her theoretical approach is usually cognitive behavioral but that she uses a lot of solution-focused therapy. She emphasized that she works with high functioning adults, describing her work as follows:

I have found with most of my clients that I'm able to ask them, you know, like what do you think the first issue you want to focus on is? And then I can sort of adjust my theory or approach to that. Most of the clients I see don't need, or they don't want, because they've already been through a program where they have regular homework and refinements, and like a lot of painful thinking about the issue, where by the time they come to see me, we're sort of able to adjust what sort of intervention they need.

She added that she uses CBT to work on thought patterns to lessen any anxiety, depression, and thoughts related to their traumatic event. She went on to say that “by the time … they get to my practice, they're really looking for … a way to positively change their thoughts trying to get … more of a solution-based sort of ‘What do I do now?’”
We segued into a discussion about the training she had undergone to provide EBPs when delivering sexual intervention to clients. She asserted that it was mostly through sex therapist training and professional conferences, as she has “never gone specifically through a sexual violence program.” She mentioned in the beginning of the interview that her work never supported trauma training; “I just went on my own.” Like Th1 with regard to graduate school emphasis on EBP and trauma, Th2 expressed that in graduate school, she was given an overview of experiences she might have and a general idea of approaches she could use. However, she stated that her master’s program emphasized trauma. She went on to say that “it’s only been as a professional that I have gone to training and tried to understand more.”

With regard to challenges she encountered when delivering EBPs to survivors of sexual violence, she talked about always trying to learn and know more about interventions for treating sexual violence. She could not think of specific challenges, but went on to say that “if there is a tricky situation a client is going through, I’ll look it up and maybe, I don’t necessarily already know it… So will look up, you know, suggestions and see if they work for the client.” She spoke about working on challenges with her supervisor, whom she sees on her own and not as part of the group practice. This led into a discussion about her lived experiences of using EBPs with clients:

My experience is always that this is such a complicated issue, has a lot of emotions with it and, trauma and flashbacks and all of that. I've found that sometimes I need to adjust what practice I'm using, and have to mold to what the client needs. It's not like a workbook that I can just like go through. So my experience is like, I'm working on this, this theory or this intervention and I see that clearly it's not working for the client, I have to pick up on that and adjust.
She paused to reflect and went on to say that emotionally she felt like she does well using theories and working with her clients’ issues. She reiterated what she said in the beginning of the interview: “I don’t necessarily have any trouble emotionally or anything with that.” As she talked about her counseling experience, she mentioned both settings in which she has worked:

Especially in a school, they want to make sure what they're paying for and how many therapists come in, because I was contracted through the school to come in. They want to make sure that you are doing something that is backed up with evidence. So especially in the school, they were very supportive. In private practice, I try and use evidence-based practices because it's ethical and researched and not like I'm over at my practice doing my own weird thing.

I prompted her to talk further about her experience in private practice and what the environment is like.

Private practice is very casual. So, if I were in an agency specifically for sexual violence, I would imagine that there would be a lot more structure, and someone checking in on all of—everything that I'm doing, but in a private practice I need to just stay updated on education and interventions myself because the structure's very loose.

She reiterated that in the school environment, including the university she worked for, there was a lot more structure to counseling. I reflected on her response about the structure’s being “very loose” and asked her to elaborate on it, asking also if she ever felt pressure to use EBPs. She explained that she felt pressured to use EBPs when she worked at the school, which was “mid-range pressure. Still wasn’t crazy, but I did have to do a lot more paperwork and make sure I was using the appropriate interventions.”
We segued into a discussion about the benefits and risks of using EBPs. She asserted, “The benefits are that it's supported by agencies, it's supported by insurance. A lot of research has been done…. there's just a lot more information that you can use, I can always look up something and find information.” With regard to the risks she stated, 

Well, then there could be therapists out there who are just sort of doing their own practice, which I think could be unethical, possibly. I also think that some clients might, suffer by not having evidence-based practices that they're benefiting from. So it might be hurting the therapist and might be hurting the client as well.

She added that when she can, she provides her clients with an article or even just and explanation that her chosen intervention is supported. She went on to compare how her clients might perceive it by stating, “They are more on board with accepting or taking it and at least thinking about it. Where if it were just my own idea that I was trying to use as an intervention they might forget it by the time they’ve left. I feel like it sometimes can help the treatment process.” She concluded by saying that it is important to give clients some sort of evidence, that we have to back up the interventions we use to treat them.

The interview concluded when I asked the participant if there were other questions that I had not asked that would enhance my understanding of her perceptions and lived experiences of EBPs when delivering sexual trauma interventions to clients. She had a few remarks to add: 

I think I would just say overall that the lived experience is that many therapists don't fully know how to deliver sexual trauma interventions, and that they aren't educated on it, or even if they are, that they don't see very many clients. I see a lot of clients with sexual issues of some sort, so I run into it very often; but if you were working with a different population, this whole area might be a non-issue. Or just a non-educated issue—you just
don't know anything about it. So, in my experience, as a therapist, I have seen many others who have no information about this topic.

This led to a discussion about training and about making more programs available at conferences for our profession. She went on to say,

“I try and always go to the sex-related sessions… and maybe there is one session that focuses on this, you know, in a whole conference. So, I think that just even on the state counselor level, or bigger conferences, we could do a better job of it.”

She concluded by stating that she sees a lot of counselors in training, either in therapy or as a supervisor of counselors in training, who don’t feel like they have adequate information on sexual trauma interventions. Returning to the previous question regarding training in graduate school, she said, “I think we could do a better job in educational programs.” I asked about any last additional information she wanted to add to the interview. She said she did not have anything to add. I thanked the participant for her time and reiterated that I would be emailing her a copy of the transcription of the interview to her for verification of accuracy and feedback.

The interview with Th2 provided a number of statements of significance that were explicitly related to analytical categories. The following table organizes these statements based on the theoretical framework guiding the study.

Table 3

Summary of the Interview with Th2

<table>
<thead>
<tr>
<th>Analytical Categories</th>
<th>Quotations of Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LIVED BODY</strong></td>
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</tr>
<tr>
<td>Lived body</td>
<td>N/A</td>
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<tr>
<td>Lived space</td>
<td>N/A</td>
</tr>
<tr>
<td>Lived time</td>
<td>My experience is always that this is such a complicated issue, has a lot of emotions with it and trauma and flashbacks and all of that.</td>
</tr>
</tbody>
</table>
Lived relationship

I have found with most of my clients that I'm able to ask them, you know, like what do you think the first issue you want to focus on is?

...by the time that they get to my practice, they're really looking for like a way to positively change their thoughts trying to get like more of a solution-based sort of, "What do I do now?"

2. BIO-ECOLOGICAL FRAMEWORK

Microsystem

I have found with most of my clients that I'm able to ask them, you know, like what do you think the first issue you want to focus on is?

Mesosystem

In the school-based things that I did, and also the university, there was a lot more structure. I've always sort of worked in practices where I operated independently

Exosystem

Especially in a school, they want to make sure what they're paying for and how many therapists come in because I was contracted through the school to come in. They want to make sure that you are doing something that is backed up with evidence...

My work never supported training. I just went on my own... When I was in an agency there wasn't money to support that.

I would say it was like mid-range pressure... but I did have to do a lot more paperwork and make sure I was proving that I was using the appropriate interventions.

Macrosystem

So I think that just even on the state counselor level, or bigger conferences, we could do a better job of offering more training.

Cronosystem

N/A

3. ISAT

Clinical relationship

I have found with most of my clients that I'm able to ask them, you know, like what do you think the first issue you want to focus on is? And then I can sort of adjust my theory or approach to that.

Nexus of personal and treatment issues

By the time they come to see me, we're sort of able to adjust what sort of intervention they need.

I need to adjust what practice I’m using, and have mold to what the client needs.

...but in a private practice I need to just stay updated on
education and interventions myself, because the structure's very loose.

In private practice, I try and use evidence-based practices because it's ethical and researched and not like I'm over at my practice doing my own weird thing.

Broader systemic and cultural influences
Especially in a school, they want to make sure what they're paying for and how many therapists come in because I was contracted through the school to come in. They want to make sure that you are doing something that is backed up with evidence...

I did have to do a lot more paperwork and make sure I was proving that I was using the appropriate interventions.

4. PROTECTIVE FACTORS

“I’m not pulling this out of nowhere” I think the benefits are that it's supported by agencies; it's supported by insurance.

I can always look up something and find information.

“It can be effective” There are interventions available to you, there's just a lot more information that you can use.

By giving, you know, giving them some sort of evidence that you have to back up what you're saying.

“I’m doing the right thing” I did have to do a lot more paperwork and make sure I was proving that I was using the appropriate interventions.

I try and use evidence-based practices because it's ethical and researched...

I think that when I can provide a client with maybe like an article or even just explain that this is an intervention that is supported, they're usually more on board with accepting or taking it and at least thinking about it.

5. RISK FACTORS

“Being careful” Well, then there could be therapists out there who are just sort of doing their own practice, which I think could be unethical, possibly.

I also think that some clients might suffer by not having evidence-based practices that they're benefiting from. So it might be hurting the therapist and might be hurting the client as well.

…Many therapists don't fully know how to deliver sexual
trauma interventions, and that they aren't educated on it.

| Lack of preparation for trauma – graduate school | When I was in my master's program I would say yes [emphasis on trauma], and then through additional training since graduate school |
| Lack of preparation for EBPs – graduate school | I feel like graduate school, for me, was more of an overview of here's all the potential things you might experience |

6. COMMON THEMES

| Multimodal approach | My overall theoretical approach is usually cognitive behavioral |
| Structure/rigid | It's not like a workbook that I can just like go through. |
| Flexibility/adaptation | There was someone to report to and make sure that the client was progressing. |
| Flexibility/adaptation | Then I can sort of adjust my theory or approach to that. |
| Flexibility/adaptation | By the time they come to see me, we're sort of able to adjust what sort of intervention they need. |
| Flexibility/adaptation | I've found that sometimes I need to adjust what practice I'm using, and have to mold to what the client needs. |
| Rewarding experience | N/A |
| Being a woman | N/A |

Th3 Interview

The third interview was conducted with a 38 year-old Caucasian female who has been working in the mental health field for 14 years. We started with the demographic questions, by which I gathered information to proceed with my inquiry. She is currently working for an outpatient mental health agency as the associate director. She has a PhD and has delivered sexual trauma interventions to victims and/or survivors of sexual violence. She has also attended training on evidence-based practices. She was fully aware of the nature of the study and stated that she was happy to be participating in this research study. She mentioned that the agency she is currently working for is a mental health recovery center that offers both social and
employment services to clients experiencing severe mental illness. We met in her office where she felt comfortable in sharing her experiences. I reviewed confidentiality, detailing how the information she shared would be protected. I also reviewed the purpose of the study and emphasized that participation in this study was voluntary and that she could leave at any time. She agreed to participate, and we both signed in the informed consent.

I prompted the participant to talk about her experience working as a trauma-focused therapist. She described how clients are referred to her agency for social rehabilitation or vocational rehabilitation, adding “but I find that there is trauma and sexual abuse in their history.” While answering this first question, the client expressed that she was feeling nervous with all the equipment around her. She went on to say, “Oh my God, and my face is turning red!” I reassured her everything was fine and explained that participants usually feel nervous about audio recording. I asked if she wanted to continue, to which she replied yes. She asked me to repeat the last question and went on to talk about the population she works with:

We offer services for adults with chronic persistent mental illness… But as you know, a lot of people with serious mental illness are also survivors of sexual abuse and trauma. And so it's definitely something that impacts their ability to sometimes work with other people, sometimes be around other people in a close proximity. And so my experience with that has been always addressing their primary reason for coming here initially, but trying to work through how the trauma and abuse affects them from being able to move forward in their recovery, being able to move forward into developing new relationships with people, maybe even just how they can move forward in their life of being in a space with a lot people.
Th3 noted that it has been challenging to gauge where her clients are in their recovery from the traumatic experience, “how safe they feel, how far to go in the conversation, how much they can handle with being around people.” She emphasized that owing to her experience in working in the mental health field for 14 years, she has a “better grasp on where they are at and maybe how that trauma has affected them or continues to affect them.”

Th3 then explained that her approach to work with her clients is person-centered:

We really do let the person take the lead on how much information and how much detail they want to go into, as far as talking about their history and their past… But really, a person-centered approach and a collaborative approach. We're never the only person working with an individual. And so there is a lot of collaboration within our organization, and then also with other organizations or treatment providers.

She highlighted the fact that her agency takes a holistic approach to assess clients, using an example to explain their approach:

I worked with this woman—it must have been 10 or 11 years ago. When she came in to meet with me, and she was on our second floor, somebody bumped into her and that in itself was very traumatic for her. It was very hard for her because they touched her, and she just could not handle being touched. And so probably if I were just seeing her in my office at that time, like I wouldn't have, she may not have thought to disclose that to me, or not even realize that it was a big issue for her. But because of the way our agency is set up and that she was in that more kind of social area, it kind of brought all of that out. So then I was able to talk to her about that, and talk about ways to feel safe and being around people. And how we can help her be able to work around all of her goals, without feeling threatened or without feeling re-traumatized just by being around people.
She further noted that she integrates cognitive behavioral therapy modalities, including DBT into what she does: “We have a woman here who DBT has helped her tremendously, and we'll help her with her distraction techniques and kind of work through some things with her. But to say that we do DBT, I feel like would be a huge disservice, but we integrate principles of it in our practice.”

Th3 emphasized the uniqueness of her agency’s interventions, especially when it comes to survivors of sexual violence. She spoke about her agency’s collaboration with other professionals that are part of the client’s treatment plan. She asserted that clients are able to develop coping strategies to deal with posttraumatic issues, “I think that part of our program is what makes it unique, in people being able to have a real-life experience here.” After she concluded her answer for the last question we segued into talking about trainings she has attended to provide evidence-based practices. She spoke about her agency being supportive of trainings and opportunities they had, with regard to attending trainings, through the department of human services. She said that they have been trained on motivational interviewing (MI), and subsequently began to elaborate on the MI model stages for their supported employment program. I asked if she had used MI with survivors of sexual violence, to which she responded,

I haven't really thought about it in that context. I think aspects of it are used because it has a very person-centered approach—letting the client take the lead, asking open-ended questions and really letting them direct the conversations. I feel like aspects of it are used, but I feel like motivational interviewing has a strong emphasis on changing a behavior, or changing an aspect of your life. And so there's just an element of it, I feel like I can connect with… I feel like the spirit of motivational interviewing is part of a lot of models, in a lot of ways.
The discussion about the training and approaches she uses to work with her clients was a good way to transition into talking about her lived experiences delivering EBP interventions to survivors of sexual violence. She reflected on the question about her lived experiences and went on to say,

I think my experience is that using a person-centered approach has been to honor the person, and let them have ownership over what they want to share, empower them—a boundary where I have not intruded on their emotional safety and how they want to share. I think that it is a respectful approach. I think that in the capacity that we work with people, I think that has been a positive experience.... And not feel pressured or overpowered, not overwhelmed with questions or anything. I feel like there's so many important changes that have happened in the field, with a lot of different issues and diagnosis.

The interview continued with a discussion of her work environment which she observed has “many, many, many strengths, and has been such a blessing in so many ways to a lot of people, staff and our clients.” However, she stated that the environment does interfere with their ability to follow a strict model of an evidence-based practice, because they provide so many services at her agency:

I feel like we do a little bit of everything with people. And so, like I said, from that perspective, it's really cool because it gives us a lot of flexibility and autonomy in our work. But at the same time, it interferes with our ability to take a practice and really develop it and really wear it and really watch people benefit from a particular model.

I then prompted her to talk about her perceptions about EBPs and non-EBPs. She paused for a moment and then said,
Well, I think that there's a lot of value in evidence-based practices because we have research—scientific research—to support that people are helped by these practices; people are not hurt by using them, and I think that that's very important. Even more important that people aren't hurt. And as far as non-evidence-based practice, I think that the value in that is that it can give the clinician a little more flexibility, and maybe creativity.

She explained that sometimes with EBPs, “we have to stay in a box and can only work within that box.” She emphasized the work experience may give counselors more flexibility to adapt and deliver their interventions to clients. I asked her to elaborate on the benefits and risks of using EBPs. She reiterated that the benefits include scientific research, support, and supervision in the practice. She added that another benefit of EBP is its structure, which can help professionals who are newer in the field or new to a particular population, as “there is some safety in that structure being given to you, and it can keep the sessions moving along. I think for some, it means there can be a beginning and an end.” As the interview continued, she also noted, “sometimes in therapy, it could go on forever and we don't realize that we're getting anywhere.”

With regard to the risks she stated,

The risks of not using it, is I think that sometimes how do you know what you're doing is helping? How do I know if I'm not re-traumatizing somebody or harming them, or how do I know if what I'm doing is effective? I think that having a lot of research in use of a model behind a particular method, you'd feel fairly comfortable knowing that it's going to be helpful or it should be helpful.

As we continued talking about her experience delivering sexual trauma intervention to clients, she voluntarily shared, with certainty:
From a person-centered perspective, I mean I can very vividly in my mind right now see a few people that I feel like—sense that I was really with them in their pain, and hearing their experience and really cared, and really just was very private. And I think that's one of the nice things about a person-centered approach, is it does create that feeling. I can just very vividly, two or three people come to mind. Where you're like, “I know this person knows I get them,” or “I know this person knows that I am here right now, and I care so much,” or “This person knows that I hurt with them, that I feel that it was so unjust what they had to go through.”

In her discussion about her overall experience using EBPs and non-EBPs, she highlighted positive aspects of approaches she has been using and seemed very confident about their benefits. I thanked the participant for her time and reiterated that I would be emailing her a copy of the transcription of the interview to her for verification of accuracy and feedback.

Once I got home, I reflected on the interview while assessing my field notes. Unlike the two previous participants, Th3 seemed to use a person-centered approach to treat her clients. Although she integrated EBPs into her interventions with survivors of sexual violence, her perspective remained holistic. She articulated her understanding of EBPs and non EBPs to explicate their strengths and how they have served her clients.

The interview with Th3 provided a number of statements of significance that were explicitly related to analytical categories. The following table organizes these statements based on the theoretical framework guiding the study.
**Summary of the Interview with Th3**

<table>
<thead>
<tr>
<th>Analytical Categories</th>
<th>Quotations of Significance</th>
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<tbody>
<tr>
<td><strong>1. VAN MANEN LIFE WORLD EXISTENTIALS</strong></td>
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<tr>
<td>Lived body</td>
<td>The first thing you want to do if you're showing them something, if you have to touch their arm, “Is it okay if I touch your arm for a second?”</td>
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<td>I mean I can very vividly in my mind right now see a few people that I feel like-- sense that I was really with them in their pain, and hearing their experience and really cared, and really just was very private.</td>
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<td>This person knows that I hurt with them.</td>
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<td>I feel like I can think and know that those feelings were there.</td>
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<tr>
<td>Lived space</td>
<td>So sometimes, especially initially, when I'm first getting to know somebody, it can be really hard to gauge where they're at: how safe they feel, how far to go in the conversation, how much they can handle with being around people.</td>
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<tr>
<td></td>
<td>Because of the nature of our facility, we are a microcosm for their bigger world experiences.</td>
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<td>If I were just seeing her in my office at that time, like I wouldn't have—she may not have thought to disclose that to me, or not even realize that it was a big issue for her.</td>
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<tr>
<td>Lived time</td>
<td>Because sometimes, we don't-- we can, as clinicians, we can get stuck which can keep our clients stuck.</td>
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<td>I think for some, it means there can be a beginning and an end. And sometimes in therapy, it could go on forever and we don't realize that we're getting anywhere.</td>
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<td>Because for some people, they've worked through this so many times with so many people, that it's sometimes hard to gauge where they are in their recovery from the traumatic experience. Because sometimes they can repeat it just matter-of-factly, because they're always repeating their history to people.</td>
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<tr>
<td>Lived relationship</td>
<td>So then I was able to talk to her about that, and talk about</td>
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ways to feel safe and being around people

We can help her be able to work around all of her goals, without feeling threatened or without feeling re-traumatized.

I think my experience is that using a person-centered approach has been honor the person, and let them have ownership over what they want to share, empower them.

I have not intruded on their emotional safety, and how they want to share and what they want to share, and I think that it is a respectful approach.

And not feel pressured or overpowered, not overwhelmed with questions or anything. Let them direct the conversation.

I know this person knows I get them, or, I know this person knows that I am here right now, and I care so much, But I feel like in that moment, in a few of our sessions, a very person-centered approach was really what she needed to cure her.

but trying to work through how the trauma and abuse affects them from being able to move forward in their recovery, being able to move forward into developing new relationships with people, maybe even just how they can move forward in their life of being in a space with a lot people.

2. BIO-ECOLOGICAL FRAMEWORK

Microsystem  So then I was able to talk to her about that and talk about ways to feel safe and being around people.

We can help her be able to work around all of her goals, without feeling threatened or without feeling re-traumatized just by being around people.

Because you don't want to re-traumatize somebody just because we think it works for one population of people.

And let them have ownership over what they want to share, empower them.

But I feel like in that moment, in a few of our sessions, a
very person-centered approach was really what she needed to cure her.

**Mesosystem**
We have an area of our building that is our social area to help individuals connect and not feel so socially isolated, to engage in recreational activity, to share meals together, to form a sense of community.

Letting the client take the lead, asking open-ended questions and really letting them direct the conversations.

So we go to training, like I go to a manager's meeting and we do trainings on motivational interviewing, and then I come back and integrate that into my supervision.

**Exosystem**
I feel very supported in following the practice, in following the model that they want us to.

**Macrosystem**
Because of the nature of our facility, we are a microcosm for their bigger world experiences.

**Cronosystem**
I think for some, it means there can be a beginning and an end. And sometimes in therapy, it could go on forever, and we don't realize that we're getting anywhere.

Because of the nature of our facility, we are a microcosm for their bigger world experiences.

**3. ISAT**

**Clinical relationship**
Letting the client take the lead, asking open-ended questions and really letting them direct the conversations.

I think my experience is that using a person-centered approach has been to honor the person, and let them have ownership over what they want to share, empower them.

I know this person knows I get them, or I know this person knows that I am here right now, and I care so much.

**Nexus of personal and treatment issues**
But trying to work through how the trauma and abuse affects them from being able to move forward in their recovery, being able to move forward into developing new relationships with people, maybe even just how they can move forward in their life of being in a space with a lot people.

So sometimes, especially initially, when I'm first getting to know somebody, it can be really hard to gauge where they're at: how safe they feel, how far to go in the conversation, how much they can handle with being around people.
I have not intruded on their emotional safety, and how they want to share and what they want to share, and I think that it is a respectful approach.

But I feel like in that moment, in a few of our sessions, a very person-centered approach was really what she needed to cure her.

Because you don't want to re-traumatize somebody, just because we think it works for one population of people.

| Broader systemic and cultural influences | N/A |

4. PROTECTIVE FACTORS

“I’m not pulling this out of nowhere”
So there's a lot of support and supervision and materials, I think, to help develop and grow in that one particular practice.

“It can be effective”
To support that this is—these people are helped by this, people are not hurt by using this, and I think that that's very important.

But I think to do no harm is equally as important as helping, and to not just start grabbing for straws to try and help, because that can actually do a lot of harm.

there are professionals in the field who have studied it extensively.

I think for some, it means there can be a beginning and an end

I think that having a lot of research in use of a model behind a particular method, you'd feel fairly comfortable knowing that it's going to be helpful or it should be helpful.

“I’m doing the right thing”
there is some safety in that structure being given to you, and it can keep the sessions moving along.

5. RISK FACTORS

“Being careful”
I don't think somebody in my position should have as much flexibility when working with somebody around trauma, because I'm not going to be as on top of the current research and knowledge.
But I think to do no harm is equally as important as helping, and to not just start grabbing for straws to try and help, because that can actually do a lot of harm.

I guess once you start manipulating it, then you're no longer following the evidence-based model.

I think that sometimes how do you know what you're doing is helping, what are you basing that decision off of on what to use; how are you protecting yourself from not letting your own agenda get in the way?

**Lack of preparation for trauma – graduate school**
I did not have a class that was specifically focused on trauma, but a professor along with a few graduate students did do a trauma seminar.

**Lack of preparation for EBPs – graduate school**
N/A

### 6. COMMON THEMES

**Multimodal approach**

But really, a person-centered approach and a collaborative approach.

Taking a holistic person-centered approach, and really gauging where they're at.

In general, we follow an evidence-based model that uses motivational interviewing.

DBT is another model that's used a lot in an individual's therapies.

**Structure/rigid**

And so I feel like they can be pretty rigid about the model. I guess that's what makes it evidence-based. I guess once you start manipulating it, then you're no longer following the evidence-based model.

But because we have to follow the model, sometimes it can feel like, "Oh, we're stuck here for a few more sessions until we can move on to the next thing, even if you're ready."

Sometimes with evidence-based practices, we have to stay in a box and can only work within that box.

**Flexibility/adaptation**

I think there may be room for a little more flexibility because of the education and the experience and so forth that they have.

And I think if someone's been practicing with that population for a really long time using those and feels that...
it's safe to be a little more flexible within that practice, then I think that's fine.

I think that the value in that is that it can give the clinician a little more flexibility, and maybe creativity.

It's really cool because it gives us a lot of flexibility and autonomy in our work

<table>
<thead>
<tr>
<th>Rewarding experience</th>
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<tr>
<td>Being a woman</td>
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Th4 Interview

The fourth interview was conducted with a 50-year-old Latina female who has been working in the mental health field for 23 years. We started with the demographic questions, by which I gathered information to proceed with my inquiry. She is currently working for a group practice as a licensed professional counselor. She has delivered sexual trauma interventions to victims and/or survivors of sexual violence. She has also attended training on evidence-based practices, and she was fully aware of the nature of the study. We met in her office where she felt comfortable in sharing her experiences. I reviewed confidentiality and how the information she shared would be protected. I also reviewed the purpose of the study, emphasizing that participation in this study was voluntary and that she could leave at any time. She agreed to participate, and we both signed the informed consent.

Her interview with an inquiry from me about her experience working in the mental health field for the past 23 years. She talked about why she first got interested in the field and spoke proudly of her work and trajectory. She explained,

I worked at (name of the agency) for the past 23 years. I started working there as a residential counselor with chronically mentally ill individuals, adults. And then I worked, all within the agency, I worked in service coordination, helping linking people to services
that they needed or benefits that they needed. Then I went back to school while I was working service coordination… I started working private practice in 2012 here. But prior to that, I was doing contract hours for an agency also in the evenings, as a therapist working with adults. And then I also worked at a hospital before and after it was sold to another hospital, in a psychiatric floor doing part time work as a relief social worker.

Th4 added that life working as a counselor is challenging and fulfilling in so many ways. I inquired about her experience working with sexual violence trauma survivors. She went on to say that the majority of her clients have been sexually traumatized. “They wouldn’t come to therapy for that particular reason, but while we were processing things, that would come out and that turned out to be the underlying issue.” I then prompted her to talk, specifically, about her experience working as a trauma-focused therapist:

My experience is that I notice that I need to, when I have clients that I am seeing that fit the profile, I need to definitely focus on my self-care more than normal, typically I'd say. Because it is hard for me as a therapist to hear their story and not feel for them in a different way, that I would feel for somebody else that would be having a different issue. Like one of the populations that I work with are couples. I see couples a lot, and the issues they come to see me for are different, and it's easy to maintain your boundary emotionally from the issues they bring. But when it comes to clients that have a sexual trauma, it's hard to do that.

I reflected that she seemed very aware of how working in the field of sexual trauma can affect her and inquired further explanation about her coping mechanisms to work as a trauma-focused therapist. She went on to say that supervision has been very helpful. The participant continued sharing about her experiences treating survivors of sexual violence:
As a professional, I think it's nice when the client stays long enough that you can see a change in certain behaviors that they bring with them. That improvement in their ability to deal with stress and to cope with, going from a victim stage or survivor, and now taking charge of their lives. So I like that. I like to be able to see that transition.

Because she has worked in different settings, I asked her to talk about her experience with clients who stay “long enough that you can see a change,” as she had mentioned earlier.

It depends. In private practice, I notice that people stay longer. In community mental health, they're a little tough to kind of keep track of. Individuals, because of other issues in their lives, tend to not keep up with the mental health treatment. Sometimes they're more symptomatic, and the symptoms get in the way of really focusing on doing what they need to do every day. But in private practice, you see people, they're somewhat more focused on their well-being and they're interested in doing this. It's not that population isn't interested, but the priorities shifted because of the situation in their lives, and so it changes in that sense.

This was very vocal about her work systems differences as well as specific needs of the populations she had the opportunity to work with during all this time.

We segued into a discussion about approaches she has used in the treatment of sexual violence survivors. At this time, the participant took a moment to talk about her educational background. She mentioned that she pursued her undergraduate studies abroad, which was focused on psychoanalysis; she smiled and said “I love psychoanalysis.” But when she moved to the United States and started graduate school, there was no place for psychoanalysis. She stated, “Especially working with individuals who suffer from a lot of trauma—you don't want to go back to the past and re-traumatize them.” However, she uses aspects of psychoanalysis to
conceptualize her cases and understand the dynamics someone’s past. She went on to say that she has come to appreciate cognitive behavior therapy and dialectical behavior therapy (DBT).

She noted,

I didn't always like it, because it seemed so trivial to me. When I first learned, it was like, “What is this? I know this.” But then, after-- because of the skills that it teaches and the-- it's kind of a no-brainer, if you will, but people really don't remember it. The more I used with clients—because at the time, when I was working with the hybrid program I told you about—that's the approach that the insurance company wanted us to use.

The participant continued sharing that there was pressure to only use CBT and she ended up liking this approach because clients were responding positively to the interventions, “It was simple, it was something that they could really easily do. I started seeing that it did work. So, I ended up adopting as one of the ways; CBT and DBT is what I use.” She mentioned that she had a client who had just started treatment so they talked about using DBT and the client agreed. I prompted her to talk about how she uses sexual trauma interventions. She explained,

When somebody brings up past trauma of whatever nature, I always let him or her know that it's okay for him or her not to talk about it if they don't want to. It's not mandatory that they talk about that, in order for these sessions to flow. I like to develop a good rapport with the person, because I think that's more important than anything that-- it becomes a trust issue when there's somebody who suffers, who are a survivor of trauma. Trust is a big deal for them. And for me to come in and re-traumatize in a way to ask, "You need to talk about this," to me, it's not a good approach. But I'm going to always kind of touch upon, and you can always tell me, "No, I'm not ready yet." And so I want to let them know that, that it's not my car here. They're driving.
Her use of the car analogy captivated me because she spoke with a lot of energy that seemed to demonstrate passion and care for her clients. I reflected on the clients’ being able to reclaim their power and be in control of their lives. She noted, “I actually use that as an analogy, especially explaining therapy to people who have never been in therapy. I tell them, ‘I'm your GPS.’ You can go wherever you want. I can tell to recalculate, but you turn wherever you want to turn.”

I inquired about her training to use EBPs with trauma survivors. She stated that she had extensive training on CBT. Her agency required therapists to use CBT, so they made training available to the staff at no cost. She also went to training offered outside her agency. As the interview continued she voluntarily shared that she was attending training on DBT next week. In the discussion about training and interventions, I asked if she had the flexibility to use different approaches with her clients. She said,

The agency, in a way, even though they really wanted us to use that modality, they understood at that time that it was about the client and not us. I had plenty of people who didn't want to do DBT at all. Like, “Don't give me homework, I'm not doing it.” I was like, “No problem. Throw it away. No need.” And so, yeah, definitely had the flexibility to do it or not do it. Although, there was an expectation that I would definitely offer, which was fine.

In her discussion of the positive aspects of using EBP interventions, she identified the value of flexibility and agency’s expectations. I asked the participant how she perceived EBPs and non-EBPs, to which she answered, “It depends on what might be. Other modalities, if they're safe for the client, that's fine. I don't—myself as a professional, I like to stick to what I'm good at.” After she explained her reason for using EBPs she offered an example:
I had a client come in here actually, and she said, ‘I really would like a Christian approach to counseling.’ And I told her that I respected her need to bring her spirituality into the counseling, and I was fine with that, but I couldn't reciprocate because that's not what I do. And I helped her find another therapist, and she's fine. She's working with my peer, actually, next-door neighbor.

As the participant shared this experience of referring a client, it was apparent that using approaches that she feels comfortable with is important and professional for her. She stated, “I wouldn’t even know where to begin with Christian counseling. But if that’s something she needed, then she should definitely get it."

She mentioned about having the freedom to use approaches that are not evidence-based. She emphasized that sometimes she needs to be able to bill insurance and in order to request more sessions for a client, she has justify her use of EBPs. She stated, “If you tell your insurance company that you're working on—no disrespect to any modality—but if you say ‘I'm using psychic connection too,’ I don't know that they necessarily would say, ‘We’ll cover it.’” She went on to say that insurance companies would allow non-EBPs if the therapist presents evidence proving that what she has used so far has not worked.

After listening to her example and use of approaches, I asked if EBPs and trauma were emphasized during her graduate work. She noted that EBPs were definitely emphasized and said that she remembered her adviser saying “this was the way of the future, and billing would be based on evidence-based practice, and we should definitely be in tune with that.” With regard to trauma courses, she remembered the name of the professor who facilitated the trauma courses at the university. She went on to share a memory about “due dates.” She chuckled as she described this story between her and her professor.
As the interview continued, we talked about her challenges using EBPs when delivering sexual trauma interventions to clients and she said, “I guess the challenges would come when things are required, and you have to do it despite of clients themselves.” She went on to say that there is a different dynamic in agencies versus private practice: “clients who come here, in private practice, for therapy they’re able to finish treatment.” I asked her to elaborate more on the dynamics, to which she gave an example from when she was working for an agency.

Somebody might show up or, say, with the program that I was with, we'd go to people's houses and see them at home. And sometimes you'd get home, and there was something that we needed to do that day. And then we couldn't do it, because their electric was shut off or they had no gas, and you had to deal with that. And then by the time you finished dealing with maybe placing them in respite or doing something else to help the situation, you couldn't do it. So those are the biggest challenges, if there was something that you actually had that had a due date. It's just the thing. Life will happen.

We segued into a discussion about her lived experiences using EBPs. Th4 sat up in her chair and+ presented a reflective demeanor, as opposed to her casual and relaxed manner prior to the question. She talked about a client with whom she used DBT. She described the process and how she attended to this client’s posttraumatic stress issues,

I listened to her story, and this was so interesting, I thought she really appeared to me at that moment that she really wanted to do something different. The long-term effects of the guilt she felt from being away from her kids, was such that; and her suicide attempts were less intentional than they were. In the moment, she just wanted to stop feeling what she was feeling. And her suicide attempts were more ways of coping with that stress in the moment, than really looking for the outcome to die.
As she shared the case with her client, it was evident that this story had been a powerful experience for her because the question was about her lived experience, and she related it to a specific case that she felt demonstrated her experience. She went on to say that as a therapist, she enjoys working on the here and now, rather than processing what has passed, “but it’s not about me. It’s about her.” She appeared aware of the transference and counter-transference that is common in trauma therapy, and she said,

But I will tell you this, one thing that to me I have a really hard time as a woman and as an individual, when I witness this raw emotion from somebody when they go into describing their trauma experience in detail… And I have such a hard time. I get so angry—not at them, of course—at what happened, at the person who did it. And I find that I really need to focus on my self-care, because it affects me so much just to witness that.

The participant seemed to be visualizing her experiencing working with trauma survivors as she verbalized it to me. She explained that it is so difficult to be there and listen to clients talk about a traumatic event. She went on to talk about one of her experiences,

I had this one client, one time, shows me a picture when she was a little child and when her abuse started, the age that she was. And she showed me that picture because she came across this photograph, and she started thinking about this was the age that it started. But look at me before it started, I was happy. It was all I could do, when she showed me the picture, not to totally counter-transfer and feel enraged for her. And I had to really focus that day not to. I don't mind. I mean, in the past, I would be worried about how my response would affect the person. But today, I think if this is how I feel, why should I
block it? So I did shed some tears that day, and it was fine. It was no big deal. I didn't want to stop. I think it would be worse if I just tried to contain.

Her sharing of this experience was very vivid, and it made me relate with my experiences in working with survivors, especially when she said, “I remember leaving here and I went home… the picture that she showed me, she looked just like my daughter. And I thought to myself, ‘If this ever happened to my daughter, somebody would be dead.’” Since she mentioned self-care I asked for more clarification regarding self-care in general and how she dealt with the countertransference case. She went on to explain,

So I went to a bookshop and got a coffee, walked around, looked at books. And I just needed to decompress and then go home… I scheduled the supervision, and that definitely helped. Because if I experienced that kind of feeling all the time, I don't think I could be effective as a therapist. But I think it's important to be in touch with the feeling and how you feel, because it's kind of a glimpse in how the person themselves feel.

We continued to discuss her coping to keep herself together emotionally and physically from working with trauma, and she seemed to have the simple answer that self-awareness is fundamental in the mental health field. The participant shared, voluntarily, that at some point she thought she could no longer do trauma work: “I had this client that had suffered a lot of trauma as a child, and she'd talk about it. And I remember that I decided that I was going to leave the profession, I couldn't do this anymore. It was hard for me.” Then she stated,

I went from this place where I was so sad and so emotionally flooded with her story, from being grateful for my life. And when I changed that, when that changed in my mind, and I can't tell you how it happened. I remembered that I was able to say, “Wait a minute, I can help you.” Because I can be grateful for my life and what I have now, and therefore I
can give some of that to somebody and be able to help them. And if I'm going to be
witness to all of this, there might be other things that I can do to protect myself, so that I
can actually do the work. But being grateful for life itself definitely helped me to
maintain that state of gratitude that despite of my life or what happened to me, that today
I'm good.

In the interim she discussed her therapist resiliency and what she does to maintain mental and
physical health to offer her client a healing experience. As the interview concluded it seemed that
Th4 had enjoyed the interview. I was grateful for this participant who promptly shared her
perceptions and experiences about EBPs when treating survivors of sexual violence. I thanked
the participant for her time and reiterated that I would be emailing her a copy of the transcription
of the interview to her for verification of accuracy and feedback.

The interview with Th4 provided a number of statements of significance that were
explicitly related to analytical categories. The following table organizes these statements based
on the theoretical framework guiding the study.

Table 5

Summary of the Interview with Th4

<table>
<thead>
<tr>
<th>Analytical Categories</th>
<th>Quotations of Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. VAN MANEN LIFE</td>
<td></td>
</tr>
<tr>
<td>WORLD EXISTENTIALS</td>
<td></td>
</tr>
<tr>
<td>Lived body</td>
<td>It's kind of a no-brainer.</td>
</tr>
<tr>
<td></td>
<td>So it is real and raw, and so hard.</td>
</tr>
<tr>
<td>Lived space</td>
<td>I thought she really appeared to me at that moment that she really wanted to do something different.</td>
</tr>
<tr>
<td></td>
<td>I think it would be worse if I just tried to contain.</td>
</tr>
<tr>
<td></td>
<td>And then every week, it was the same day every week, same time every week, I'd go to her house. And for an hour, we'd work on the manual.</td>
</tr>
</tbody>
</table>
### Lived time

You don't want to go back to the past and re-traumatize them.

I think it's nice when the client stays long enough that you can see a change in certain behaviors that they bring with them.

### Lived relationship

They know better, and I just happen to be here witnessing their process.

I went from this place where I was so sad and so emotionally flooded with her story.

I like to develop a good rapport with the person.

I find that sometimes doing scales in the beginning and at the end, or asking people to fill out a form, doesn't really feel real.

But it's not about me. It's about her.

Because it is hard for me as a therapist to hear their story and not feel for them in a different way, that I would feel for somebody else that would be having a different issue.

### 2. BIO-ECOLOGICAL FRAMEWORK

<table>
<thead>
<tr>
<th>Microsystem</th>
<th>I think it's nice when the client stays long enough that you can see a change in certain behaviors that they bring with them.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>I always let them know that it's okay for them not to talk about it if they don't want to.</td>
</tr>
<tr>
<td></td>
<td>You have to put a lot of energy to bring them in on board to respond the way your plan goes. Because otherwise, if people don't do it, it kind of falls apart.</td>
</tr>
<tr>
<td>Mesosystem</td>
<td>So if you reach out to people, they respond. It's a matter of communication.</td>
</tr>
<tr>
<td>Exosystem</td>
<td>I did feel that I could. The agency, in a way, even though they really wanted us to use that modality, they were understanding at that time that it was about the client and not us.</td>
</tr>
<tr>
<td></td>
<td>I guess the challenges would come when things are required, and you have to do it despite of the clients themselves.</td>
</tr>
</tbody>
</table>
It's a lot of case management.

Macrosystem | That's the approach that the insurance company wanted us to use. So I was kind of forced to get into it….
--- | ---
I was lucky that I had a lot of freedom to make decisions for my program. And then within reason, just pretty much run it, and I had a good result that I was supported and encouraged.

Now, at times when—like insurance companies say, “I'm not going to pay anymore,” but you still clinically see that your client needs to come in.

And generally speaking, they were pretty good at giving it to us, but sometimes they would make us jump through all kinds of hoops.

Cronosystem | You don't want to go back to the past and re-traumatize them.
--- | ---
I mean, in the past, I would be worried about how my response would affect the person.

3. ISAT

Clinical relationship | I always let them know that it's okay for them not to talk about it if they don't want to.
--- | ---
I like to develop a good rapport with the person

I thought she really appeared to me at that moment that she really wanted to do something different.

Nexus of personal and treatment issues | They know better, and I just happen to be here witnessing their process.
--- | ---
I started noticing that was so helpful to her, because she was actually doing the homework, the exercises on the book.

And it was almost as if a light went on, that she realized, "I don't do that. I need to learn how to do this. I don't know how to feel better."

Why are you seeing everybody for an hour? Is everybody the same? Like no, everybody is not the same,

Broader systemic and cultural influences | That's the approach that the insurance company wanted us to use. So I was kind of forced to get into it.
I guess the challenges would come when things are required, and you have to do it despite of the clients themselves.

Now, at times when-- like insurance companies say, “I'm not going to pay anymore,” but you still clinically see that your client needs to come in.

And generally speaking, they were pretty good at giving it to us, but sometimes they would make us jump through all kinds of hoops.

4. PROTECTIVE FACTORS

“I’m not pulling this out of nowhere”
If you work in a community mental health and you have to justify your billing, you can use that to back up your clinical review.

“It can be effective”
He would encourage us to think about like scales to assess people as they were coming in, and then as they went out or ready to be discharged. So we can see where they were when they started, and where they are now that they're being discharged, that kind of thing.

“I’m doing the right thing”
that's the approach that the insurance company wanted us to use.

I like to stick to what I'm good at.

"No, we did A, B, C, D and-- " or duration of, "This person has been here for six months," or whatever, that kind of thing.

5. RISK FACTORS

“Being careful”
And it's not a matter of me giving an opinion, as to whether this is good or bad. It's just as a professional.

Lack of preparation for trauma – graduate school
In grad school, I had the—I forget now the discipline, but we had the—we had Dr…., I remember her, she was great. It was a class on trauma.

Lack of preparation for EBPs – graduate school
I remember my adviser in grad school saying that this was the way of the future, and billing would be based on evidence-based practice, and we should definitely be in tune with that.

He [professor] would encourage us to think about like scales to assess people as they were coming in, and then as they went out or ready to be discharged.

Rewarding experience
That improvement in their ability to deal with stress and to cope with, going from a victim stage or survivor, and now
taking charge of their lives. So I like that. I like to be able to see that transition.

6. COMMON THEMES

Multimodal approach
My education was all in psychoanalysis… use it to kind of conceptualize cases

CBT is what I use. But DBT, I definitely used with some clients

Structure/rigid
I guess the challenges would come when things are required, and you have to do it despite of the clients themselves.

We'd work on the manual.

I started noticing that that was so helpful to her, because she was actually doing the homework, the exercises on the book.

Now, at times when—like insurance companies say, "I'm not going to pay anymore," but you still clinically see that your client needs to come in

Flexibility/adaptation
It's not mandatory that they talk about that, in order for these sessions to flow.

Definitely had the flexibility to do it or not do it. Although, there was an expectation that I would definitely offer, which was fine.

I was lucky that I had a lot of freedom to make decisions for my program. And then within reason, just pretty much run it, and I had a good result that I was supported and encouraged.

Rewarding experience
That improvement in their ability to deal with stress and to cope with, going from a victim stage or survivor, and now taking charge of their lives. So I like that. I like to be able to see that transition.

Being a woman
One thing that to me I have a really hard time as a woman and as an individual, when I witness this raw emotion from somebody when they go into describing their trauma experience in detail.

Th5 Interview
The fifth interview was conducted with a 33-year-old African-American female who has been working in the mental health field for over 8 years. We started with the demographic questions by which I gathered information to proceed with my inquiry. She is currently working in an outpatient program for adults with mental health issues and drug and alcohol abuse. She has a Master of Arts in Clinical Mental Health Counseling and has delivered sexual trauma interventions to victims and/or survivors of sexual violence. She has also attended trainings on evidence-based practices. She was fully aware of the nature of the study and seemed excited to talk about her perceptions and experiences with EBPs when delivering sexual trauma intervention to clients. She mentioned that she has been working for the same agency for over 8 years. We met in a room in a private office where she felt comfortable sharing her experiences. I reviewed confidentiality and protection of the information she shared. I also reviewed the purpose of the study and emphasized that participation in this study was voluntary and that she could leave at any time. She agreed to participate, and we both signed the informed consent.

Th5 displayed a lot of enthusiasm and started talking about her work as soon as she met me outside of my office. When we started the audio recording, I prompted her to talk about her background working in the mental health field, to which she offered this description:

I work for an agency in the adult outpatient unit on neighborhood X. We see a large array of individuals who have severe persistent mental illness, some of those who have experienced different lines of trauma, either sexual, or child abuse, or physical.

After discussing her background in the mental health field, she continued to talk about her experience working with survivors of sexual violence:

My experience has been quite interesting. I say that because with trauma, it's a very specialized type of line of work. Dealing with clients, I feel like pretty much all of the
people that I serve, and through my experience working at the agency, most of them have experienced some line of trauma whether it be sexually based or whatever. It's just been that a lot of people just experience something in their lives that really dictates who they are now, and what they're doing, and how they perceive the world.

She seemed confident expressing her experience to working with her clients. She noted that most of the clients she sees have been diagnosed with bipolar disorder, depression, or anxiety. She explained that working as a trauma-focused therapist has been quite an experience. I followed up with the question about her approach to treat survivors of sexual violence. She answered,

> With sexual violence, I know it's a complete, again, a different section. It's a different specialty and understanding with it, but from my approach whenever I meet with individuals who have a history of sexual violence. It's just creating a space where they feel safe to talk about what happened. And getting them to tell their story about how, whatever it was that they experienced in the past, and how they feel about themselves now. And really trying to create a space where they can understand that. It's not what's wrong with them, but what has happened to you.

The participant continued sharing that at her agency they mostly use CBT and MI. She expressed that she would like to attend more training on specific issues because she does not feel that she knows enough. She added that she has used rational emotive behavioral therapy (REBT), dialectical behavioral therapy, Adlerian therapy, and reality therapy. She went on to explain, however, that she uses more CBT “because it’s tangible, and people can see their thought process and understanding how they are thinking and where those thoughts are coming from.” I asked for some more clarification regarding the approaches she uses to which she explained more about
using REBT and thought restructure, using an example from a client. “But in our session, as we broke down her thought process about the guilt; I pointed out that with her telling somebody about her molestation that she was actually taking care of herself, like looking at it from that perspective.” When I asked if she used any specific protocols, she said that she does not have a lot of sexual intervention training, but based on what she knows about CBT, “I just kind of adapted as best as I can to what the situations is with the person, and it seems to work out pretty well.”

Since we were talking about training, I prompted her to elaborate on her training in using EBPs when delivering sexual trauma interventions to clients. She stated that she was trained within her agency and in CBT as well as MI. In answer to my follow-up with the question about her training on EBP and trauma during graduate school, she said,

So what I remember, we had, the closest thing that we had to it was the crisis—I can't remember what they titled the class itself, but I want to say it was something like Crisis Intervention and Substance Use, or something like that. I remember the class being very quick because it was during a summer track, which was very unfortunate, because I wanted to gain a lot more from just a really short period of time. But I do remember within the Crisis Intervention, which I thought was really neat, when they taught— I know it's not quite trauma, but kind of similar—that when they talked about crisis that it's those opportunities and trying to find a way to deal with the chaos that's going on … inside of everything.

She repeated that she had no trauma courses either. I reflected back to her that she seemed very invested in her work to help survivors of sexual violence. Then I inquired about her perceptions of EBPs and non-EBPs. She replied,
I feel that evidence-based practices are very helpful, and the fact that there is a lot of research surrounding and supporting that they work effectively. I think sometimes that they're a little bit rigid in terms of how they're delivered, but I feel that that's where the therapist can step in and kind of mold it or make it their own for the particular client that they are seeing. The non-evidence-based practice is, I think that there's a lot of caution that people need to be mindful of and not just using a particular approach and not really knowing enough about it or knowing if it's something that will actually work and just kind of implementing it at will. That's a little scary. I think that that can kind of get dicey, especially with working with a population of individuals who do have sexual violence background or trauma background.

I asked if she could elaborate on “sometimes they’re a little bit rigid,” to which she replied that she believes it is important to adapt an approach to meet clients where they are, “Even though it does not look exactly like the model and there are pieces and parts of the particular practice involved within the sessions, that it’s very effective.” She added that it is important to consider the population one works with—for example, “individuals who have different learning disabilities and severe persistent mental illness and that understanding of what is, not making it too lofty or too complex like it is.”

The participant appeared very confident in her elaboration of EBPs and related accurately the reality of her day-to-day practice. There was a sense of pride that she projected and filled the room during the interview.

With regard to challenges in using EBPs, she reiterated that counselors have the freedom to adapt the approach:
So with cognitive behavioral therapy, because it's so organized and structured that whenever you're sitting down across from somebody, and they have a million and one things that they need to say to you, and you're trying to be structured and everything else in the practice that it doesn't work—it doesn't turn out as pretty. So that's one thing that I noticed that happens, and you know that's where that flexibility comes in, to kind of help guide and redirect the client to something that kind of looks like whatever that practice is, but keeping in mind that it's not always going to be very organized.

I invited the participant to take this opportunity to share what her lived experiences were when delivering EBPs to sexual trauma survivors. She took a moment and then said that it is important to be attentive and present when using EBPs with somebody who has history of sexual violence:

It is like pulling myself into what it is that they're discussing but not getting too wrapped up and involved with the story to where it gets too muddied or far out. So letting the person share what it is that they're experiencing, understanding where they're coming from, but then also to using a lot of the different techniques to be able to pull everything together…

I think that whenever I have those experiences, it's a lot of work. And I say that because it's something where I know that I have to be present. Not to say that I'm daydreaming or anything like that, but in terms of really trying to understand what that experience was for somebody, knowing that I personally didn't experience what they experienced. So it's like putting myself in there, and trying to see it through their lens, but then also trying to capture where there might be some pain or some loss or anything else that's there to really try to harness it, and not letting it grow so far. So my own personal
experience, I would say that it's difficult but it's really—it's worth it. It's like a worthwhile experience in the sense.

Th5 appeared aware of difficulties with regard to vicarious traumatization when working with trauma survivors. After we discussed further issues about EBPs and non-EBPs, I asked her about the benefits and risks of using EBPs to treat survivors of sexual violence. She explained, “I think the benefits are that it's something that's trackable. It's something that is reliable, sustainable. All those good ‘ables’ that exist that you can really rely on it, and use it, and know that you're going to get a produced outcome from it.” In terms of risks, she said,

I think the risks are therapists just kind of making up their own thing and calling it something, and it not really being anything. So we got the “ables” and the “ings.” So using some type of practice, but not really having any substantiated evidence about it. And for some reason when I think about this, I think of harm to the client. If you're doing something that's so far out, and you don't know how it's going to affect somebody, but yet you're testing it out anyway without any founded proof that would be harm, and that's scary.

She affirmed that her overall experience with EBPs has been positive. She seemed very optimistic about investing in more research to bring about therapies and modalities to help clients who struggle with posttraumatic stress disorder. As we approached the end of the interview, I asked if there were other questions I had not asked that would enhance my understanding of her perceptions and experiences with EBPs when delivering sexual trauma interventions to clients. She recommended inquiry about vicarious traumatization. I acknowledged her suggestion, thanked the participant for her time, and reiterated that I would be emailing her a copy of the transcription of the interview to her for verification of accuracy and feedback.
The interview with Th5 provided a number of statements of significance that were explicitly related to analytical categories. The following table organizes these statements based on the theoretical framework guiding the study.

Table 6

*Summary of the Interview with Th5*

<table>
<thead>
<tr>
<th>Analytical Categories</th>
<th>Quotations of Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. VAN MANEN LIFE WORLD EXISTENTIALS</td>
<td></td>
</tr>
<tr>
<td>Lived body</td>
<td>N/A</td>
</tr>
<tr>
<td>Lived space</td>
<td>And so it takes a lot to be able to be patient and understanding of that. And to really create a space where somebody can open up and talk about their experiences. It's just, kind of again, creating a space where they feel safe to talk about what happened. Whenever you're sitting down across from somebody, and they have a million and one things that they need to say to you, and you're trying to be structured and everything else in the practice that it doesn't work. Whenever I'm using an evidence-based practice with somebody who has a sexual violence background, that being very attentive and being very present with the person through what it is that they're sharing. I say that because it's something where I know that I have to be present. Not to say that I'm daydreaming or anything like that.</td>
</tr>
<tr>
<td>Lived time</td>
<td>It's just been that a lot of people just experience something in their lives that really dictates who they are now, and what they're doing, and how they perceive the world. If they have a certain belief about the general construct of the world and how the world treats them is really trying to pull apart those pieces, and showing that person where they are in the present moment.</td>
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<tr>
<td>Lived relationship</td>
<td>And getting them to tell their story about how—whatever it</td>
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</table>
was that they experienced in the past, and how they feel about themselves now.

So it's like putting myself in there, and trying to see it through their lens.

It's not what's wrong with them, but what has happened to you, in that type of sense.

But in terms of really trying to understand what that experience was for somebody, knowing that I personally didn't experience what they experienced.

Like pulling myself into what it is that they're discussing, but not getting too wrapped up and involved with the story to where it gets too muddied or far out.

But then also to using a lot of the different techniques to be able to pull everything together to show if they're having a cognitive distortion about themselves, about what's currently happening in relationships.

<table>
<thead>
<tr>
<th>2. BIO-ECOLOGICAL FRAMEWORK</th>
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<tbody>
<tr>
<td><strong>Microsystem</strong></td>
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<td></td>
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<tr>
<td></td>
</tr>
<tr>
<td><strong>Mesosystem</strong></td>
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<tr>
<td><strong>Exosystem</strong></td>
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<td></td>
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<tr>
<td><strong>Macrosystem</strong></td>
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</table>
on in the treatment plan, if it's matching up with what we're
doing in session, and if those sessions are, in fact, related
to some kind of evidence-based practice.

<table>
<thead>
<tr>
<th>Cronosystem</th>
<th>It's just been that a lot of people just experience something in their lives that really dictates who they are now, and what they're doing, and how they perceive the world.</th>
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<tbody>
<tr>
<td></td>
<td>If they have a certain belief about the general construct of the world and how the world treats them is really trying to pull apart those pieces, and showing that person where they are in the present moment.</td>
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</table>

3. ISAT

<table>
<thead>
<tr>
<th>Clinical relationship</th>
<th>Whenever you're sitting down across from somebody, and they have a million and one things that they need to say to you, and you're trying to be structured and everything else in the practice that it doesn't work.</th>
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<td></td>
<td>But in terms of really trying to understand what that experience was for somebody, knowing that I personally didn't experience what they experienced.</td>
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<tr>
<td>Nexus of personal and treatment issues</td>
<td>And so it takes a lot to be able to be patient and understanding of that.</td>
</tr>
<tr>
<td></td>
<td>It's not what's wrong with them, but what has happened to you, in that type of sense.</td>
</tr>
<tr>
<td></td>
<td>Not making it [treatment] too lofty or too complex like it is, it's very important to make it more simplified.</td>
</tr>
<tr>
<td>Broader systemic and cultural influences</td>
<td>I think that also too, working with a population with individuals who have different learning disabilities and severe persistent mental illness and that understanding of what it is,</td>
</tr>
<tr>
<td></td>
<td>I think that the environment is very supportive of evidence-based practices, and they talk about them often.</td>
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<tr>
<td></td>
<td>They [the county] want to see whatever it is that we're working on in the treatment plan, if it's matching up with what we're doing in session, and if those sessions are, in fact, related to some kind of evidence-based practice.</td>
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</tbody>
</table>

4. PROTECTIVE FACTORS

| “I’m not pulling this out of nowhere” | I feel that evidence-based practices are very helpful, and the fact that there is a lot of research surrounding and supporting that they work effectively |
“It can be effective”  That it's something that's traceable. It's something that is reliable, sustainable.
You can really rely on it, and use it, and know that you're going to get a produced outcome from it.

“I’m doing the right thing”  N/A

5. RISK FACTORS

“Being careful”  They [the county] want to see whatever it is that we're working on in the treatment plan, if it's matching up with what we're doing in session, and if those sessions are, in fact, related to some kind of evidence-based practice.
And for some reason when I think about this, I think of harm to the client.
If you're doing something that's so far out, and you don't know how it's going to affect somebody, but yet you're testing it out anyway without any founded proof that would be harm, and that's scary.

Lack of preparation for trauma – graduate school  They offered a trauma information class, but it was an elective.
The closest thing that we had to it was the crisis—I can't remember what they entitled the class itself, but I want to say it was something like Crisis Intervention and Substance Use, or something like that. So they melded those two things together. I remember the class being very quick because it was during a summer track, which was very unfortunate, because I wanted to gain a lot more from just a really short period of time.

Lack of preparation for EBPs – graduate school  N/A

6. COMMON THEMES

Multimodal approach  Focus on more of the CBT based
I like to use—like with REBT, like the ABCDE

Structure/rigid  I think sometimes that they're a little bit rigid in terms of how they're delivered.
With cognitive behavioral therapy, because it's so organized and structured

Flexibility/adaptation  They're trying to change that modality of really trying to help people where they are and trying to move them on with the coping skills and everything through therapy.
I feel that that's where the therapist can step in and kind of mold it or make it their own for the particular client that they are seeing.

That even though it doesn't look exactly like the model and there are pieces and parts of the particular practice involved within the sessions, that it's still very effective.

I think that it's trying to make them so it fits.

And you know that's where that flexibility comes in,

<table>
<thead>
<tr>
<th>Rewarding experience</th>
<th>So it was neat—was just changing over that cognitive thought process into something that was really positive.</th>
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<tbody>
<tr>
<td>Being a woman</td>
<td>N/A</td>
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**Th6 Interview**

The sixth interview was conducted with a 32-year-old Black female who has been working in the mental health field for 13 years. We started with the demographic questions by which I gathered information to proceed with my inquiry. She works as the executive director and clinician for an organization that addresses trauma. She has a PhD and has delivered sexual trauma interventions to children, adolescents, and adult victims and/or survivors of sexual violence. She has also attended training on EBPS. Being fully aware of the nature of the study, she agreed to do the interview via Internet. The interview was conducted through Facetime from her office where she felt comfortable in sharing her experiences. I reviewed confidentiality and information protection procedures. I also reviewed the purpose of the study and emphasized that participation in this study was voluntary and that she could leave at any time. She agreed to participate and sent her informed consent signed via email.

Following a review of the information, we discussed the current climate with regard to issues related to the mental health field, as she practices counseling in another state. As part of
our conversation, I prompted the participant to talk about her experience working as a trauma-focused therapist, to which she noted,

For the most part, I will say that it's pretty stressful. You're hearing a lot of atrocious activities like, things that, horrible things have been done to people. I think that after hearing such things so often, I think it in one way or one shape or another, it kind of takes its effect on you. So my experience has been sometimes dreading hearing more, to be honest with you.

She then spoke about treating survivors and feeling overwhelming “especially being a woman.”

Th6 took some time to reflect after she expressed her experience working with survivors and then went on to say,

Sometimes, I think about—I hear things that happened to people. In one regard, I'm like, “Oh my goodness. I've been so fortunate that certain things haven't happened to me.” But then another time, on the other end, it kind of puts a little bit of fear in me too like, “Oh my God. That could be me. I'm not better than any one of my clients.” I look at some women who've contracted a sexually transmitted disease, like HIV and AIDS, because they were raped.

I took a moment to let that sink in and was really struck with this honest disclosure of her experience working with survivors of sexual violence. I sensed that she felt anxious in a world where “atrocious” things happen. I reflected on my own fears working as a trauma-focused therapist and thought of her comment about “especially being a woman.” This led into a discussion about self-care and supervision, in which she reflected on peer support: “I know that I talk a lot, which I think is helpful for me, whether it’s to a colleague… or will just call a mentor.” I asked if there was anything else she wanted to add about her experience working as a
trauma-focused therapist before moving to what approach she has used in counseling survivors of sexual violence. She said that we could move on and that if she thought of something else with regard to the first question, she would let me know.

She then stated that her approach to counseling is to use CBT. She emphasized that CBT has helped her work with clients who are still experiencing symptoms regardless of past or recent sexual traumatic event. She added, though, that most of the time her clients come to see her because of past sexual abuse, though that may not be evident at first: “A lot of times, I'll be working with them, and they're coming in for something completely different. And then come to find out, it's because they're still dealing with the trauma of their rape or their molestation.” Th6 went on to talk about a client who has disclosed about her past sexual violence by a boyfriend. The participant mentioned some of her client’s posttraumatic stress symptoms and explained the treatment she has been using,

We've really been using CBT to really look at how her current behaviors—how her thoughts are affecting her current behaviors and really trying to give her some assignments to process her thoughts to kind of challenge, actually, the thoughts that are leading to the aggressive behavior. I found for her, that that's worked.

She voluntarily added that with some other clients the structure of CBT might not be helpful. She stated,

To be honest with you, although I love CBT in that regard, I can't say that I just sit in the box with that. On the other end, for example, this same particular client, I feel like she really needs the time to really process that experience and sitting. And going by this very rigid box with CBT or any other approach, it's not really that effective for her.
Th6 was vocal about her perceptions and experiences with EBPs, expressing a recent concern with regard to the future of her agency:

At the agency, we can be very flexible. But we actually are getting our article 31, and so with article 31, we have to really be very strict with the Medicaid guidelines. So this actually put a little bit of fear in me because I'm like, "What are we going to do?" And I haven't really been able to figure out how I'm answering that or what we're going to do. But for now, yes, it's very flexible. We don't have a timeframe. We don't have to stop at 18 sessions or do anything like that.

I shared with the participant that she seemed to take her job seriously and to place a lot of value on her role as a clinician and a leader in her agency. I also agreed with her that dealing with insurance companies can be stressful, and it takes time to learn their expectations regarding treatment, billing, and coverage, among other requirements. The informant took a deep breath, looked at me, and simply said, “I am really nervous about that.” She continued,

I am, and all of our therapists, we're really open. So although, again, I'm using CBT for the most part, but there's days where I'm very psychoanalytic and I just allow them to explore. They tell me about the dreams that they have. And granted, we can challenge the dreams with some CBT, but I'm like, "No." I'm like, "Let's talk about the meaning making process for. Does it take you back to your childhood? Does it take you back here?" I mean, and I let that happen.

Because she mentioned EBPs and non-EBPs, I asked about her perceptions of these two approaches. She expressed a liking for the strengths of both approaches. She smiled and said, “I don’t like to hear any therapist say that they just use only one evidence-based approach because how realistic is that?” She stressed the importance of using EBPs because “it really is been
proven that they work.” She went on to explain that “I appreciate EBP, but I just don’t think that it should be-all-end-all to your practice. The reason why is because human beings are not one size fits all.”

The participant appeared very confident in her understanding of EBPs. She seemed very enthusiastic and proud when talking about her experiences delivering sexual trauma interventions to clients. I asked if she dealt with any challenges using EBPs and how she dealt with challenges, to which she responded not feeling comfortable with “going step-by-step process in a book.” She chuckled and said, “I guess I’m a little rebellious”; then she went on to explain:

For instance, not only is the fact that I—and I know this is a focus on evidence-based practice, but as you know, I do a lot of work with people who are from other countries. And so these individuals, they don't even have a language for mental health or a language for a trauma. Or in their eyes—let's say their husband raped them; they will never even see it as a rape because that's their husband. So the first few sessions is a lot of psycho-education, because they're not even ready yet. So if I was really going by a specific module, and then I'm up to session number five and I haven't even started technique yet, I am just really just creating a space where they could just say whatever they want and just get comfortable. In the evidence-based model, that really wouldn't work.

She continued to talk about adapting EBPs to work with clients who do not fit the protocol because of the cultural piece. I reflected that she seemed very aware of how to attend to different systems and cultural needs. She elaborated further:

So a lot of times with these clients that I mention, because of the cultural piece, we really don't start the actual—for instance, I'll talk about CBT again. After practice session one,
you should be done with psycho-education. But in my experience, we can be in session three, four and we're still doing psycho-education. So, yeah, the way I handle that is I just do it. I just do what comes natural, what feels appropriate and okay with that person at that moment.

I informed her that the research on EBPs I had reviewed also provided some challenges to using EBPs with clients from a different culture. Therefore, there is a need to adapt an approach to a client’s culture. She then voluntarily brought up another challenge: “I think another challenge that I have also is my motherly instinct, being a woman, and just feeling for…I don’t want to rush the process at all.” These words impressed me deeply because they were a clear indication for this confident clinician that gender can influence countertransference in delivering sexual trauma interventions to clients. As a male, trauma-focused therapist who has been working with survivors of sexual violence, I could not relate with Th6 on the same level, as she said, “just thinking about my own sensitivity as a woman.”

We segued into a discussion about her lived experiences. She reiterated going to supervision or a peer to talk about her cases. She mentioned vicarious trauma: “I wonder about myself and my own safety.” She stated,

All of these things that—"Wow. That could be me." So, honestly, one of the other things, when I was at my program, one of the professors was doing a vicarious trauma versus stress and trying to show you when you're getting towards the threshold of moving from stress to vicarious trauma. And a lot of those symptoms sounded like me. And I was like, “Oh my God.”

She talked about peer support and the sense of community, which has helped her ground herself to do her trauma work. I asked about her environment and how it has affected her decision when
delivering sexual trauma interventions to her clients. She stated that she has the leeway in her agency and that she makes the rules at the organization. She reiterated that she stands by EBPs but that she is flexible to attend her clients’ needs: “our environment is very supportive of whatever’s the right fit for the client.” She spoke highly of her team during the interview and seemed to appreciate their support.

As the interview continued, we talked about the benefits and risks of using EBPs. With regard to the benefits she emphasized that having a framework is important. “I don’t think that any organization or any therapist in general should just winging it… I think you should have an orientation, framework… structure and organization.” She also stressed the fact that EBPs have been researched; “research is instrumental in our career, and … we should abide by our research.” She then spoke about the risks of highlighting professionalism and research, “the risk of not using any type of evidence-based treatment is people not getting better, and that’s a major risk you take… symptoms may not be reduced.”

As we were concluding the interview, I asked Th6 how she felt, overall, about her experience using EBPs when delivering sexual trauma intervention to clients. She reflected on the question and explained that she felt good about it:

If I had to sum it up into one word, it's challenging. This kind of work is not an easy kind of work dealing with the sexual violence. But it takes a special type of people, I think, to go into this kind of field and to deal with these kinds of issues and challenges, this kind of trauma.

She went on to talk about the work with survivors being rewarding when you can see that the person is stable, they're able to use the tools that they learned and move forward. It's powerful not only for the client, but it's powerful when you get to
observe that. You get to be part of that experience. So to be honest with you, I'd say if I had to sum up both evidence-based and working with victims of sexual trauma, that at the end of the day, the good outweighs the bad, to be honest.

The interview concluded when I asked the participant if there were other questions that I have not asked that would enhance my understanding of her perceptions and lived experiences of EBPs when delivering sexual trauma interventions to clients. She suggested adding more questions about self-care: “What are they using? What are the different strategies? What do they know out there? Some alternative methods to immediate cope.” I acknowledged her recommendation and validated the need for more self-care information for trauma-focused therapists. At this point, I realized that I had forgotten to address the issue of emphasis on whether EBPs were addressed or if there were courses on trauma in graduate school. I asked if it would be fine if I asked her one more question, to which she replied it would be fine.

She stated that during graduate school there was not much focus on EBPs, though they learned generally what they were. She added, “It wasn't until I really got into the field and I was doing all these trainings that it was like a constant conversation about evidence-based practice, evidence-based practice for trainings.” With regard to trauma courses, she did not remember having a specific course on trauma. She said, “I really got the education, the knowledge I needed about trauma training outside my master’s program.” We concluded by talking about the importance of having more education on trauma during graduate school and the alarming statistics on trauma. I thanked the participant for her time and reiterated that I would be emailing her a copy of the transcription of the interview to her for verification of accuracy and feedback.
The interview with Th6 provided a number of statements of significance that were explicitly related to analytical categories. The following table organizes these statements based on the theoretical framework guiding the study.

Table 7

*Summary of the Interview with Th6*

<table>
<thead>
<tr>
<th>Analytical Categories</th>
<th>Quotations of Significance</th>
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<tbody>
<tr>
<td><strong>1. VAN MANEN LIFE WORLD EXISTENTIALS</strong></td>
<td></td>
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<tr>
<td>Lived body</td>
<td>If I could think of the first thing that comes to mind, would be, I think, overwhelming.</td>
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<td></td>
<td>It kind of puts a little bit of fear in me too.</td>
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<td></td>
<td>So my experience has been sometimes dreading hearing more,</td>
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<tr>
<td></td>
<td>Once they trust you, they just throw all this extra stuff in your lap, and you're like, &quot;Whoa.&quot;</td>
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<td></td>
<td>I think it's a constant having to kind of pinch myself. &quot;Get back here.”</td>
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<tr>
<td>Lived space</td>
<td>I will say that it's pretty stressful [day-to-day]</td>
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<tr>
<td></td>
<td>And going by this very rigid box with CBT or any other approach,</td>
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<tr>
<td></td>
<td>I can't say that I just sit in the box with that.</td>
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<tr>
<td>Lived time</td>
<td>And I'm literally a generation removed from having dealt with really horrible trauma.</td>
</tr>
<tr>
<td></td>
<td>I'm not any better because sexual trauma doesn't discriminate against race, sexual orientation, class, socioeconomic status, anybody.</td>
</tr>
<tr>
<td>Lived relationship</td>
<td>I am, and all of our therapists, we're really open.</td>
</tr>
<tr>
<td></td>
<td>People change. One day your client is one person, and then tomorrow, they trust you.</td>
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</table>
It all goes back to the core values as a clinician of therapy, counseling from the client's point of view, counseling for the clients.

I am just really just creating a space where they could just say whatever they want and just get comfortable.

I think that sensitivity also, for me, allows me to create a space where I just want people to heal at their own time.

I connect from the demographic—like, "Oh my goodness, this is a woman, a black woman just like me."

2. BIO-ECOLOGICAL FRAMEWORK

<table>
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<tr>
<th>Microsystem</th>
<th>People change. One day your client is one person, and then tomorrow, they—once they trust you.</th>
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<td>I connect from the demographic—like, &quot;Oh my goodness, this is a woman, a black woman just like me.&quot;</td>
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<tr>
<td></td>
<td>“This is not you. This is not your experience.&quot; So those conversations afterwards and even the conversations that I have with myself during</td>
</tr>
<tr>
<td>Mesosystem</td>
<td>I know that I talk a lot, which I think is helpful for me, so whether it's to a colleague, whether I need to-- once I'm done for the day, I'll just call a mentor or something like that….</td>
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<tr>
<td></td>
<td>Peer support, that's what I use right now.</td>
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<td></td>
<td>When I hear something pretty atrocious, I would take the time to talk to somebody else.</td>
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<td></td>
<td>I am, and all of our therapists, we're really open.</td>
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<td>I'm speaking with a peer to kind of be reminded again that it's not about you.</td>
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<td></td>
<td>We do our case conceptualization presentations, and everybody, of course, we all talk about what model we're using with the case we're presenting.</td>
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</tbody>
</table>
**Exosystem**  
We have a really great relationship with our local politicians.  
We get referrals from other nonprofit organizations, community center, religious leaders, word of mouth.

**Macrosystem**  
So with article 31, we have to really be very strict with the Medicaid guidelines.  
I have the leeway because I kind of make the rules at the organization.

**Cronosystem**  
And I'm literally a generation removed from having dealt with really horrible trauma.

### 3. ISAT

**Clinical relationship**  
People change. One day your client is one person, and then tomorrow, they—one they trust you.  
And so these individuals, they don't even have a language for mental health or a language for a trauma.

**Nexus of personal and treatment issues**  
I am, and all of our therapists, we're really open.  
I'm using CBT for the most part, but there's days where I'm very psychoanalytic and I just allow them to explore.  
I don't want to hear anyone say they don't use evidence-based because….  
if someone is in therapy, you need to use technique in order to help this person treatments.  
We do our case conceptualization presentations, and everybody, of course, we all talk about what model we're using with the case we're presenting.  
Attend to what the client needs.  
I think that sensitivity also, for me, allows me to create a space where I just want people to heal at their own time.

**Broader systemic and cultural influences**  
So with article 31, we have to really be very strict with the Medicaid guidelines.

### 4. PROTECTIVE FACTORS

“I’m not pulling this out of nowhere”  
I really appreciate evidence-based because it really is been proven that these things work.
That's why we do research, is so we can improve our practice. And so the research shows us that evidence-based practice works.

And the reality is, is the reason why we have all these textbooks and all this research is because somebody needed it.

“It can be effective” I think research is instrumental in our career, and that we should abide by our research.

This is what works. This is how you can-- if you use these steps, you can, not guarantee, but you have a high probability of these symptoms decreasing in these.

“It’s doing the right thing” It all goes back to the core values as a clinician of therapy, counseling from the client's point of view, counseling for the clients.

5. RISK FACTORS

Multimodal approach My style, my orientation is CBT.

I do use a lot of CBT.

“Being careful” Well, are we going to just put things on paper just because we have to even though that's not really what we're doing?

I don't think that any organization or any therapist in general should just wing it.

Lack of preparation for trauma – graduate school In my master's program, there wasn't a specific course on trauma.

Lack of preparation for EBPs – graduate school I would say more in my doctoral than my master's. In my master's program, we learned about it, but I wouldn't necessarily say that there was this high focus on that's what you have to do.

6. COMMON THEMES

Structure/rigid And going by this very rigid box with CBT or any other approach.

I can't say that I just sit in the box with that. And going by this very rigid box with CBT or any other approach, it's not really that effective for her.

So you can't use any treatment to just be one size fits all for people.

Flexibility/adaptation
I'm using CBT for the most part, but there are days where I'm very psychoanalytic and I just allow them to explore.

And so these individuals, they don't even have a language for mental health or a language for a trauma.

I just do what comes natural, what feels appropriate and okay with that person at that moment.

Rewarding experience
I think that my overall experience has been good. It's been mostly rewarding.

When you can see that the person is stable, they're able to use the tools that they learned and move forward, I think it's very powerful.

At the end of the day, the good outweighs the bad, to be honest.

Being a woman
Overwhelming, especially being a woman, to be honest with you.

My motherly instinct, being a woman, and just feeling for… just thinking about my own sensitivity as a woman, I don't want to rush the process at all.

Th7 Interview
The seventh interview was with a 39-year-old Caucasian female who has been working in the mental health field for 8 years. We started with the demographic questions, by which I gathered information to proceed with my inquiry. Th7 is currently working as a behavioral health therapist. She has a master’s degree in social work, is a licensed independent clinical social worker, and has attended training on EBPs. She was fully aware of the nature of the study and agreed to do the interview via Internet. The interview was conducted using Facetime from her residence where she felt comfortable in sharing her experiences. I reviewed confidentiality and protection of her information. I also reviewed the purpose of the study, emphasizing that participation in this study was voluntary and that she could leave at any time. She agreed to participate and sent her informed consent signed via email.
Th7 displayed a lot of excitement and started talking about her current work as soon as we started Facetime. When we started the audio recording, I prompted her to talk about her background working in the mental health field and experience working as a trauma-focused therapist. She stated,

I find it rewarding work, but I think it's also very, even if you don't talk about yourself, it becomes very personal. Because you are the person who could experience this or know people who have experienced. So, it's very—it ends up being intensely personal even with good boundaries.

She spoke about working with survivors and noted that it is challenging at times though rewarding, “and as hard as it is to fight or struggle with secondary trauma or being impacted by people's stories, you're also impacted by their healing. So, it's this nice balance when people have progressed.” She went on to explain that she comes from a place of multiple experiences of people growing and healing, so she can offer more confidence to her clients: “I have many, many, many, more experiences of going, ‘Okay this can change, just stick with it.’” She noted that clients can feel it; “it's like wisdom, the more you have, the more confidence you have that things could change, the more people feel confident that they can change.” She ended by saying, “Eight years of working in a field. Lots of stories.” This remark led into a discussion about her trajectory toward becoming a trauma-focused therapist, which included work abroad and hands-on experience at a rape crisis center. She appeared proud to have worked with well-known trauma researchers and to have observed the development of EBPs. She stated that her experience included working with in- and outpatient populations in an array of diagnoses.

We segued into a discussion about the approaches she has used to treat survivors of sexual violence. She stated that she tends to be eclectic in her approaches: “I’ve had people do
some art… I’ve done exposure. Just having the people tell me the story over and over. And some mindfulness techniques.” She then spoke about her training in cognitive processing therapy (CPT) and Eye Movement Desensitization and Reprocessing (EMDR). She has worked in a rape crisis center where she had to use these two approaches. She stated “I love CPT because it gave me … this real understanding of people.” Since we were talking about her experiences as a trauma-focused therapist, I asked if she could elaborate on her perception of EBPs and non-EBPs:

I think as a clinician you can use all kinds of different ways of getting people where they need to go, but I personally—if somebody comes in and tells me that they have this history and all the confusion that goes with it and all the assumptions and maladaptive thoughts and what have you to go along with a trauma history, I think it's ethical for me to start with something that is evidence-based.

The participant sounded very confident in her statement about EBPs. She then added that if there is an aspect of the EBP that is not fitting, there is no problem with the therapist’s “getting creative or integrating something to help them, [it’s] fine.” She repeated what she says to her clients:

“Hey, here's this approach. Many, many, many, many people that have had very similar life experiences have benefited from it. I've worked with such people. I've seen them benefit from it. Here's a way to explain that to you. Here are some resources,” and that they can go out and look up stuff, and find other people saying, “Yeah, this has been life-changing.” I think that's so valuable. So I would say I have a preference, even though I'm not very rigid about how I use said evidence-based practices.
I asked her for some more clarification regarding her assertion “I’m not very rigid.” The participant went on to explain that CPT has a structure of 12 sessions. Although she tries to follow the sequence of the protocol, something can happen in the client’s life that will put a hold on or change the sequence of the protocol. In that sense she is “not very rigid” because at that point, she needs to pause and address the more pressing issues. She added that sometimes the clients need a break because working on the trauma is “too much,” and they just want to talk about something grounding. She also talked about being “not very rigid” in her use of EMDR:

With EMDR also, sometimes people have a very intense reaction to starting it and they need a break, especially if they've been doing regular talk therapy; or assessment takes so long, by that time it feels like they want to come in and talk. Lo and behold, there's actually a rationale to what they've been doing for three, four, or five sessions, but they don't see it that way. They see it as talking, so now we try something, and now they want to go back to talking. So, that's fine, and then maybe later we go back to it or maybe they say, "You know what, that was intense, that was interesting, but I'm not interested in going back to it." Fine. I don't tend to use the EMDR for trauma memories of violence; generally I tend to use the EMDR for social experiences around the trauma.

Th7 has a great deal of experience working in different settings. She described working in stricter settings were “there was an expectation that I would primarily do CPT.” She mentioned that in her last job “nobody [was] telling anybody what they needed to do. It was really self-guided.” She talked about working for an in-patient clinic where there was pressure to discharge patients. She reflected and expressed a sense of indignation:

‘Wait a second, you sent somebody to an in-patient program with severe trauma. Lo and behold, most of them have trauma in their past, like childhood trauma, sexual trauma was
there, whatever. And then you want them back to work in two weeks? I don't know if that's how it works but we'll do our best.’

She seemed aware of the dynamics in different mental and behavioral working settings. I suggested that it might have been difficult to handle challenging situations and asked if she could elaborate on how she dealt with them when using EBPs. She said that “the reality of using an evidence-based practice is just the reality of doing anything, that you forget the training a little bit as you go along, and you make it your own.” She went on to say that unless you have had and are receiving constant supervision, it is challenging to maintain fidelity to a protocol. She smiled and said, “I wonder how much my version of CPT matches a pure version of CPT, and how much does that matter as far as outcomes go?” She went on to explain that “in a perfect world,” she would have to put forth a lot effort to maintain loyalty to an approach. She stated, however, that “in the real world of almost private practice,” it does not happen: “So you could definitely have very different experiences with CPT based on the agency and how it's followed up and if that's a name.” This led into a discussion about her lived experiences of using EBPs with clients. She repeated “my lived experiences,” paused a moment, and went on. “I would say it's very good, because I do think about, ‘Am I helping people?,’ and it's been helpful to fall back on research.” She recalled, “I had one experience with the EMDR where I worried that I did it wrong; I shouldn't have given myself a hard time. Later on the rest of the story came out and the person was actually dealing with something else. It wasn’t necessarily the work we had done.” She noted further:

The evidence-based practice compliments the relationship with most clients… I do this, this is the training in it; and you can provide them that well-studied information, it builds trust. “This isn't just somebody who wants my 130 bucks cash to listen to me. This is
somebody who's actually taken the time to learn something that might really help me.”

And I think that's incredibly beneficial.

With regard to risk, she said “that one size doesn’t always fit all” and that there is a risk of losing a client if the therapist is not tuned to a client’s needs. She went on to say that the client might think, “Wait a second, I came here in this state with the expectation that you would listen, because that’s my idea of what therapy is, and instead you said, ‘Okay, were are doing session three.’ And gave me a lecture.”

Th7 checked the clock and said she would have to end soon. I acknowledged her taking time for this interview and asked the two last questions. At the end, she said that she did not have any questions to add and went on to say,

I probably covered it before, but I do think that the evidence-based practice is a benefit to the clinician because it helps you to—you have a path. You have a destination. You know, especially with people with multiple traumas. And that can be really hard. But you can keep saying to yourself, "Okay, but we're not there yet. We're still here." So you have this goal for yourself as well, to quell the discomfort of talking about very, very disturbing material. Or feeling, whatever the process is. So I think the evidence base practices help the clinician to stay healthy, which helps the client to get healthier. So I'm a big fan.

She concluded by adding, “as long as nothing’s done rigidly.” We ended the interview when she no longer had any information. I sensed her confidence and appreciated her openness about her perception and experience with EBPs when delivering sexual intervention to clients. I thanked the participant for her time and reiterated that I would be emailing her a copy of the transcription of the interview for verification of accuracy and feedback. After ending Facetime
with this participant, I reflected in my field notes about this belief that EBPs are “rigid” and structured. This statement about EBPs has been consistent, thus far, throughout all the interviews, and the participants express that they often try to adapt EBPs to develop a treatment plan that meets a client’s need.

The interview with Th7 provided a number of statements of significance that were explicitly related to analytical categories. The following table organizes these statements based on the theoretical framework guiding the study.

Table 8

Summary of the Interview with Th7

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<td>I think the evidence-based practices help the clinician to stay healthy, which helps the client to get healthier.</td>
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<td>Lived space</td>
<td>Because you know there's another side.</td>
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<td></td>
<td>I had to sit there and think, Okay, they don't want to do trauma work. Why are they coming so much?</td>
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<td>Lived time</td>
<td>I come from a place of multiple experiences of seeing people grow and heal.</td>
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<td></td>
<td>And finally I tapped into its human healing. It's people healing and surviving.</td>
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<td>That helps me to keep going with somebody’s very painful past.</td>
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<td></td>
<td>People are ever-changing.</td>
</tr>
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<td>Lived relationship</td>
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<tr>
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<td>Then we're going to get back to the work when they feel</td>
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comfortable and safe and what have you.

I think people can feel that and tell that, whether or not I say it.

I think that all evidence-based practices recognize that people aren't robots.

2. BIO-ECOLOGICAL FRAMEWORK

Microsystem

I think people can feel that and tell that whether or not I say it.

At least for my confidence, that this person has explored this enough cognitively to go in further.

Hey, here's this approach. Many, many, many, many people that have had very similar life experiences have benefited from it.

If by session four, the client comes in, and something is going on in their life that is more pressing, generally sort of psychosocial issues, then I'm going to pause and address that.

Then we're going to get back to the work when they feel comfortable and safe and what have you.

Truth be told, because they have all these crazy things going on in their life but they're not changing them.

This isn't just somebody who wants my 130 bucks cash to listen to me.

This is somebody who's actually taken the time to learn something that might really help me.

Mesosystem

I had some good supervisors.

I have a supervisor that I can check in with, but he doesn't guide me on you do this, you should do that, or we want you to do anything.

I would do a little booster, and maybe watch some videos, or connect with somebody on some training, or reread a handbook or something like that.

Exosystem

My agency, they do free CEUs, but they're in house and they're always something like….

She wasn't my supervisor, but she oversaw the clinics, so I
was able to be near her and learning....

My current employer, it feels like I'm in private practice.

| Macrosystem | Every now and then, I'll get these forms that I have to fill out [third party payers]. And then the other one [insurance paperwork] will list off evidence-based, including my CBT. I felt intense pressure to get people out the door and hooked up with services so that was more of a psychosocial pressure [when working for a hospital]. Working with service members because their bosses, like their and stuff, wanted them to be "better" and ready to go back to work and that was sort of bizarre. Like, "Wait a second, you sent somebody to an in-patient program with severe trauma. Lo and behold most of them have trauma in their past, like childhood trauma, sexual trauma was there, whatever. And then you want them back to work in two weeks?" So you could definitely have very different experiences with CPT based on the agency and how it's followed up. |
| Cronosystem | In a perfect world.... But in the real world of almost private practice.... It always comes back to this argument of whether it's the relationship with the clinician or the practice. That discussion is old as time. People are ever-changing |

3. ISAT

| Clinical relationship | If by session four, the client comes in, and something is going on in their life that is more pressing, generally sort of psychosocial issues, then I'm going to pause and address that. Then we're going to get back to the work when they feel comfortable and safe and what have you. Truth be told, because they have all these crazy things going on in their life, but they're not changing them. |
**Nexus of personal and treatment issues**

Even if you don't talk about yourself, it becomes very personal.

I come from a place of multiple experiences of seeing people grow and heal.

I love CPT because it gave me like this real understanding of people.

Hey, here's this approach. Many, many, many, many people that have had very similar life experiences have benefited from it.

It's really up to me to decide how to work with each client.

**Broader systemic and cultural influences**

My current employer, it feels like I'm in private practice. There's no agenda.

Nobody telling anybody what they needed to do.

So you could definitely have very different experiences with CPT based on the agency and how it's followed up and if that's a name.

**4. PROTECTIVE FACTORS**

<table>
<thead>
<tr>
<th>“I'm not pulling this out of nowhere”</th>
<th>“Here are some resources,” and that they can go out and look up stuff, and find other people saying, &quot;Yeah, this has been life-changing.&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>It's been helpful to fall back on research.</td>
</tr>
<tr>
<td></td>
<td>I like the idea of things being researched and continuing to grow.</td>
</tr>
<tr>
<td>“It can be effective”</td>
<td>I have many, many, many, more experiences of going, &quot;Okay this can change, just stick with it.&quot;</td>
</tr>
<tr>
<td></td>
<td>Hey, here's this approach. Many, many, many, many people that have had very similar life experiences have benefited from it.</td>
</tr>
<tr>
<td></td>
<td>They were happy to do something that made sense.</td>
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<tr>
<td></td>
<td>This is what you're shooting for.</td>
</tr>
<tr>
<td>“I'm doing the right thing”</td>
<td>I think it's ethical for me to start with something that is evidence-based.</td>
</tr>
</tbody>
</table>
I do this, this is the training in it, this is what it's supposed to do" 

I do think that the evidence-based practice is a benefit to the clinician because it helps you to—you have a path. You have a destination.

5. RISK FACTORS

“Being careful”  

So even though I may have also been a little bit not rigid with it, I was more on point with it.

You forget the training a little bit as you go along, and you make it your own

Lack of preparation for trauma – graduate school

Went to graduate school at (name of the city), did everything I could to get any experience working with trauma, was at the PTSD outpatient clinic with Dr….

Lack of preparation for EBPs – graduate school

We definitely talked about them [EBPs]. I do remember some discussion. It always comes back to this argument of whether it's the relationship with the clinician or the practice, and that discussion is old as time.

6. COMMON THEMES

Multimodal approach  

I have used EMDR.

I love CPT.

Structure/rigid  

So even though I may have also been a little bit not rigid with it, I was more on point with it.

I was more trying to get people to decrease their score on the PCL and in a reasonable amount of time, for sure.

How soon are you going to get them out the door?

I wonder how much my version of CPT matches a pure version of CPT, and how much does that matter as far as outcomes go?

The reality that one size doesn't always fit all.

I'm a big fan. As long as nothing's done rigidly.

Flexibility/adaptation  

Getting creative is fine or integrating something to help them relax while doing the work with this or that, or whatever, it may be fine.

I would say I have a preference, even though I'm not very rigid about how I use evidence-based practices.
I felt like the agency was okay with exceptions. I didn't feel like this is, "Give them these 12 sessions and they're out the door."

And the benefit of that is making it your own.

<table>
<thead>
<tr>
<th>Rewarding experience</th>
<th>I find it rewarding work.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>You're also impacted by their healing.</td>
</tr>
<tr>
<td></td>
<td>And finally I tapped into its human healing. It's people healing and surviving.</td>
</tr>
</tbody>
</table>

| Being a woman | N/A |

**Th8 Interview**

The fourth interview was with a 66-year-old Caucasian female who has been working in the mental health field for 20 years. We started with the demographic questions by which I gathered information to proceed with my inquiry. She is currently working in private practice. She has a Master of Arts in Clinical Mental Health Counseling and has delivered sexual trauma interventions to victims and/or survivors of sexual violence. She has also attended training on EBPs. She was fully aware of the nature of the study. We met in her office where she felt comfortable sharing her experiences. I reviewed confidentiality and information protection. I also reviewed the purpose of the study and emphasized that participation in this study was voluntary and that she could leave at any time. She agreed to participate, and we both signed the informed consent.

We arrived at her office at the same time, and I complimented her for having a welcoming and comfortable office. She asked me where I wanted to sit. We started talking about the difference between working in private practice and in an agency before starting the audio recording. Once I finished setting up the audio recording devices, I began the interview inquiring about her experience working in the mental health field for the past 23 years. The participant stated that she has worked for few agencies in the past, including a rape crisis center where she
worked for almost 15 years. At the rape crisis center, she worked primarily with adult survivors of sexual violence. She added that she also worked as an education trainer: “I went out into the community and did training programs on sexual abuse.”

After talking about her background in the field of mental health, I asked the first question about her experience in working as a trauma-focused therapist. She took a moment and said with a smile,

It is, to me, the most rewarding work I think a therapist can do. At least for me. And I have never been sorry that that's what I primarily did. I think it's allowed me to see the best and worst of humanity, represented by the things that have happened to my clients. I think it's very real. And it's not a superficial kind of thing, as you know. You have to be willing to be with it and be with that person.

The participant appeared very confident in her expression of her work as a trauma-focused therapist. There was a sense of pride that she emanated and which filled the room in the beginning of the interview. We segued to talking about her experience in treating survivors of sexual violence. She noted, “Sometimes it’s exhausting. But most of the time, it’s always rewarding.” She went on to elaborate:

My guiding principle has been, be a conduit not a container so that means that I can really be with somebody when they're in here in my office. But when they leave, I realize it's not mine to keep and to hold onto. I can let it flow through me in some way. The mental picture I get is that I let it go back to the universe or the earth, or whatever you want to say, that can absorb all the horrible things that have happened. And I don't have to walk around carrying the feelings of it.
I felt a sense of comfort in listening to her talk eloquently about her “guiding principle.” I followed up with asking her about supervision, to which she replied that she found it “very valuable” to belong to a peer group supervision of other therapists in the area. I commented to her that peer support has been very helpful for me too. She stated immediately, “That’s one thing I miss about agency work, is that if you had a really hard session, you can run down the hall and say, ‘Oh, my heavens. Wait until you hear this one.’” She went on to speak about other resources she uses for supervision and concluded by saying, “[a]nd probably in the beginning of my career, I wouldn’t have been able to work outside an agency quite as easily.”

This led into a discussion about the approaches she has used in counseling trauma survivors of sexual violence. She stated that when she started out she used “interpersonal… trauma-focused… it was really trauma-informed and trauma-competent. And then in 2011, I became trained in EMDR.” When prompted how she has used these interventions, she stated that she has realized over the years that most of what is going on with survivors is related to attachment. The participant explained that because most of her clients are adult survivors of childhood sexual abuse, she is a “big believer in attachment theory. That it all goes back to attachment that even over and above the actual mechanics of the trauma, everything that there are so many Stockholm syndrome ….” She went on to say that she has used EMDR with very dissociative people: “Once I have gotten to know their internal system or the way they operate and because I think to not get to know that can be really.” She further disclosed, “I've got a new client now who was really unsettled by somebody that dove right in to EMDR and she just totally decompensated.”

Following a discussing of approaches, I began to ask about how she was trained to provide EBPs, to which she replied,
The only one that strictly meets the evidence-based criteria is the EMDR. So I had the two training sessions, and then we had the phone calls and the phone supervision…. I have used EMDR in all kinds of non-classic ways. I've had people put the headphones on their head and just talk while it's going and for some people that really, really works.”

She was clear about the adaptation and flexibility of protocols and observed throughout the interview the importance of being able to integrate different approaches to meet clients where they are with regard to their traumatic event. We segued into a discussion about her perceptions of EBPs and non-EBPs when delivering sexual trauma intervention to clients. She stated,

I don't know a lot about the other ones except the CPT. And I read some of the stuff about that and heard some of the things like there shouldn't be any attachment issues here. I thought, “This is insane.” For trauma clients? No. This is not going to—I don't like exposure therapies as a general rule. That's what van der Kolk says, something about trying to get a dissociated person to use CBT, or CPT, or an exposure therapy is like inviting a legless person to run a race. They don't have access to these parts of themselves. If they did, it would be different and we have to get there.

She expressed skepticism of evidence-based practices because they tend to use a “one-size-fits-all approach, or they try to help people think their way out of an emotional dilemma.” She did affirm that she likes EMDR because she has seen it work with some of her clients. She voluntarily used an analogy to express her experience with EBPs:

I think EBPs tends to be one of those things like looking for your keys under the street lamp. That it's easy to measure but the stuff that really works is usually the relationship, the connection, the sense of being heard. So EBPs to me are, it's more about trying to manualize things. And I am not a fan.
This comment segued into a discussion about challenges she has dealt with while using EBPs. She responded that she probably tried to introduce EMDR in the treatment of some clients prematurely. She elaborated:

It became very clear to me that it felt too mechanized to them. And what they were looking for, I realized in talking to them, that what they were looking for was more of an interpersonal connection. So sometimes that happens. And I will back away from it then, if I feel like what they want is to feel heard by somebody more than “I got to get this trauma out of my head” kind of thing.

The participant also talked about Dissociative Identity Disorder (DID) and challenges working with survivors: “when you're using it [an approach] with dissociative clients, you have to be prepared for some other part of self is going to pop out.” I asked if she used any specific approach with DID clients, to which she responded, “Not any kind of manualized thing. It’s definitely interpersonal relational models.” She explained further about working with trauma survivors who present dissociative issues, appearing very confident on her skills to work as a trauma-focused therapist.

My next question to the participant was about her education on trauma and whether there was any emphasis on EBPs during graduate school. She replied no, that “[t]hey were very existential. No EBPs there.” She when on to say that she did not even remember talking about EBPs until late 90s, early 2000s, “when it actually became a term.”

We talked, briefly, about the changes over the years with regard to health insurance requirements. I prompted her to talk about her lived experiences of suing EBPs to treat clients’ survivors of sexual violence. She immediately responded, “Some of the successes have been remarkable.” She provided me with an example:
I had a young man. He started at the agency with me, and I did EMDR when several
different people had sexually assaulted him. I'm not kidding you, after the first session he
was way better. He just really got into it. Was able to move through some stuff. He was
one of the first clients I used it with and it was an astoundingly successful thing for
him… I've since had a couple of other experiences like that where—are the ideal EMDR
success stories. In general, it seems like we use EMDR. I'll do talk therapy first and get to
know the person, and we'll just use EMDR with something we've identified.

She has been using EMDR for a while, and she mentioned that at her last agency she had the
flexibility to use any approach she wanted with her clients. In private practice now, she stated it
is the same way, she can choose from any approach to work with her clients. We segued into
talking about the benefits and risks of using EBPs. With regard to risks, she quickly responded,
“I don't particularly see any risks.” She stated about the benefits that she knows what EBP can
do, “You can predict what might happen, and it does often.”

I inquired about the participant’s overall perception and experience using EBPs when
delivering sexual trauma intervention to clients. She stated that EMDR has been a very great toll,
in addition to “my way of working with people.” She seemed to be client-centered and to use
humanistic approaches to help survivors of sexual violence. We concluded the interview after
Th8 expressed that she had no further information to provide. I thanked the participant for her
time and reiterated that I would be emailing her a copy of the transcription of the interview to her
for verification of accuracy and feedback.

The interview with Th8 provided a number of statements of significance that were
explicitly related to analytical categories. The following table organizes these statements based
on the theoretical framework guiding the study.
Table 9

Summary of the Interview with Th8

<table>
<thead>
<tr>
<th>Analytical Categories</th>
<th>Quotations of Significance</th>
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<tbody>
<tr>
<td><strong>1. VAN MANEN LIFE</strong></td>
<td><strong>WORLD EXISTENTIALS</strong></td>
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<tr>
<td>Lived body</td>
<td>Sometimes it's exhausting.</td>
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<td></td>
<td>The mental picture I get.</td>
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<td></td>
<td>They don't have access to these parts of themselves.</td>
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<td></td>
<td>It's more about trying to manualize things.</td>
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<td></td>
<td>I don't understand it. It's like they're burying their heads in the sand.</td>
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<tr>
<td>Lived space</td>
<td>I think it's very real.</td>
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<tr>
<td></td>
<td>There's some very deep things.</td>
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<tr>
<td></td>
<td>I can really be with somebody when they're in here in my office.</td>
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<td></td>
<td>I realize it's not mine to keep and to hold onto.</td>
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<td></td>
<td>And I don't have to walk around carrying the feelings of it.</td>
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<tr>
<td>Lived time</td>
<td>I think it's allowed me to see the best and worst of humanity, represented by the things that have happened.</td>
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<td></td>
<td>I let it go back to the universe or the earth or whatever you want to say that can absorb all the horrible things that have happened.</td>
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<tr>
<td></td>
<td>We will come back and see how it's integrated into their life and then go back and do some more EMDR.</td>
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<tr>
<td>Lived relationship</td>
<td>You have to be willing to be with it and be with that person.</td>
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<tr>
<td></td>
<td>I can let it flow through me in some way.</td>
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<td></td>
<td>I realized in talking to them, that what they were looking for was more of an interpersonal connection.</td>
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<tr>
<td></td>
<td>That it's easy to measure but the stuff that really works is usually the relationship, the connection, the sense of being heard.</td>
</tr>
</tbody>
</table>
Most of them really seem to feel a need to have me know.

2. BIO-ECOLOGICAL FRAMEWORK

<table>
<thead>
<tr>
<th>Microsystem</th>
<th>You have to be willing to be with it and be with that person</th>
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<tbody>
<tr>
<td></td>
<td>I can really be with somebody when they're in my office.</td>
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<tr>
<td></td>
<td>That it's easy to measure but the stuff that really works is</td>
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<tr>
<td></td>
<td>usually the relationship, the connection, the sense of being</td>
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<tr>
<td></td>
<td>heard.</td>
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<tr>
<td></td>
<td>I realized in talking to them, that what they were looking for</td>
</tr>
<tr>
<td></td>
<td>was more of an interpersonal connection.</td>
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<tr>
<td></td>
<td>I'll do talk therapy first and get to know the person.</td>
</tr>
<tr>
<td>Mesosystem</td>
<td>I belong to a peer group supervision of other trauma therapists</td>
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<tr>
<td></td>
<td>in the area.</td>
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<td></td>
<td>That's the one thing I miss about agency work, is that if you</td>
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<td></td>
<td>had a really hard session, you can run down the hall and say,</td>
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<tr>
<td></td>
<td>&quot;Oh, my heavens. Wait until you hear this one.&quot;</td>
</tr>
<tr>
<td></td>
<td>Because I needed the feedback more often.</td>
</tr>
<tr>
<td>Exosystem</td>
<td>CBT, well it's measurable. Somebody can stick it in a manual.</td>
</tr>
<tr>
<td>Macrosystem</td>
<td>N/A</td>
</tr>
<tr>
<td>Cronosystem</td>
<td>I think it's allowed me to see the best and worst of humanity,</td>
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<tr>
<td></td>
<td>represented by the things that have happened to my clients.</td>
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<td>I let it go back to the universe or the earth or whatever you</td>
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<td></td>
<td>want to say that can absorb all the horrible things that have</td>
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<td></td>
<td>happened.</td>
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<tr>
<td>3. ISAT</td>
<td></td>
</tr>
<tr>
<td>Clinical relationship</td>
<td>You have to be willing to be with it and be with that person.</td>
</tr>
<tr>
<td></td>
<td>I'll do talk therapy first and get to know the person.</td>
</tr>
<tr>
<td>Nexus of personal and</td>
<td>Be a conduit, not a container.</td>
</tr>
<tr>
<td>treatment issues</td>
<td>It became very clear to me that it felt too mechanized to them.</td>
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</tr>
<tr>
<td></td>
<td>was more of an interpersonal connection.</td>
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</tbody>
</table>
Broader systemic and cultural influences  N/A

4. PROTECTIVE FACTORS

<table>
<thead>
<tr>
<th>“I’m not pulling this out of nowhere”</th>
<th>You can predict what might happen, and it does often.</th>
</tr>
</thead>
<tbody>
<tr>
<td>“It can be effective”</td>
<td>N/A</td>
</tr>
<tr>
<td>“I’m doing the right thing”</td>
<td>N/A</td>
</tr>
</tbody>
</table>

5. RISK FACTORS

<table>
<thead>
<tr>
<th>“Being careful”</th>
<th>She really encouraged me to take advantage of getting trained at the EMDR. I was skeptical of it because it seemed like so much magic.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of preparation for trauma – graduate school</td>
<td>No one mentioned [about trauma]… there were no—there was nobody doing a trauma course, even a voluntary one or an optional one. Nobody mentioned trauma.</td>
</tr>
<tr>
<td>Lack of preparation for EBPs – graduate school</td>
<td>I was in a psychology program, and they were very existential. No EBPs there. And I don't even remember that as being a—EBPs. I don't even remember it until what, the late 90s? Early 2000s. When it actually became a term.</td>
</tr>
</tbody>
</table>

6. COMMON THEMES

<table>
<thead>
<tr>
<th>Multimodal approaches</th>
<th>When I started out we were basically using interpersonal or trauma-- it was always trauma-based.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>I became trained in EMDR… I have used EMDR in all kinds of non-classic ways.</td>
</tr>
<tr>
<td></td>
<td>Hypnosis, I did have a course in hypnosis but most of the time what I've done is just taken advantage of the trances that people get into or else do something like a light trance, guided imagery kind of thing.</td>
</tr>
<tr>
<td>Structure/rigid</td>
<td>If you're trying to get some trauma survivor to follow a protocol, forget it.</td>
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<tr>
<td></td>
<td>CBT, well it's measurable. Somebody can stick it in a manual.</td>
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<td></td>
<td>It's very strict and rigid.</td>
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<tr>
<td>Flexibility/adaptation</td>
<td>But he [trainer] also gave me some different ways to use EMDR that aren't exactly following the protocol.</td>
</tr>
<tr>
<td></td>
<td>I have used EMDR in all kinds of non-classic ways.</td>
</tr>
<tr>
<td></td>
<td>I am skeptical because they tend to do one-size-fits-all</td>
</tr>
</tbody>
</table>
It's easy to measure but the stuff that really works is usually the relationship, the connection, the sense of being heard.

It is the relationship that heals eventually. I mean many multiple studies have shown that.

Some people really love it and it works wonders with them.

I don't particularly see any risks.

<table>
<thead>
<tr>
<th>Rewarding experience</th>
<th>It is to me, the most rewarding work I think a therapist can do.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being a woman</td>
<td>N/A</td>
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</table>

**Th9 Interview**

The ninth interview was conducted with a 47-year-old Caucasian male who has been working in the mental health field for 20 years. We started with the demographic questions by which I gathered information to proceed with my inquiry. He is currently working in a psychiatric hospital and in private practice as a licensed professional counselor. He has delivered sexual trauma interventions to children and adolescent victims and/or survivors of sexual violence. He has also attended training on EBPs. He was fully aware of the nature of the study. We met in his office where he felt comfortable in sharing his experiences. I reviewed confidentiality and protection of his information. I also reviewed the purpose of the study and emphasized that participation in this study was voluntary and that he could leave at any time. He agreed to participate, and we both signed the informed consent.

When I arrived at the office, he immediately started talking about his practice and the reason why he chose that location. The office is very private and spacious. It felt very comfortable and welcoming. As we finished reviewing the above documents, we started the interview. I prompted Th9 to talk about his experience working in the mental health field for this past 20 years. He talked about why he first got interested in the field and spoke proudly of his
work and trajectory. He explained that right after completing his bachelor’s degree in psychology, he worked with the severe mentally ill as a resident adviser, “just helping mental health consumers with day-to-day living, duties, shopping, cooking, getting to appointments, making sure they’re taking their medicine on time, and things like that.” After a year he moved on to work with teenagers that were adjudicated dependents; for a variety of reasons—“abuse, neglect, these teenagers could not be at home.” He went on to speak about working for over 14 years with adolescents as well as his completion of a master’s degree in counseling. His work at a psychiatric hospital offered an opportunity to work with boys that were sexually reactive and sexual offenders. He stated,

So, for the past 8 years, I've been working exclusively with seriously traumatized kids that were victims of sexual abuse, and they're either sexually reactive or were actually adjudicated as offenders. In the meantime, the hospital position gave me the flexibility to get my license, and I immediately opened a private practice, and I've been seeing clients in the evenings and on weekends for the last 5 years.

We segued into talking about EBPs and trauma during graduate school. He went on to say that EBP “was the big buzzword” when he went to graduate school in the 1990s. He also explained that at the time, he was working for a non-profit organization, and all the county contracts moved towards EBPs: “if you wanted a contract with Allegheny County or any surrounding, you had to have been using some kind of EBP.” He could not recall, though, any course specific to trauma while in school.

As the interview continued, I prompted him to talk about his experience working as trauma-focused therapist. He spoke about being a trauma-focused therapist working at the psychiatric hospital for the past 8 years. He noted having the opportunity to receive some
trauma-specific training with renowned professionals in the community, including supervision. “Through my work itself I had a supervisor who's a trauma therapist, expert in the field, and of course, have been reporting to him for weekly supervision for the past 7 or 8 years or so.” I asked for some more clarification on what it has been like for him to work with survivors of sexual violence. He said,

Honestly, think you have to have a knack for it, and when I say that I mean, for example, 10 people can be exposed to the same traumatic event and only one or two of them receive some kind of serious trauma from witnessing that. I think it's the same in therapy, as well. I think some people can be traumatized by proxy, like vicarious trauma, working in the field and continuing to hear trauma stories over and over. And I think that some people can just cope with that a little bit better. And for some reason, I've always had a knack or an ability to be able to, when I step away from a therapy session, to pretty much step away from it.

It appeared that his experience and constant supervision have contributed to developing coping skills for dealing with his work as a trauma-focused therapist. However, his mentioning a few times “I have a knack for it” made me wonder about how people know about their abilities to work with trauma survivors. I asked for some more clarification regarding his statement “I’ve always had a knack for it.” He explained that he has always had an ability to separate himself from the trauma he typically hears in session. Although there were a few times he had to attend to countertransference issues, he went on to say,

I think you get better with it with experience. I think self-care is important. Whenever you're young you don't really think about self-care as a concept. As you get older, I think
that you learn about self-care and value it, and try to have some kind of balance between your professional and your personal life.

After talking about his experience and self-care, we moved on to the next question. Th9 was prompted to speak about approaches he uses to work with victims and survivors of sexual abuse. He stated,

At the hospital we use CBT, cognitive behavioral therapy model, almost exclusively. So it's evidence-based practice. Of course, CBT speaks to a variety of different modalities, but again getting back to evidence-based, with our contracts and our different accreditation bodies that come in to the hospital, and the insurance companies that are paying for the children to be in care, everything has to be evidence-based. I mean, that's just the environment that we're in, so….

I inquired about flexibility, whether or not he could use other modalities to treat his clients. He stated that he takes an eclectic approach, but the core of treatment in CBT. He emphasized that he uses a variety of different approaches in private practice, but he still comes from a foundation of CBT because those are the modalities he is most comfortable with when delivering sexual trauma intervention to clients. We segued into talking about his use of interventions with clients. He said, “To the best of our ability we try to individualize treatment, but we have at the hospital a plethora of resources at our disposal. We have workbooks that we use. They're geared specifically towards rehabilitation.” He mentioned the name of the company where he gets his workbooks, describing the workbooks and his implementation of them for the population he works with at the hospital: “Repetition is a really big thing for kids. And a workbook, frankly, takes us about 6 months to get through. So typically, a child will work through two workbooks
while they're with us.” He seemed very confident and passionate about the work he has been doing with child survivors of sexual violence.

I inquired about his training for delivering EBP interventions to his clients. He explained about receiving specific training in trauma-informed care: “all of our kids come to us with the trauma history; we have to treat all clients with universal precautions. So we have to presume that the trauma history is there.”

Trauma can be re-triggered by any of the five senses. It could be as simple as a staff person goes out on their break and smokes a cigarette, which they're allowed to do, that they come back in and a kid smells cigarette smoke on them and their perpetrator was a cigarette smoker that could be instantly—there can be a trauma response from that. And the staff person's going, “Why is this kid acting out?” And would have no clue that it was something like that.

He stated that all of his training has been on-the-job-training: “you can only get good at this by doing this on the job regularly. It’s the only way.” He appeared proud of his work with his clients and emphasized that using EBPs can be very helpful for survivors’ recovery. At this moment, I inquired about his perception of EBPs and non-EBPs. Th9 paused and asked if I could give him an example of a non-EBP. Though the question caught me a bit off guard, I mentioned modalities that have been used to work with trauma survivors, such as some humanistic-existential models. He replied,

There are going to be some overlap with some of the things that are not evidence-based and evidence-based. I wouldn't go as far as to say we're using unconditional positive regard because CBTs of—it can be confrontational at times.
He went on to describe his perception of CBT and how it works with his clients. He concluded, “But it takes time, and over the course of a year, you can just really see the kids progress, and by the time they're done with our program they could sit here and teach you about CBT.” I inquired if he had dealt with any challenges using EBPs, to which he elaborated on working with children and adolescent in different stages of developments: “But challenges would be with younger kids, using CBT with younger kids, and with the autistic population, it can be challenging depending on where they're at on the spectrum.” I inquired if he had any issues when dealing with insurance companies. He stated,

I'm going to go out on a limb and say they will not contract with someone at this point in time that's not evidence-based because that's part of the authorization process is we have to speak to what our evidence-based protocol is.

I think they've been understanding. I think flexible's an okay word to use. Yeah. With the insurance company, you have to demonstrate that there's progress, as long as you're demonstrating that there's progress. I've never made a request of an insurance company either at the hospital or in the private practice that's not been understanding and flexible with payment.

When inquired about his lived experiences with EBPs, the participant said, “It's a very rewarding thing.” He did mention one impact on his personal life, however: “when you do the kind of work that I do, or we do, with trauma, I think at home I've been probably a little, if I'm being honest, a little more hypervigilant with raising my daughter.” He went on to speak about being more aware of sexual abuse and its prevalence because of the work he has been doing with children and adolescents.
We segued into a discussion about the benefits and risks of using EBPs. With regard to risks he stated, “Your business would probably suffer, first and foremost. Your clients would not be receiving the best possible care that’s available.” When he talked about the benefits, he mentioned confidence that the treatment protocol has been studied, and tested, and proven to be effective. “If you're going to be in business and stay in business, these are the treatment protocols that you have to use if you're going to contract or provide services for the major insurance companies that are funding treatment. That's the bottom line.”

After discussing the benefits and risks of using EBPs, he expressed his overall perception of and experience with EBPs when delivering sexual trauma interventions to clients. “Overall being trained with evidence-based practice, and this is the only protocol I've really ever known to do this kind of work, it's really difficult for me to think of anything else but using an evidence-based treatment protocol.” He seemed confident expressing his experience to working with his clients. Even though we had covered a lot about his perceptions and experiences with EBPs when delivering sexual trauma interventions to clients, I asked if there were other questions that I had not asked that would enhance my understanding of his experience as a trauma-focused therapist. He considered for a moment and then said, “You know what, I think it was pretty comprehensive.” I thanked the participant for his time and reiterated that I would be emailing him a copy of the transcription of the interview to him for verification of accuracy and feedback.

The interview with Th9 provided a number of statements of significance that were explicitly related to analytical categories. The following table organizes these statements based on the theoretical framework guiding the study.

Table 10

Summary of the Interview with Th9
<table>
<thead>
<tr>
<th>Analytical Categories</th>
<th>Quotations of Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. VAN MANEN LIFE WORLD EXISTENTIALS</strong></td>
<td></td>
</tr>
<tr>
<td>Lived body</td>
<td>That's really how I got my teeth cut in the field, was through this non-profit.</td>
</tr>
<tr>
<td></td>
<td>Because, as you know, trauma can be re-triggered by any of the five senses.</td>
</tr>
<tr>
<td>Lived space</td>
<td>When I step away from a therapy session, to pretty much step away from it.</td>
</tr>
<tr>
<td></td>
<td>Whenever you're doing trauma work it's not linear, it's fragmented.</td>
</tr>
<tr>
<td>Lived time</td>
<td>I've always had a knack or an ability….</td>
</tr>
<tr>
<td></td>
<td>I think you get better with it with experience.</td>
</tr>
<tr>
<td></td>
<td>When you're reconstructing trauma or a trauma story, it's like putting together a puzzle again, piece-by-piece, and not in a linear fashion. You don't start recalling trauma in chronological order.</td>
</tr>
<tr>
<td>Lived relationship</td>
<td>First they learn about their thinking errors and we just start out teaching 10 basic thinking errors.</td>
</tr>
<tr>
<td></td>
<td>I don't know what you would call it—countertransference, if you will.</td>
</tr>
<tr>
<td></td>
<td>We have to treat all clients with universal precautions. So we have to presume that the trauma history is there.</td>
</tr>
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</table>
### 2. BIO-ECOLOGICAL FRAMEWORK

<table>
<thead>
<tr>
<th>System</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Microsystem</strong></td>
<td>First they learn about their thinking errors and we just start teaching 10 basic thinking errors. It takes time, and over the course of a year you can just really see the kids progress.</td>
</tr>
<tr>
<td><strong>Mesosystem</strong></td>
<td>Maybe a relative will take over as the parenting role, and they get really involved, and that's a tremendous support. You're going to have the older kids that are further along in treatment. There's no denial. They've been through the protocol.</td>
</tr>
<tr>
<td><strong>Exosystem</strong></td>
<td>Through my work itself, I had a supervisor who's a trauma therapist, expert in the field, and of course, have been reporting to him for weekly supervision for the past seven or eight years or so. A big role as part of the treatment is to make sure that the staff are trauma informed so that they're not doing anything that's going to re-trigger trauma in the kids.</td>
</tr>
<tr>
<td><strong>Macrosystem</strong></td>
<td>Because it was huge. I was with the non-profit at the time, and all the county contracts moved towards evidence-based practice. With our contracts and our different accreditation bodies that come in to the hospital, and the insurance companies that are paying for the children to be in care, everything has to be evidence-based. The insurance company has a managed care officer and once a month we have to give a comprehensive report on where we're at with that child through the treatment protocol. I'm going to go out on a limb and say they will not contract with someone at this point in time that's not evidence-based because that's part of the authorization process is we have to speak to what our evidence-based protocol is. We directly report to the funding body.</td>
</tr>
<tr>
<td><strong>Cronosystem</strong></td>
<td>Due to just a series of circumstances, personal issues, the death of my father, things like that, I stepped away from—it was a very grueling responsibility. My daughter was about the same age as those kids at the time and it was pretty difficult for me to do that.</td>
</tr>
</tbody>
</table>
I think you get better with it with experience.

### 3. ISAT

<table>
<thead>
<tr>
<th>Clinical relationship</th>
<th>It takes time, and over the course of a year you can just really see the kids progress.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nexus of personal and treatment issues</td>
<td>I come from a foundation of CBT, so those are the modalities that I'm most comfortable with.</td>
</tr>
<tr>
<td>Broader Systemic and Cultural Influences</td>
<td>To the best of our ability we try to individualize treatment, Because it was huge. I was with the non-profit at the time, and all the county contracts moved towards evidence-based practice. With our contracts and our different accreditation bodies that come in to the hospital, and the insurance companies that are paying for the children to be in care, everything has to be evidence-based. We directly report to the funding body. The insurance company has a managed care officer, and once a month we have to give a comprehensive report on where we're at with that child through the treatment protocol.</td>
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### 4. PROTECTIVE FACTORS

| “I’m not pulling this out of nowhere” | You get the confidence that you're using a treatment protocol that's been studied, and tested, and proven to be effective. |
| “It can be effective” | Repetition is a really big thing for kids. And a workbook, frankly, takes us about six months to get through. So typically, a child will work through two workbooks while they're with us. At the hospital we track outcomes… I think we have some pretty good success with that. |
| “I’m doing the right thing” | You have to use if you're going to contract or provide services for the major insurance companies that are funding treatment. |

### 5. RISK FACTORS

| “Being careful” | I don't know what you would call it - countertransference, if you will. Your clients would not be receiving the best possible care that’s available. |
| Lack of preparation for trauma – graduate school | I can't recall if there was a course specific to trauma. |
Lack of preparation for EBPs – graduate school

When I was in graduate school, evidence-based practices, that was the big buzzword.

6. COMMON THEMES

<table>
<thead>
<tr>
<th>Multimodal Approach</th>
<th>At the hospital we use CBT, the Cognitive Behavioral Therapy model, almost exclusively.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>I use a variety of different approaches here in private practice, but again, I come from a foundation of CBT.</td>
</tr>
<tr>
<td>Structure/rigid</td>
<td>We have to teach the frontline workers that are working on the unit, the day-to-day activities with the kids.</td>
</tr>
<tr>
<td>Flexibility/adaptation</td>
<td>We can certainly take an eclectic approach to things.</td>
</tr>
<tr>
<td>Rewarding experience</td>
<td>It's a very rewarding thing.</td>
</tr>
<tr>
<td>Being a woman</td>
<td>I think at home I've been probably a little, if I'm being honest, a little more hypervigilant with raising my daughter.</td>
</tr>
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</table>

Th10 Interview

The tenth interview was conducted with a 50-year-old Caucasian male who has been working in the mental health field for 20 years. We started with the demographic questions by which I gathered information to proceed with my inquiry. He has a PhD and is a Licensed Professional Counselor who has delivered sexual trauma interventions to victims and/or survivors of sexual violence. He has also attended training in using EBPs, and he was fully aware of the nature of the study. We met in my office where he felt comfortable sharing his experiences. I reviewed confidentiality and the protection of his information. I also reviewed the purpose of the study and emphasized that participation in this study was voluntary and that he could leave at any time. He agreed to participate, and we both signed the informed consent.

Th10 displayed a lot of enthusiasm and started talking about his work as soon as he met me outside of my office. As we started the audio recording, I prompted him to talk about his background working in the mental health field, in answer to which he described his trajectory working in different settings throughout his twenty years in the mental health field. He
mentioned that he has worked with children, adolescents, and adults, although his clientele in private practice consists of adults only. He stated,

With people that I get in private practice, they're sort of more exploratory, supportive. Certainly, anxiety and sexual abuse has come out... And just a big wide group of clientele, including—I work with a woman and she's referred me to sex addicts, as well. And there's a lot of, well, I don't know if there's a lot of traumatizing. I don't know if there's a lot of early sexual in sex addicts. It's hard to—I know in my population I have, I feel like there is.

After he talked about his background and experience in the mental health field, I started with the first question on the semi-structured protocol. I prompted Th10 to talk about his experience working as a trauma-focused therapist. He spoke about feeling disorganized and immediately added that it may not be a feeling. He went on to say, “This is heavy. What has this person experienced? When I try to imagine the space they are in.” While describing his experience working as a trauma-focused therapist, he offered an example about a client survivor of sexual violence:

I have a gentleman who is trying to piece together memories. He actively talks about not being able to piece together the memories too well. So the stories can be nightmarish and fantasy-like, and I'm like, “Is this fantasy-like? Is this a fantasy, or did that really happen to him?” So there's that, too. I'm not at all skeptical, at all, in fact. It's like when somebody's telling you something, and it's from the depths. It's not like they're chatting, so I'm not saying lying. It's not like they're like—but they feel something down inside even though—because this gentleman I'm thinking about, he's very rational, logical, non-emotive. He's never cried in 7 years, ever.
We segued into talking about what it has been like for him to treat survivors of sexual violence. He stated that it has been emotional as well as exciting. He stated, “It's invigorating… I mean that's why you kicked in to be a therapist. You have the potential to think you can piece back together a personality, but when you see it start to happen, it is rewarding.” It appeared that his experience and skills have helped him process his work as a trauma-focused therapist effectively.

I inquired about supervision, and he stated that he typically consults with his colleagues, especially the clinical director of one of his practices.

After talking about his experience and supervision, we moved on to discuss the next question. Th10 was prompted to speak about approaches he uses to work with victims and survivors of sexual abuse:

So somewhere, the nexus of psychodynamic, existential, and narrative therapy, where those things come together. I don't know if that makes sense to you, but let's just say those three approaches. Narrating and then changing the narrative if need be. Look, I'm psychodynamic. I think that trauma appears in the ego in life patterns. Making people aware of that, or having them get inside into that, I'm an inside therapist because I know that can be criticized lately. And existential, how has this thing meant to you and how has your journey out of it or in it or through it, and what has that meant for you as a part of a major part of a narrative? So as you're going to pin me down on approaches, that's how I construct the dialogue.

I inquired if he used these same approaches when he worked for an agency. He stated that he could use any interventions with his clients. However, he explained that when he worked in the family therapy division, he had to go for three years of training in structural family therapy. I prompted him to elaborate further on the training he has attended. He mentioned motivational
interviewing. “When substance abuse and trauma come together, you have to get somebody sober before you’re going to process or clean whatever.” He went on to explain, “You can use for substance abuse, but it's humanistic psychotherapy with a little bit of Freud thrown in.” He also attended Gestalt training, and he is a certified Jungian Therapist.

We segued into discussion his perception about EBPs and non-EBPs. He immediately stated, “I find evidence-based practices are good for structure. If they become rigid, they are not good at all.” I asked if he could expand on his words “become rigid”; what did that mean to him? He said,

Cognitive behavioral therapy without some kind of narrative context doesn't make any sense to me. I've had people—in fact, I think that in the beginning, they help out a lot, because people feel secure in them, so I want to think of what the client likes, as well. I inquired about his statement “because people feel secure in them” and asked if he could expand on that as well. He stated, “Maybe just because of the structure. They’re able to understand what’s going on and be active in it. It’s a little scary to be out on your own just narrating things. That’s my intuition.” With regard to non-EBPs, he noted that he “like[s] them very much.” He went on to say,

I think that they would be evidence-based practices like, for instance, just straight psychodynamic psychotherapy. Nobody researches it anymore. There hasn't been a call to research it in 20 years. Therefore, we don't have research, but it's easy to research cognitive-based practices. I like the long-term, holistic psychotherapy, wherever you call it. Humanistic, psych, things that go on through one life span, where you try to get insight on the past because I think it's lasting.
He then spoke about an article stating that “the cognitive-based therapies have a great spike in the beginning of how people change, but then it drops off.” He then compared CBT to psychodynamic approaches stating, “Psychodynamic, it’s an umbrella for a lot of other things. I am talking about existential or whatever. Kind of the effects are more long lasting over a lifetime.” After he emphasized the difference between approaches, he smiled and said, “Now, you’ve got me on my soapbox. Nobody cares but me.”

This statement really stood out to me because it was a clear indication that this confident, trauma-focused therapist thinks that that non-EBPs are under researched and that preference is giving to CBT approaches. He noted that “it's good to have it laid out in a book or be trained, but therapy room is so flexible and open. It's a dance. It's a dance, and the dance floor goes on forever.” I inquired about challenges he has dealt with when delivering sexual trauma interventions to clients. He stated quickly that he has not met any challenges, but when on to say, “Always trust in your therapeutic intuition versus the structure that many evidence practices say follow. I'm pigeonholing evidence practices between its just cognitive stuff or like super, and I shouldn't do that. I know there’s a lot more.” He emphasized the importance of integrating because all approaches have their strengths.

I took this moment to inquire about his graduate school and if they emphasized EBPs and trauma. He replied that his graduate school did not stress EBPs: “I actively chose schools and programs that wouldn’t do that.” He could not remember any courses in trauma, but “it’s not that trauma didn’t come up in the courses I had.”

The participant then described his lived experiences with EBPs:

I try to use the awareness of my body and how my body feels, and I, often, through my own psychological complexes, can often monitor and feel tense in my body. It's an
anxiety-producing thing. It's an anxiety-producing thing. You have to monitor anxiety. I know clinicians like to talk about anxiety, lately, and everyone's like… “Oh my God. I hope we're connecting.” Lived space. I mean, to visit the spaces, well, I call lived space, not just like between you and I right now, but the spaces in the head, like where they once lived. I try to get in tune with that. And that's a very enveloping. Like, I was here. I'm trying to piece this together here. I'm talking about sexual trauma as emotional. I try to be very calm and still when I'm working with trauma and any evidence-based or not. We segued into a discussion about benefits and risks of using EBPs. With regard to risks he stated, “If you don't have a community of peers and you don't spend your time developing from this literature, what common experiences are for people who have been helped in therapy, then you're not really a therapist. You're just some dude.” He went to speak about countertransference and being trained to deliver any approach, “You have to have some idea of what the hell you're doing.”

After discussing the benefits and risks of using EBPs, he expressed his overall perception and experience with EBPs when delivering sexual trauma interventions to clients. He stated, “So, overall, I feel a profound sense of gratitude that I'm a psychotherapist, and I have a PhD. When I know that I did good work, and that I'm like, ‘Oh, my God, this stuff actually works. It's crazy.’” He seemed confident when expressing his experience in working with his clients. Even though we had covered a lot about his perceptions and experiences with EBPs when delivering sexual trauma interventions to clients, I asked if there were other questions that I had not asked that would enhance my understanding of his experience as a trauma-focused therapist. He said, “The one thing that occurred to me was, also, we didn't talk about that is the Freudian tradition. My
own countertransference with my own experiences with said trauma." I asked if he would like to talk about it and he took a moment and stated,

I don't want to delve into that, but that's something that I monitor, as well. It's both meaningful, but it's difficult, I mean, so. And that's all I really want to say about that, but it's the old Freudian stuff of like, “Make sure you don't project, but also you empathize.”

I thanked the participant for his time and reiterated that I would be emailing him a copy of the transcription of the interview for verification of accuracy and feedback.

The interview with Th10 provided a number of statements of significance that were explicitly related to analytical categories. The following table organizes these statements based on the theoretical framework guiding the study.

Table 11

*Summary of the Interview with Th10*

<table>
<thead>
<tr>
<th>Analytical Categories</th>
<th>Quotations of Significance</th>
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<tbody>
<tr>
<td><strong>1. VAN MANEN LIFE WORLD EXISTENTIALS</strong></td>
<td></td>
</tr>
<tr>
<td>Lived body</td>
<td>It's my observing ego trying to assess how much of it they're giving light in their own head.</td>
</tr>
<tr>
<td></td>
<td>Let's face it.</td>
</tr>
<tr>
<td></td>
<td>&quot;Oh, I know the future, I can read your mind.&quot;</td>
</tr>
<tr>
<td></td>
<td>I try to use the awareness of my body and how my body feels.</td>
</tr>
<tr>
<td></td>
<td>I can often monitor and feel tense in my body.</td>
</tr>
<tr>
<td></td>
<td>But the spaces in the head, like where they once lived.</td>
</tr>
<tr>
<td></td>
<td>You'll be driving home thinking, it's in your head.</td>
</tr>
<tr>
<td>Lived space</td>
<td>When I try to imagine the kind of a space they're in. Being in that space, it's not a fun space to be in.</td>
</tr>
<tr>
<td></td>
<td>I'm an inside therapist.</td>
</tr>
</tbody>
</table>
I'm kind of alone here.

But therapy room is so flexible and open.

I try to be very calm and still when I'm working with trauma and any evidence-based or not.

I try to have respect for all that's really going on in the room because there's so much that is.

But I feel like there's a process that I have in mind.

<table>
<thead>
<tr>
<th>Lived time</th>
<th>It's like when somebody's telling you something, and it's from the depths.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kind of like the effects are more lasting over a lifetime.</td>
<td></td>
</tr>
<tr>
<td>I, often, through my own psychological complexes</td>
<td></td>
</tr>
<tr>
<td>I feel like I'm going to have a long time with this person.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Lived relationship</th>
<th>Wow. This is heavy. What has this person experienced?</th>
</tr>
</thead>
<tbody>
<tr>
<td>It's a dance. It's a dance, and the dance floor goes on forever.</td>
<td></td>
</tr>
<tr>
<td>I feel anxious when I see a new client, like I feel a definite anxiety rise,</td>
<td></td>
</tr>
<tr>
<td>Oh my God. I hope we're connecting.</td>
<td></td>
</tr>
<tr>
<td>My own countertransference with my own experiences with said trauma.</td>
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2. BIO-ECOLOGICAL FRAMEWORK

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<th>Microsystem</th>
<th>&quot;Oh, I know the future, I can read your mind.&quot;</th>
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<td></td>
</tr>
<tr>
<td>I feel like I'm going to have a long time with this person.</td>
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</table>

| Mesosystem                             | If you don't have a community of peers and you don't spend your time developing from this literature, what common experiences are for people who have been helped in therapy, then you're not really a therapist. |

| Exosystem                              | I don't want to make this diatribe about the communal health system, but it needs reform, I mean…. |

| Macrosystem                            | But I think good therapists know how to do these things in the relationship already. |

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They recognize I have the PhD.

<table>
<thead>
<tr>
<th>Cronosystem</th>
<th>Kind of like the effects are more lasting over a lifetime.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>I think because the culture got really—this goes back to the</td>
</tr>
<tr>
<td></td>
<td>behavioral routes of psychology, research culture from the</td>
</tr>
<tr>
<td></td>
<td>'20s.</td>
</tr>
<tr>
<td></td>
<td>The cognitive revolution which has been great for so many</td>
</tr>
<tr>
<td></td>
<td>things.</td>
</tr>
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</table>

3. ISAT

<table>
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<td>Nexus of personal and treatment issues</td>
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<td>Humanistic, psych, things that go on through one life span, where you try to get insight on the past because I think it's lasting.</td>
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<td>It's good to have it laid out in a book or be trained.</td>
</tr>
<tr>
<td></td>
<td>I probably tried to used briefer interventions more to help them out better.</td>
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<tr>
<td>Broader systemic and cultural influences</td>
<td>I don't want to make this diatribe about the communal health system, but it needs reform, I mean….</td>
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4. PROTECTIVE FACTORS

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<th>“I’m not pulling this out of nowhere”</th>
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<tr>
<td>“It can be effective”</td>
<td>I've had people—in fact, I think that in the beginning, they help out a lot.</td>
</tr>
<tr>
<td>&quot;Oh, my God, this stuff actually works. It's crazy.&quot;</td>
<td></td>
</tr>
<tr>
<td>“I’m doing the right thing”</td>
<td>They're able to understand what's going on and be active in it. It's a little scary to be out on your own just narrating things, I think.</td>
</tr>
</tbody>
</table>

5. RISK FACTORS

<table>
<thead>
<tr>
<th>“Being careful”</th>
<th>It's the same risk as not analyzing your countertransference. It's the same. It's analogous.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of preparation for trauma – graduate school</td>
<td>I don't want to offend anybody in the community. I just don't remember any courses on trauma.</td>
</tr>
<tr>
<td>Lack of preparation for EBPs – graduate school</td>
<td>No, and I had no [preparation for EBPs], but I actively chose schools and programs that wouldn't do that, though</td>
</tr>
</tbody>
</table>

### 6. COMMON THEMES

| Structure/rigid | I find evidenced-based practices are good for structure. |
| Flexibility/adaptation | To be able to integrate because they all have their strengths |
| Rewarding experience | It's invigorating to begin to—I mean that's why you kicked in to be a therapist. That's rewarding as hell. Overall, I feel a profound sense of gratitude that I'm a psychotherapist, and I have a PhD. |
| Being a woman | N/A |

### Cross-Case Analysis

The tables above present a summary of each interview. The participants expressed many similar thoughts during the interview regarding their perceptions and experiences with EBPs when delivering sexual trauma interventions to clients. Six analytical categories were used to organize significant quotations derived from the participants’ narratives. The first three analytical categories, which include van Manen’s life world existentials (lived body, lived space, lived time, and lived relation), Bronfenbrenner’s bio-ecological model (microsystem, mesosystem, exosystem, macrosystem, and chronosystem), and ISAT model (clinical relationship, nexus of personal and treatment issues, and broader systemic and cultural influences) provided the framework for elucidating the data collected.

The subsequent analytical categories of protective factors, risk factors, and common themes were used to organize supporting statements that could be linked with the themes that emerged across the interviews. An interpretation of the findings from the emerged themes may be found in Chapter V of this study, where they are paired with the research questions that they
answer best. The themes that emerged from the participants’ narratives were remarkable. They revealed significant statements related to risk and protective factors, such as “clients might suffer by not having evidence-based practices that they’re benefiting from”; “Many therapists don’t fully know how to deliver sexual trauma interventions”; “That’s the approach that the insurance company wanted us to use. So I was kind of forced to get into it”; and “You can really rely on it…and know that you’re going to get a produced outcome from it.” All of the participants spoke of the benefits of flexibility and adaptation of EBPs when treating survivors of sexual violence. The participants also elucidated consistently, throughout the interviews, their experiences with EBPs as being structured/rigid. They expressed their perceptions using phrases such as “Going by this very rigid box with CBT or any other approach”; “The reality that one size doesn’t always fit all”; “I feel like they can be pretty rigid about the model”; “The challenges would come when things are required, and you have to do it despite of the clients themselves.”

The participants expressed many similar experiences and perceptions about EBPs when delivering sexual trauma intervention to clients. However, not all of the analytical categories were represented in each individual interview. The following table provides a cross-case analysis of the quotation of significance linked with the analytical categories that emerged as common across the cases.

Table 12

Cross-Case Analysis

<table>
<thead>
<tr>
<th>Analytical Category</th>
<th>Th1</th>
<th>Th2</th>
<th>Th3</th>
<th>Th4</th>
<th>Th5</th>
<th>Th6</th>
<th>Th7</th>
<th>Th8</th>
<th>Th9</th>
<th>Th10</th>
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</thead>
<tbody>
<tr>
<td>1. VAN MANEN LIFE WORLD EXISTENTIALS</td>
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<td>Time</td>
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<td>Relationship</td>
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<td><strong>2. BIO-ECOLOGICAL FRAMEWORK</strong></td>
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<td><strong>Microsystem</strong></td>
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<td><strong>Mesosystem</strong></td>
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<tr>
<td><strong>Exosystem</strong></td>
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<td>** Macrosystem**</td>
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<tr>
<td><strong>Chronosystem</strong></td>
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<tr>
<th><strong>3. ISAT</strong></th>
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<tbody>
<tr>
<td><strong>Clinical Relationship</strong></td>
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<tr>
<td><strong>Nexus of Personal and Treatment Issues</strong></td>
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<tr>
<td><strong>Broader Systemic and Cultural Influences</strong></td>
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<table>
<thead>
<tr>
<th><strong>4. PROTECTIVE FACTORS</strong></th>
</tr>
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<tbody>
<tr>
<td>“I’m not pulling this out of nowhere”</td>
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<tr>
<td>“It can be effective”</td>
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<tr>
<td>“I’m doing the right thing”</td>
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<tr>
<th><strong>5. RISK FACTORS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>“Being careful”</td>
</tr>
<tr>
<td>Lack of preparation for trauma</td>
</tr>
<tr>
<td>Lack of preparation for EBPs</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>6. COMMON THEMES</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Multimodal approach</strong></td>
</tr>
<tr>
<td><strong>Structure/rigid</strong></td>
</tr>
<tr>
<td><strong>Flexibility/adaptation</strong></td>
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<tr>
<td><strong>Rewarding experience</strong></td>
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<tr>
<td><strong>Being a woman</strong></td>
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</table>

Table 12 provides the foundation for the development of themes revealed in the individual interviews as well the conceptual framework elements. The common themes emerged from the participants’ perceptions and experiences with EBPs when delivering sexual trauma interventions to clients. All the participants discussed their experiences working as trauma-focused therapists as well as their experiences treating survivors of sexual violence. The cross-case analysis precedes an in-depth discussion of the findings in Chapter V, along with a summary of emerged themes related to the research questions that guides this study.
All participants spoke about their perceptions of EBPs including its challenges, benefits, and risks. Participants’ lived experiences were explored using the conceptual framework of van Manen’s (1990) existentials. Themes were also derived from participants’ experiences of using EBPs, within the context of Bronfenbrenner bio-ecological model (1979) and Levers’ (2012) ISAT model, particularly relating to issues of context and systems. I anticipated that trauma-focused therapists’ perceptions and experiences with EBPs would vary based on the type of their workplaces, such as hospitals, agencies, health centers, and private practice. My expectation was grounded on the fact that trauma-focused therapists’ work settings might affect their decision-making processes when delivering sexual trauma interventions to clients.

The participants expressed their feelings about using EBPs through brief examples from cases and sharing of work experience. Most participants described their lack of preparation for trauma counseling as well as lack of training in EBPs during graduate school. Several additional themes emerged, some consistent throughout all the interviews, such as structure vs. rigid, whereas others were less frequent, such as being a woman. The quotations of significance in the cross-case analysis have been used to develop essential themes that are further discussed in the subsequent chapter.

**Trauma-Focused Therapist Interviews and Lifeworld Existentials**

Part of exploring a trauma-focused therapist’s experience with EBPs is to understand his or her reality or “lifeworld” (van Manen, 1990). Participants in this research elucidated their everyday work in counseling survivors of sexual violence. Van Manen (1990) noted that “[i]n drawing up personal descriptions of lived experiences, the phenomenologist knows that one’s own experiences are also the possible experience of others” (p. 55). Throughout the interviews conducted with trauma-focused therapists, lived experiences were revealed.
Lived Body

The vast majority of participants expressed an understanding of their physical presence in the world as practitioners. Eight out of the ten participants provided a number of references to the lived body experience: “So I always in my head, feel like…”; “I'm always very aware of that in the back of my head”; “I mean, I can very vividly in my mind right now”; “It’s kind of a no brainer”; “I could think of the first thing that comes to mind”; “The mental picture I get.” These descriptions were usually followed by an explanation of their experience and how it felt in their body to work with survivors of sexual violence: “I was really with them in their pain, and hearing their experience and really cared, and really just was very private”; “Because it is hard for me as a therapist to hear their story and not feel for them in a different way”; “So it is real and raw, and so hard”; “Once they trust you, they just throw all this extra stuff in your lap, and you're like, ‘Whoa.’” The study participants spoke of lived body using words related to physical and emotional pain as well. Their descriptions spoke clearly to the visceral, emotionally charged part of working with trauma survivors: “I don't want to leave them in this open wound here”; “This person know that I hurt”; “I can often monitor and feel tense in my body.” Two of the participants spoke about having to ground themselves to feel present in the session: “I think it's a constant having to kind of pinch myself: ‘Get back here’”; “I try to use the awareness of my body and how my body feels.” Indeed, trauma-focused therapists in this study expressed their lived experience of feeling in their body the awful nature of the abuse while conveying confidence in the client’s capacity for recovery, as stated by Th7: “and finally I tapped into its human healing.” According to van Manen (1990), “In our physical or bodily presence we both reveal something about ourselves and we always conceal something at the same time—not necessarily conscious or deliberately, but rather in spite of ourselves” (p. 103). These
experiences described by the participants that relate to lived body seem to indicate that they are affected by the client’s pain, but they model emotional regulation to validate clients’ capacity to develop their own emotional response.

Th7 spoke about evidence-based practices helping her stay healthy, “which helps the client to get healthier.” She referred specifically to the structure of EBPs and used as an example a client’s scoring a decrease on a self-report assessment for PTSD. Experiencing her clients’ posttraumatic stress subsiding helps her feel, vicariously, less tension in her body. Th10 expressed trying to use the awareness of his body because he can often feel tense. These participants recognized that being mindful of their bodies’ response while delivering sexual trauma interventions to clients is an essential part of being a trauma-focused therapist.

**Lived Space**

The lived space that was expressed by participants was related to their day-to-day experience with EBPs as a clinician. Th1 and Th4 expressed their frustration: “hearing just trauma, after trauma after trauma…”; “then every week, it was the same day every week, same time every week… And for an hour, we'd work on the manual.” Van Manen (1990) elucidated that lived space is our daily experience of events and “in addition it helps us uncover more fundamental meaning dimensions of lived life” (p. 103). Some participants spoke about their sense of space as being present with their clients in the office, where clients feel safe and comfortable to share their traumatic events. For instance, Th8 expressed, “I can really be with somebody when they're in here in my office.” Th10 stated, “… therapy room is so flexible and open. Participants’ description of lived space included their perceptions of how they experience their clients’ presence, as Th6 put it, “Because you know there is another side.” Th10 expressed
his empathy: “When I try to imagine kind of a space they're in. Being in that space, it's not a fun space to be in.”

I noticed that some participants used expressions to describe their lived experience. With regard to lived space expressions such as “I can't say that I just sit in the box with that”; “… going by this very rigid box with CBT or any other approach”; “I don't feel comfortable just going by a step-by-step process in a book.” The use of the word “box” and “book” in this context, suggests that they have felt uncomfortable following a protocol and the structure inherent in EBPs. Th10 also referred to trying “to imagine kind of a space they're in. Being in that space, it's not a fun space to be in.”

Lived Time

The participants revealed the essence of being a trauma-focused therapist including their dynamic perception of time, wherein the past influences the present and future, and the present or future, in turn, influences perceptions of the past (van Manen, 1990). The participants identified this concept as fundamental to managing the challenges characteristic to trauma work. They used phrases such as “I will tell you this is definitely hard in the beginning”; “I come from a place of multiple experiences of seeing people grow and heal”; and “I think you get better with experience” to describe how they have processed and made sense of their work as trauma-focused therapists.

Many of the participants reported their understanding of lived time when delivering sexual trauma intervention to clients. For instance, Th3 observed, “as clinicians, we can get stuck which can keep our clients stuck.” She also affirmed, “Sometimes in therapy, it could go on forever and we don't realize that we're getting anywhere.” In a sense, Th3’s statement about her perception of time reflected the challenging work of a trauma-focused therapist with regard to
helping survivors make sense of their own time in reference to their traumatic experience. On a similar note, Th9 alluded to time as challenging when working with trauma survivors. He noted, “When you're reconstructing trauma or a trauma story, it's like putting together a puzzle again, piece-by-piece, and not in a linear fashion. You don't start recalling trauma in chronological order.” This participant understood that trauma can have an impact on survivors’ perceptions of time, which consequently affects the intervention he uses with a client. He expressed that both experience and his “knack or an ability to be able to work with survivors” has helped him work more effectively with trauma survivors.

Many statements related to lived time overlapped with live relations. Van Manen (1990) affirmed that lived existentials can be differentiated but not separated. Trauma-focused therapists’ lived relationships with clients are intrinsically connected to lived time; thus, it is evident that the experiences of lived time and lived relation in this context have intersected. The following findings, which relate to the lived relation of trauma-focused therapists, complement the discussion about lived time.

**Lived Relations**

The aspect of lived relations emerged strongly from participants’ responses. This last existential, as I predicted, is highly significant in understanding trauma-focused therapists’ experiences with and perceptions of EBPs when delivering sexual trauma interventions to clients. Van Manen (1990) stated, “As we meet the other, we are able to develop a conversational relation which allows us to transcend our selves” (p. 105). Participants expressed positive feelings about their relationships that share space with clients, indicating that their interventions are affected by how they perceive sexual trauma work. Participants used words such as “safety,” “comfortable,” “relationship,” and “trust,” with more frequency than in
discussing any other lifeworld existential. Th8 stated, “I realized in talking to them, that what they were looking for was more of an interpersonal connection.” Participants appeared to value the relationship with their clients as the most therapeutic factor in the process of delivering interventions to survivors of sexual violence.

With regard to relating to clients, Th3 expressed statements such as being able “to talk to her (client) about ways to feel safe and being around people,” and “I have not intruded on their emotional safety, and how they want to share and what they want to share, and I think that it is a respectful approach.” Th3 spoke specifically about using a “respectful approach” to relating with her clients, and endorsed a person-centered approach to “honor the person, and let them have ownership over what they want to share, empower them.” Th6 also spoke about her perspective on using a client-centered approach to work with her clients: “It all goes back to the core values as a clinician of therapy, counseling from the client's point of view, counseling for the clients.” In the same context, Th7 referred to acknowledging clients where they are in their recovery process and delivering the intervention accordingly: “Then we're going to get back to the work when they feel comfortable and safe and what have you.” Other participants spoke about their connection with clients as being the most important part of their lived relation with survivors of sexual violence. Th4 and Th5 emphasized the meaning of building rapport as well as being attentive to clients’ story, “whatever it was that they experienced in the past, and how they feel about themselves now.” Many participants emphasized their experience of being able to empathize with their clients. Th5 stated, “So it's like putting myself in there, and trying to see it through their lens.” Th8 said, “You have to be willing to be with it and be with that person.” Additionally, participants seemed aware of maintaining a healthy boundary with their clients, so they would not be affected emotionally by clients’ traumatic experiences. Th1 affirmed, “So
there's kind of like this disconnect from me to them that I've had to gain in order to keep my own sanity right.” She seemed aware of her own limits as a trauma-focused therapist in relating with her clients. Th7 noted that “it ends up being intensely personal even with good boundaries; at least for my confidence, that this person has explored this enough cognitively to go in further.”

On the other hand, Th4 and Th10, spoke of feeling overwhelmed and hesitant about their connection with clients: “I went from this place where I was so sad and so emotionally flooded with her story”; “Wow! This is heavy. What has this person experienced?”; and “Oh my God, I hope we're connecting.” Some of the participants’ negative comments revealed a deep level of fear in being able to process a client’s traumatic experience, as it is part of their therapeutic relationship; yet participants seemed to feel confident in their ability to overcome their insecurities and trust in their counseling skills. Th8 eloquently described her way of processing the trauma brought by survivors into session: “I let it go back to the universe or the earth or whatever you want to say that can absorb all the horrible things that have happened.” In this way, the participants’ skills in dealing with trauma work were expressed through sharing their lived relation experiences.

The next section shows how the lived experiences of trauma therapists can be explicated using Bronfenbrenner’s (1979) bioecological model (see Figure 2).
All the participants in this study have experience with EBPs when delivering sexual trauma interventions to clients, and they seemed confident about their clinical skills. In their report of daily interactions with clients, participants described the inner, face-to-face system that is their context for delivering sexual trauma interventions to clients. At this level, participants’
understandings conveyed their lived relations, which happened in two ways. The trauma-focused therapists in this study have influenced the client’s understanding of the treatment/counseling process, and clients have also influenced the therapists’ perception of how to approach treatment. Many participants described their therapist-client relationship with such observations as “I have found with most of my clients that I'm able to ask them, you know, like what do you think the first issue you want to focus on is?”; “I always let them know that it's okay for them not to talk about it if they don't want to”; and “So letting the person share what it is that they're experiencing, understanding where they're coming from.” Through the responses that highlighted participants’ view of their active role in the therapist-client relationship, some emphasized the importance of trust as an essential aspect of the therapeutic relationship; as expressed by Th6, “I am just creating a space where they could say whatever they want and just get comfortable… once they trust me.” It appeared that the trauma-focused therapist builds an intimate connection with survivors at the microsystem level. When describing her relationship with a client, Th8 said, “I can really be with somebody when they're in here in my office.” This connection seems to cultivate and strengthen the therapeutic relationship, which might affect how trauma-focused therapists choose an intervention to work with clients.

Th5 spoke about EBPs’ rigid structure being a barrier in building a relationship with a client: “Whenever you're sitting down across from somebody, and they have a million and one things that they need to say to you, and you're trying to be structured and everything else in the practice, it doesn't work.” Other participants indicated that explaining to clients how the approaches they use have helped other survivors is their way of starting to build a relationship; for example, Th7 might say, “Hey, here's this approach. Many, many, many, many people that have had very similar life experiences have benefited from it.” At the microsystem level,
participants’ responses suggested that valuing the relationship is the most important aspect of sexual trauma interventions. They endorsed the use of EBPs if the therapist can choose to adapt them so that survivors can process the traumatic event at their own pace.

**Mesosystem**

The mesosystem, as conceptualized by Bronfenbrenner (1979), is a dynamic area constituted of “the interrelations among two or more settings” (p. 25). The mesosystem can include the therapeutic relationship, working environment, coworkers, and peers. This layer produces the connections between the structures of therapists’ microsystems. Throughout the interviews, participants discussed their settings and how they have influenced their experience of EBPs when delivering sexual trauma interventions to clients. The participants working in private practice seemed to have experienced a different dynamic compared to participants who report to work within the norms and regulations established by their agencies, hospitals, or health centers. Participants working in private practice spoke about feeling isolated: “I don't really get the opportunity to consult a whole lot, or receive supervision a whole lot now that I'm not required to as an independently licensed clinician” and “That's the one thing I miss about agency work, is that if you had a really hard session, you can run down the hall and say, ‘Oh, my heavens. Wait until you hear this one.’” Such observations reflected their lack of a regular connection with peers.

Conversely, some participants spoke about the positive aspects of working in settings where they had the opportunity to consult with peers. Th7 shared that she had some very supportive supervisors. Th6 noted, “I know that I talk a lot, which I think is helpful for me, so whether it's to a colleague, whether I need to—once I'm done for the day, I'll just call a mentor.” Participants expressed a positive attitude toward supervision and consultation with peers,
indicating that a lack of supervision can contribute to their perception of their work with trauma as more difficult to bear on a day-to-day-basis.

**Exosystem**

Trauma-focused therapists are not active in the exosystem, but it affects them. It includes the larger systems that might affect therapists’ decisions to use a specific intervention(s) when treating sexual trauma survivors. In the context of this study, the therapists’ exosystem might be the agency or private practice policies, counseling system, or administrative decision. Within the exosystem, trauma-focused therapists can experience the impact others’ systems have on their clinical decision-making process. Administrative decisions made on the internal and/or external levels may influence clinicians’ perceptions and experiences with EBPs when delivering sexual trauma intervention to clients. Th1’s frustration was evident when she said, “So we're very much medically focused, and that is the priority there. I feel like sometimes, we're just not as important as the medical.” Th2 voiced her frustration with lack of support from the settings where she has worked: “My work never supported training. I just went on my own… When I was in an agency there wasn't money to support that.” However, the majority of the participants reported that they felt supported by their system, even with decisions that are out of their control.

Three participants noted that their systems monitor their use of EBPs. For example, Th2 expressed,

Especially in a school, they want to make sure of what they're paying for and how many therapists come in because I was contracted through the school to come in. They want to make sure that you are doing something that is backed up with evidence...
Th5 had a similar experience: “They want to see whatever it is that we're working on in the treatment plan, if it's matching up with what we're doing in session, and if those sessions are, in fact, related to some kind of evidence-based practice.” In the same context, Th4 expressed, The agency, in a way, even though they really wanted us to use that modality, they understood at that time that it was about the client and not us. I guess the challenges would come when things are required, and you have to do it despite of the clients themselves.

It is interesting to note that several participants expressed fear and feelings of being pressured by the current state of regulations from their agency and other major systems that establish the requirements for psychotherapy practice.

Some participants referred to professional counseling and psychological organizations’ lack of sexual trauma related training. Th2 observed, “I think that just even on the state counselor level, or bigger conferences, we could do a better job of offering more training.” Th3 also suggested keeping all the staff educated about important topics “even if it isn't through formal training.”

**Macrosystem**

The macrosystem encapsulates all of the trauma-focused therapists lower-order systems. It is the overarching pattern of micro, meso, and exosystems that exist at the level of the subculture, the culture as a whole (Bronfenbrenner, 1979, 2005). Participants’ macrosystems affect how they perceive EBPs when delivering sexual trauma intervention to clients. Legal mandates, values, rules, and laws can be included in this layer. For example, several of the participants alluded to the impact on their system from the requirements of state laws and third party payers. Th6 expressed concern about this aspect:
I'm going to be perfectly honest with you, I'm a little nervous about this because, right now, at the agency, we can be very flexible. But we actually are getting our article 31 in the state, and so with article 31, we have to really be very strict with the Medicaid guidelines. And so with the Medicaid guidelines, we can't kind of like divert ourselves. So this actually put a little bit of fear in me because I'm like, ‘What are we going to do?’

Th4 shared that in one of the settings she worked for, she had to use approaches that the insurance company wanted: “I was kind of forced to get into it.” Th9 recounted his experience when he first learned about EBPs. “It was huge. I was with the non-profit at the time, and all the county contracts moved towards evidence-based practice.” These statements are evidence of the impact that higher-level decisions have on trauma-focused therapists’ clinical decisions, which indicates that the implementation of EBPs can pressure clinician to use approaches whether they like them or not. Th9 asserted confidently,

I'm going to go out on a limb and say they will not contract with someone at this point in time that's not evidence-based because that's part of the authorization process is we have to speak to what our evidence-based protocol is.

These participants appeared to have experience with the potential effects of not implementing EBPs. Some of them seemed more concerned than others. However, they appeared generally confident that the rules and laws guiding EBPs do consider clinicians’ perceptions and experiences of implementation and practice.

**Chronosystem**

The last layer is the chronosystem, which incorporates the temporal dimension as it relates not only to the characteristics of the individual, but also to the environment in which that individual lives. This layer is related to the existential of lived time (van Manen, 1990).
Participants elucidated the effects that broader systems have in their trauma work context. Th1 explained that “anytime people have been through trauma we can be impacted, and then it can affect every part of our life into our adulthood if in some situations.” Th6 reflected on being “a generation removed from having dealt with really horrible trauma.” At this level, several participants asserted their perception of time as it relates to their experience as a professional and as a person embedded in a system. Th8 articulated her perception of being a trauma-focused therapist: “I think it's allowed me to see the best and worst of humanity, represented by the things that have happened to my clients.” In the same vein, Th9 noted that at a certain point, “due to just a series of circumstances, personal issues, the death of my father, things like that, I stepped away from—it was a very grueling responsibility.” These statements are testaments of participants’ own experiences with trauma, including loss or separation of a loved one, which can influence the way they perceive traumatic experiences overall.

**Integrative Systemic Approach to Trauma (ISAT)**

In seeking further understanding of the phenomenon under investigation, this inquiry also used the ISAT model (see Figure 3) to explore trauma-focused therapists’ experience with EBPs as a parallel to the bio-ecological framework. The three interconnected elements of clinical relationship, nexus of personal and treatments issues, and broader systemic and cultural influences, complemented the knowledge gained from the interviews about participants’ issues of context and systems.
Clinical Relationship

The participants were unanimous in saying that the therapeutic relationship is paramount when delivering sexual trauma interventions to clients. Although some participants emphasized rapport building more than others, they all seemed to value the impact of the therapist-client connection as part of the healing process. The client-therapist dyad also suggests Bronfenbrenner’s Microsystems. The participants expressed their clinical orientation to building
relationships with clients with sentiments like the following: “Letting the client take the lead, asking open-ended questions, and really letting them direct the conversations”; “I know this person knows I get them, or I know this person knows that I am here right now, and I care so much”; and “You have to be willing to be with it and be with that person.” Additionally, such words as “trust,” “empower,” and “secure” emerged as participants recounted their experiences in counseling survivors of sexual violence. For instance, Th3 said, “I think my experience is that using a person-centered approach has been honor the person, and let them have ownership over what they want to share, empower them.” From the data collected, it is also evident that the structure characteristic of EBPs can influence trauma-focused therapists’ clinical decision making. As Th3 put it, “You don't want to re-traumatize somebody, just because we think it works for one population of people.” Another participant, Th5, also emphasized that “[w]henever you're sitting down across from somebody, and they have a million and one things that they need to say to you, and you're trying to be structured and everything else in the practice, it doesn't work.” These statements indicate that while implementing EBPs into their practice, identifying what the client’s needs are influences the clinicians’ adherence to an approach.

For participants in this study, adjusting EBPs when delivering sexual trauma interventions entails an understanding of what works for them as well. Levers (2012) stressed that in trauma work, while treating survivors, clinicians undergo an ecological transition themselves. The interview data revealed, for example, that the client-therapist dyad depends on how comfortable trauma-focused therapist feel with their intervention choice. Th1 said that “being able to decide what approach works for me and what works for my clients is nice.” Th5 described the client-therapist dyad “[i]n terms of really trying to understand what that experience was for somebody, knowing that I personally didn't experience what they experienced.” These
experiences may indicate that an adaptive and supportive system is conducive to the adoption and delivery of sexual trauma interventions.

**Nexus of Personal and Treatment Issues**

Levers (2012) wrote that this element of ISAT goes beyond the client-therapist dyad to include individuals who might influence the treatment process. She identified these as individuals who come from both clients’ and therapists’ systems and who can shape how trauma interventions are delivered. The nexus of personal and treatment issues is parallel to Bronfenbrenner’s (1979) mesosystem. Although the nexus of personal issues also includes clients’ personal characteristics, this study highlighted the nexus of the personal and professional characteristics of the therapists. For instance, Th9 explained, “I come from a foundation of CBT, so those are the modalities that I'm most comfortable with.” Th10 also elucidated that it is in “the nexus of psychodynamic, existential, and narrative therapy, where those things come together.” Th8 noted that some EBPs “felt too mechanized” and explained that she has experienced clients’ “looking for more of an interpersonal connection.”

Participants seemed to be cognizant of the dynamics of client-therapist relationships. Th7 revealed, “even if you don't talk about yourself, it becomes very personal.” She also explained “it ends up being intensely personal even with good boundaries at least for my confidence, that this person has explored this enough cognitively to go in further.” All participants spoke about using intervention to treat survivors of sexual violence. Although cognitive behavioral modalities took precedence when delivering sexual trauma interventions to clients, participants seemed to tailor their approach based on aspects of the client’s system. For instance, Th1 explained, “I need to use more brief therapy approaches in case they are going to be leaving or drop off at any point.” Th2 asserted, “I need to adjust what practice I’m using, and have mold to what the client needs.”
These trauma-focused therapists felt that clinicians need to be open to understanding where a client is coming from to develop a treatment plan. Th4 emphasized that clients “know better, and I just happen to be here witnessing their process.” With attention to the needs pertinent to clients’ sexual trauma, participants in this study endorsed intervention delivery that addresses survivors’ systems; and through understanding of both sides’ (therapists and clients) nexuses, they will move toward healing.

**Broader Systemic and Cultural Influences**

This element of ISAT parallels Bronfenbrenner’s (1979) macrosystem. Aspects of broader systemic and cultural influences can affect treatment delivery. Participants in this study mentioned words related to agency policies, county requirements, and health insurance, to explain their experience with different systems when delivering sexual trauma interventions to clients. For instance, Th1 stated, “I want to be ethically using them as well. We know managed care; I use that a lot of the time.” Th4 also noted, “That’s the approach that the insurance company wanted us to use.” Another participant, Th10, spoke about systems that influence clinical-decision making and expressed concern: “I don't want to make this a diatribe about the communal health system, but it needs reform.”

**Common Themes**

In using van Manen’s lifeworld existentials, Bronfenbrenners’ bioecological model, and Levers’ ISAT model as lens for analyzing the interview data, I identified phrases and words that continuously came up when participants described their perceptions and experiences with EBPs in treating sexual violence trauma. I then categorized them into themes based on the conceptual framework elements of the study described above and the research questions (see Figure 4).
The eleven emergent themes that relate to the research questions and their inferences are summarized here and have been presented in detail in the next chapter.

Figure 4. Common themes and their relationships to the theoretical framework
Table 13 provides an overview of the 11 common themes derived from the research.

Table 13

Major Themes Derived from the Research

<table>
<thead>
<tr>
<th>Theme #1</th>
<th>Multimodal approach</th>
</tr>
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<tbody>
<tr>
<td>Theme #2</td>
<td>Rewarding experience</td>
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<tr>
<td>Theme #3</td>
<td>“Being a woman”</td>
</tr>
<tr>
<td>Theme #4</td>
<td>“I’m not pulling this out of nowhere”</td>
</tr>
<tr>
<td>Theme #5</td>
<td>“It can be effective”</td>
</tr>
<tr>
<td>Theme #6</td>
<td>“I’m doing the right thing”</td>
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<tr>
<td>Theme #7</td>
<td>“Being careful”</td>
</tr>
<tr>
<td>Theme #8</td>
<td>Lack of preparation for trauma</td>
</tr>
<tr>
<td>Theme #9</td>
<td>Lack of preparation for EBP</td>
</tr>
<tr>
<td>Theme #10</td>
<td>Flexibility/adaptation</td>
</tr>
<tr>
<td>Theme #11</td>
<td>Structured/rigid</td>
</tr>
</tbody>
</table>

1. **Multimodal approach.** Participants revealed using several EBPs when delivering sexual trauma interventions to clients. They all spoke about using cognitive behavioral therapy, though some participants use it more than others. They said they used other modalities, such as rational emotive behavioral therapy (REBT), trauma-focused cognitive behavioral therapy (TF-CBT), cognitive processing therapy (CPT), eye movement desensitization and reprocessing (EMDR), dialectical behavioral therapy (DBT), and motivational interviewing (MI), though MI is not used exclusively to work with survivors of sexual violence. Some participants highlighted
the importance of being holistic and person-centered when counseling survivors of sexual violence. Participants favored eclecticism and integration, indicating the benefits of combining elements of various theories and techniques based on the needs of each client.

2. **Rewarding experience.** Eight out of the 10 participants said that their work as trauma-focused therapists is rewarding. This theme was voiced through the lived experience of the majority of the trauma-focused therapists. Although participants shared unique narratives, there were many similarities in their experience and how they feel about the work they do.

3. **Being a woman.** Three out of 10 participants spoke about their lived experience as a woman and a trauma-focused therapist. These participants related their feelings to being part of a population who is most vulnerable to being sexually assaulted. They reflected on listening to their clients’ accounts of their sexual trauma and sharing the same fears. One of the male participants disclosed fearing for his daughter’s safety because he is aware of survivors of sexual violence being mostly women.

4. **“I’m not pulling this out of nowhere.”** Eight out of 10 of the participants believed that the research supporting sexual trauma interventions is significantly important. Many positive explications were provided to support why therapists should use EBPs when delivering sexual trauma interventions to clients. Participants discussed ethical principles, including “do no harm” when talking about this protective factor theme.

5. **“It can be effective.”** In the same context as that of the previous theme, nine of 10 participants noted aspects of EBPs that support positive treatment outcomes. Some participants spoke about making their clients aware that the treatments they use are
EBPs. Participants also spoke about assessment tools and the benefits of using them. They described cases where clients had a significant improvement of PTSD symptoms during treatment.

6. “I’m doing the right thing.” The participants in this study described third party payers’ requirements and agencies’ policies and procedures regarding EBPs. They expressed feeling pressured to use only EBPs, but complying because they felt it was the right thing to do. Even those participants in private practice endorsed understanding that they have to use EBPs, as it is highly recommend by insurance companies. Additionally, they reported being aware of the research supporting the effectiveness of EBPs and then feeling ethically responsible to use it.

7. “Being careful.” This theme related to trauma-focused therapists’ concern about other professionals who use EBPs without appropriate training when treating survivors of sexual violence. Some participants also asserted that therapists should not be doing their “own thing.” A participant emphasized that treatments used for trauma work must be proven effective through research to benefit survivors and not re-traumatize them. This theme appeared across all interviews, and participants emphasized the importance of being trauma-informed while delivering sexual trauma intervention to clients.

8. Lack of preparation for trauma. Most participants talked about not having enough preparation during graduate school to do trauma work. Only two participants spoke about having specific trauma courses in their master’s programs. Most of the participants who talked about lack of preparation during graduate school referred to programs in the mental health field minimizing how much therapists have to deal
with trauma issues. These participants noted that they had to seek training and further education on trauma to work with trauma survivors after finishing their graduate studies on their own.

9. **Lack of preparation for EBPs.** Eight out of 10 participants stated that they were not prepared during graduate school to implement EBPs. Two of these eight participants said that they intentionally chose schools that had a phenomenological approach to counseling instead of cognitive-behavior-oriented institutions. However, they were aware of EBPs and their impact on the mental health field. Few participants expressed being advised by their professors that EBPs would have a major impact on the mental health field and that they should be attuned to it.

10. **Flexibility/adaptation.** All of the participants endorsed flexibility and adaptation when using EBPs to treat survivors of sexual violence. Some spoke on how adapting the protocol or making it “their own” can help clients’ recovery process. Others described flexibility as being able to pull from different approaches to strengthen the treatment being delivered. They referred to “one size doesn’t fit all” to indicate that manualized treatments can restrict their ability to integrate from other modalities.

11. **Structured/rigid.** The last common theme referred to participants’ unanimous perception that EBPs can be overly systematized and rigorous. They perceived structured protocols and/or manuals, commonly used with EBPs, to get in the way of building a solid therapeutic relationship with their clients. Some participants seemed to appreciate the structure of EBPs; however, they recognized that EBPs could miss the relational aspect fundamental to treating survivors of sexual violence.
Summary

This chapter has elucidated the data gathered from 10 individual interviews. The chapter contains a description of the interview process and provides illustrations of the quotations of significance relating to the research questions. These descriptions also integrate my observations from the interview session and my field notes. A case-by-case analysis of the data collected is provided in this chapter, as well as tables that organized the quotations of significance, offering a clear representation of the text obtained. The chapter concludes with a cross-case analysis of the quotes of significance within the analytical categories obtained through explication of the data, and a description of the elements used in the data analysis followed by a brief description of the emerged common themes. These data descriptions have been used for further interpretation of the findings, which I turn to in Chapter V.
Chapter V: Discussion

Introduction

The purpose of this study was to explore trauma-focused therapists’ perceptions of and lived experiences with EBPs when delivering sexual trauma interventions to clients. It was hoped that a better understanding of clinicians’ use of EBPs to treat survivors of sexual violence would provide insight for clinical practice and research in the mental health field to proceed from a more informed perspective in terms of implementation and dissemination of EBPs in treating sexual trauma.

This research used a phenomenological inquiry to collect qualitative data by conducting in-depth interviews. The participants in this study were 10 trauma-focused therapists. The data collected from the interviews were coded, analyzed, and categorized using NVivo software, guided by the conceptual framework of the life worlds, bioecological model, and ISAT model. The study was based on the following research question: How do trauma-focused therapists perceive evidence-based practices in treating sexual trauma? The following subsidiary questions assisted in answering the guiding question:

1. What EBPs do trauma-focused therapists use when delivering sexual trauma interventions to clients?
2. What are the lived existentials, according to van Manen (1990, lived time, person, space, and relationship) of trauma-focused therapists who use EBPs when delivering sexual trauma interventions to clients?
3. What risk and protective factors affect decision making by trauma-focused therapists who use EBPs when delivering sexual trauma interventions to clients?
4. How do trauma-focused therapists understand their experiences of using EBPs, within the context of Bronfenbrenner bio-ecological model (1979) and Levers’ (2012) ISAT model, particularly relating to issues of context and systems?

A presentation of the problem, background, and rationale was provided in the preceding Chapter I to enhance the understanding of trauma-focused therapists’ experiences with EBPs when treating survivors of sexual violence. In Chapter II, the research question and a literature review were presented and discussed. A methodology for the inquiry was described in Chapter III, and analytical categories were directly aligned with each of the research questions. These same analytical categories were used to code and analyze the data, and the results were presented in Chapter IV. This chapter provides a discussion of the research findings based on the conceptual framework of van Manen’s (1990) existentials, Bronfenbrenner’s (1979) bio-ecological model, and Levers’ (2012) ISAT. The findings from the themes that emerged are also provided and paired with the research questions that best match them.

The Process of Interpreting Results

This study has enabled me to engage in the “lifeworld” of participants who shared their journey during years of work with survivors of sexual violence. As the researcher, I gained a perspective through this process of the phenomenon of EBPs related to sexual trauma interventions. This perspective allowed me to observe how the trauma-focused therapists make sense of their experience as they shared it with me. I have experience using EBPs with survivors of sexual violence on a regular basis, but these participants welcomed me into their world to share their own perceptions and experiences about their practice. As I processed participants’ experiences with EBPs, I reflected on my search for guidance from when I first realized how intricate and complex the topic of EBP could be. There is no question that EBP influences
trauma-focused therapists’ clinical-decision making processes at any stage in their careers. All of the participants in this study agreed that delivering an ethically sound intervention that ultimately benefits clients’ healing processes should be a priority, whether it is EBP or not.

Researchers in the mental health field have pointed out that the use of EBPs is one of the most important professional issues in the scientific and clinical practice world (Addis, Cardemil, Duncan, & Miller, 2006; Anderson, 2006; Gray, Elhai, & Schmidt, 2007; Miller, 2010.) The movement toward using EBPs has stirred significant discussion within the mental health care field, including their use in services directed at treating victims and survivors of sexual violence.

Many psychotherapeutic approaches have been developed to treat posttraumatic stress issues related to sexual trauma. However, a gap has existed in the academic discussion about the perceptions among trauma-focused therapist regarding their experiences with EBPs. The research literature on EBPs is informative, but it focuses on outcome, manualized treatments, diagnosis, and cognitive behavioral approaches. In conducting this research, my main purpose was to explore trauma-focused perceptions and lived experiences with EBPs. It is my hope that the findings of this research will contribute valuable information to the development, implementation, and policy relating to EBPs and sexual trauma, and that it will also serve as a catalyst for additional empirical research to further inform practices regarding sexual trauma interventions.

**Impact of EBPs on Trauma-focused Therapists**

The focus of this research was to explore trauma-focused therapists’ perceptions and lived experiences of EBPs when delivering sexual trauma interventions to clients. The trauma-focused therapists in this study endorsed experiencing some level of pressure to use only EBPs in their practice. They expressed that the structure characteristic of EBPs can be overly rigorous for
work with trauma survivors. As expressed by Th5, “I think sometimes that they're a little bit rigid in terms of how they're delivered.” The overriding finding in this study revealed that trauma-focused therapists associate EBPs with structure and rigor, and they tended to support practices that are integrative and client-centered when treating survivors of sexual violence. In the same context, the findings in this inquiry also revealed that the participants have felt, at some point in their experience, compelled to deliver only EBP interventions when treating survivors of sexual violence. One participant stated that “everything has to be evidence-based.” The trauma-focused therapists in this study also described finding it beneficial to have modalities based on thorough research. They expressed appreciation for the research and support related to EBPs; for example, Th6 noted that “research shows us that evidence-based practice works.” Participants used words such as confidence, repetition, ethical, and resourceful to connote positive perceptions of EBPs.

Ten trauma-focused therapists participated in this study to describe their perceptions and experience with EBPs when treating survivors of sexual violence. The individual interviews conducted for this study produced a variety of perspectives and experiences that, when they were analyzed in their entirety, yielded 11 common themes. The next section is an in-depth discussion of the findings and the emergent themes, which are derived from a phenomenological analysis of the text from the interviews. Following that, the limitations of the study, implications for the field, implication for future research, and questions generated by the research are discussed, followed by the conclusion.

**Discussion of the Findings**

The participants’ perceptions and lived experiences with EBPs when delivering sexual trauma interventions to clients were revealed in the narratives generated through semi-structured
interviews with 10 trauma-focused therapists. The resulting data were analyzed in Chapter IV to yield themes related to the central research question of this study. In each interview, the themes reflecting a participant’s perceptions and lived experiences with EBPs were categorized into lifeworld existentials, ecological factors, protective and risk factors, and common themes. Lifeworld existentials encapsulated themes related to a participant’s experiences of lived body, lived space, lived time, and lived relation as a trauma-focused therapist. Counseling, social, political, economic, and cultural systems provided contexts for the trauma-focused therapists’ experiences within the immediate contexts of their practices, and were identified under the category of “ecological factors,” which relate to the conceptual framework from Bronfenbrenner’s bioecological model and Levers’ ISAT model. Risk and protective factors affecting clinical decision-making when using EBPs to treat survivors of sexual violence were also identified. Common themes were derived from the conceptual framework elements and research questions. In this section, the findings and common themes are discussed and interpreted as answers to the research questions.

Research Question #1

The movement toward using EBPs has stimulated significant debate among trauma-focused therapists. As a result of the growing accumulation of EBPs, the scientific community has endorsed such specific therapies, and various agencies have embraced their concepts. The first question in this inquiry was as follows: What EBPs do trauma-focused therapists use when delivering sexual trauma interventions to clients? Spending time with participants in the interviews clarified that cognitive behavioral therapies were referred to the most in the discussions about EBPs.
The first theme represents participants’ perceptions of use of several interventions, including non-EBPs, when treating survivors of sexual violence. Some differences emerged among the participants in terms of how they perceived EBPs. Some participants felt some opposition to CPT, a well-known EBP in the field of trauma to treat survivors of sexual violence. Th7 stated, “I love CPT,” whereas Th8 noted, “When I looked at the whole protocol for CPT, I wanted to gag.” Overall, trauma-focused therapists working with survivors of sexual violence experienced EBPs as beneficial, but did not seem to favor limiting their practice to using only EBPs. Consistent with the literature on EBPs, clinicians seemed to struggle finding a balanced way to implement EBPs so that they feel comfortable integrating other modalities to meet the needs of their clients, especially when treating sexual trauma survivors.

**Theme #1 Multimodal Approach**

The participants mentioned an array of psychotherapies, which included cognitive behavioral therapy (CBT), rational emotive behavioral therapy (REBT), trauma-focused cognitive behavioral therapy (TF-CBT), cognitive processing therapy (CPT), eye movement desensitization and reprocessing (EMDR), dialectical behavioral therapy (DBT), and motivational interviewing (MI), though MI is not used exclusively to work with survivors of sexual violence.

The discussion about participants’ perceptions of EBPs revealed their feelings regarding the treatments they have used, including non-EBPs. For example, two trauma-focused therapists expressed opposition to EBPs: “EBPs to me are, it's more about trying to manualize things, and I am not a fan,” and the other participant stated, “evidence-based practice is what I know… it’s really difficult for me to think of anything else but using an evidence-based treatment protocol.”
The literature indicates that the EBP movement has experienced a shift in demand in their favor. Typically, EBPs, especially those directed to treat posttraumatic stress issues, fall under the cognitive and behavioral therapy approach. Participants in this study offered insights about the strengths and challenges of using EBPs, including the recognizable fact of being research based but at times, they believe, missing the relational aspect essential to therapy. Researchers and practitioners have pointed out that EBPs have neglected to consider the importance of developing a therapeutic relationship. Some participants in this study endorsed the idea that EBPs are “manualized,” rigid, and “book like” treatments that can feel unappealing when trying to build rapport with clients. Hence, two themes emerged from their comments: structure/rigid and flexibility/adaptation. Although these statements express extreme views of EBPs, most participants endorsed flexibility so that they could use integrative approaches. Participants’ work settings seemed to influence their clinical-decision making process. Five out of the 10 participants expressed experiences of having to use only EBPs. Th9 stated, “At the hospital we use CBT, Cognitive Behavioral Therapy model, almost exclusively.” Participants in private practice seemed to be more prone to pull from other modalities; for example, Th8 mentioned, “I did have a course in hypnosis but most of the time what I've done is just taken advantage of the trances that people get into or else do something like a light trance, guided imagery kind of thing.” All participants used a variety of EBPs; however, the clear majority of interventions mentioned were EBPs, specifically cognitive-behavioral therapy modalities.

Research Question #2

Central to the exploration of trauma-focused therapists are their experiences with EBPs when delivering sexual trauma interventions to clients. Van Manen’s (1990) four life world existentials informed the question, “What are the lived existentials, according to van Manen
(1990, lived time, person, space, and relations), of trauma-focused therapists who use EBPs when delivering sexual trauma interventions to clients?

Two common themes were derived from the analysis of the four lifeworld existentials related to the trauma-focused therapists’ lived experiences. The themes that emerged were “Rewarding experience” and “Being a woman.” Both themes appeared across participants’ narratives and seemed to relate to their lived experiences as trauma-focused therapists. It is fundamental to reiterate van Manen’s emphasis on the four existentials of lived body, lived space, lived time, and lived relation as being “differentiated but not separated.” This postulation held true in this research as participants shared lived experiences that complemented each of the lived existentials and provided a holistic prospective on their experience.

Theme #2 Rewarding Experience

This theme was connected to participants’ descriptions of their lived experiences working for many years as trauma-focused therapists. Although they perceived counseling survivors of sexual violence as challenging, the majority of participants conveyed their passion as well as satisfaction from having the skills to help survivors recover from posttraumatic stress issues. All participants described aspects of their experiences that were related to the lifeworld existentials. For instance, this sense of fulfillment from helping survivors appeared to be one of the lived experiences that they all shared. Finding trauma work rewarding was closely related to their experience of lived relation. Participants’ accounts included vivid descriptions of the lived relation they maintain with clients in the interpersonal space they share with them during therapy sessions.

When talking about their work being rewarding, they used statement such as “It’s worth it…. a worthwhile experience,” and “I think that my overall experience has been good. It’s been
mostly rewarding.” The participants who have been counseling for more than 14 years indicated unrelenting passion; Th6 stated, “when you can see that the person is stable, they're able to use the tools that they learned and move forward, I think it's very powerful.” Th10 spoke about witnessing clients recover and feeling a sense of accomplishment; he explained, “It’s invigorating to begin to, I mean that’s why you kicked in to be a therapist.” In the same context, Th7 revealed her sense of realization when she felt that she had “finally tapped into its human healing.” Participants possessed the skills to do trauma work and seemed aware of their own challenges working with survivors of sexual violence. Th4 spoke passionately about her struggle doing trauma work at some point in her career, but finding the resilience to continue helping survivors recover from their posttraumatic stress issues. She observed that she had contemplated leaving the profession after working on a very difficult sexual abuse case. She recounted, “I couldn't do this anymore. It was hard for me. I just couldn't deal with listening to that.” She went on to say that she went from feeling very overwhelmed, sad, and “emotionally flooded, to being grateful for my life.” She stated,

I remembered that I was able to say, “Wait a minute, I can help you.” Because I can be grateful for my life and what I have now, and therefore I can give some of that to somebody and be able to help them. And if I'm going to be witness to all of this, there might be other things that I can do to protect myself, so that I can actually do the work. But being grateful for life itself, definitely helped me to maintain that state of gratitude that despite of my life or what happened to me, that today I'm good.

The trauma-focused therapists’ expression of their experience with EBPs as explained through the lived existentials provided a holistic reading of the fundamental meaning of the work they do. Beyond asserting that trauma-focused therapists witness, as one participant put it, “the best and
worst of humanity, represented by the things that have happened to my clients,” this inquiry demonstrates the lived experience of those who have firsthand understanding of delivering treatment to survivors of sexual violence.

**Theme #3 Being a Woman**

Lived time was revealed in the theme of “being a woman.” In the context of this study, lived time related to the “temporal way of being in the world… whatever I have encountered in my past now sticks to me as memories” (van Manen, p. 104). This common theme emerged from participants’ narratives concerning their awareness of being a woman. Although it was not a common theme among most of the participants, three out of the ten participants mentioned sharing the same pain and fear that woman survivors of sexual violence have, including a male participant who expressed his concerned about his daughter. Considering that the majority of survivors of sexual violence are females, it is not unexpected that women in general feel more vulnerable to sexual violence. Th6 revealed that counseling survivors can be “overwhelming, especially being a woman”; she also mentioned her “motherly instinct, being a woman, and just feeling for them.” There was definitely a sense of being able to relate with her client because of understanding where the client comes from as a woman. I believe this theme caught my attention as a male trauma-focused therapist who works specifically with survivors of sexual violence. Hearing other clinicians’ sharing their lived experience helped me understand certain struggles that I cannot relate to because of my gender. However, one of the male participants of this study shared that “at home I've been probably a little, if I'm being honest, a little more hypervigilant with raising my daughter.”

This theme indicated that participants’ gender influences their perceptions as trauma-focused therapists. As participants explicitly shared their fear of victimization, issues related to
vicarious traumatization and secondary traumatization were raised. Th6 mentioned, “one thing that to me I have a really hard time as a woman and as an individual, when I witness this raw emotion from somebody when they go into describing their trauma experience in detail.” It seems that although some participants appear to have developed an ability to process the effects of their clients’ trauma on their personal life, they may still find their trauma work a challenge.

**Research Question #3**

The third research question for this study was, “What risk and protective factors affect clinical decision-making by trauma-focused therapists who use EBPs when delivering sexual trauma interventions to clients?” The examination of trauma-focused therapists lived experiences from an ecological systems perspective was valuable in deriving a picture of the risk and protective factors and processes functioning within trauma-focused counselors’ environments. As the literature indicates, risk factors for not using EBPs have been identified in the mental health field. Sanderson (2003) stated that clinicians are both ethically and legally vulnerable if they ignore the set standards of care that are characteristic of EBPs: “the implications are clear: Failure to provide an empirically supported treatment from these guidelines, when one exists, may constitute malpractice in the eyes of the payer” (p. 294). As clinical guidelines and EBPs continue to emerge for various psychological and emotional issues, including posttraumatic stress difficulties, they pose a significant impact on the way trauma-focused therapists deliver sexual trauma interventions. The essence of this question was to identify what risk factors and protective factors are associated with trauma-focused therapists’ perceptions of EBPs. Participants expressed that both protective and risk factors are connected because the lack of attention to protective factors increases risk factors.
Theme #4 “I’m not pulling this out of nowhere”

All participants in this study pointed to research as being the best indicator of a protective factor. They endorsed the importance of empirical studies that validate treatments used for posttraumatic stress issues, especially sexual trauma interventions. Phrases such as the following emerged: “there’s research out there that shows that this works. So I'm not just pulling this out of nowhere and thinking”; “I feel that evidence-based practices are very helpful, and the fact that there is a lot of research”; “That's why we do research, so we can improve our practice. And so the research shows us that evidence-based practice works”; “You get the confidence that you're using a treatment protocol that's been studied, and tested, and proven to be effective.” All of these comments illustrated a positive attitude toward using EBPs when delivering sexual trauma interventions to clients.

The participants were very confident in identifying scientific evidence as a protective factor for sexual trauma interventions. They emphasized the easy access clinicians have to EBP resources. Th3 stated, “So there's a lot of support and supervision and materials, I think, to help develop and grow in that one particular practice.” This perception is in line with efforts put forth by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the U.S. Department of Veterans Affairs - National Center for PTSD with regard to promoting and implementing EBPs. A great number of resources including journal articles, survivors testimonies about treatment, videos about EBPs, and books related to the topic of treatment efficacy, among others, are available for clients and clinicians on the Web or in print form as well.

Two participants expressed the influence of third party payers in relation to EBPs. Th2 stated, “I think the benefits are that it’s supported by insurance.” Th4 explained, “If you work in
community mental health and you have to justify your billing, you can use that to back up your clinical review.” Both statements acknowledge the connection between EBPs and health insurance companies. Mental health agencies, health centers, and hospitals are typically dependent on third party payers for behavioral health services. Participants agreed that establishing a good relationship with health insurance is a protective factor, as most clients’ insurance coverage requires that clinicians use EBPs to treat clients.

**Theme #5 “It can be effective”**

Participants spoke about the effectiveness of EBPs as an important protective factor in delivering sexual trauma interventions to clients. Eight of the participants described the benefits of using EBPs, indicating that they have had a positive experience with EBPs. Statements made by participants that described these positive views of EBPs included the following: “I think that having a lot of research in use of a model behind a particular method, you'd feel fairly comfortable knowing that it's going to be helpful or it should be helpful”; “You can really rely on it, and use it, and know that you're going to get a produced outcome from it”; "This is what works. This is how you can—if you use these steps, you can, not guarantee, but you have a high probability of these symptoms decreasing”; “Many, many, many, many people that have had very similar life experiences have benefited from it.” Additionally, some participants mentioned positive outcomes related to assessment tools commonly used for EBPs to measure posttraumatic stress symptoms. Th4 talked about being encouraged to use scales to assess clients “so we can see where they were when they started, and where they are now that they're being discharged.” Participants mentioned self-report assessments, including the Posttraumatic-Stress Disorder Check List (PCL), Beck’s Depression Inventory (BDI), The Child PTSD Symptom Scale (CPSS-5), among others, to exemplify reliability related to EBPs. As Th5 put it, “It's something that's
traceable. It's something that is reliable, sustainable.” The same participant stated, “You can really rely on it, and use it, and know that you're going to get a produced outcome from it.” Th5’s observation is consistent with the underpinning of EBPs on the ability of clinicians to measure clients’ treatment progress, which can be evidence based if measured by reliable and valid assessment tools.

Although measuring treatment effectiveness is an important aspect of knowing where clients stand with regard to their symptoms of posttraumatic stress, Th5 stated that “sometimes doing scales in the beginning and at the end, or asking people to fill out a form, doesn't really feel real.” It is interesting to note that many of the participants seemed to find structure/rigid a protective factor because as one participant put it “there can be a beginning and an end.” However, they all endorsed flexibility as an important aspect of being a trauma-focused therapist.

Theme #6 “I’m doing the right thing”

This theme emerged as a robust protective factor because the majority of participants mentioned professional ethics related to using EBPs. Th1 stated, “That's part of our ethical obligation is to do no harm and to not cause harm.” It was clear that most participants are required to document what approach they are using with their clients. This requirement seemed to be more prominent from those participants working in settings other than private practice. Participants in private practice mentioned documentation requirements regarding EBPs as well; however, they noted receiving less pressure from the environment owing to the nature of practicing in a private setting. Five participants praised EBPs, for example: “First and foremost, I'm always making sure I'm delivering evidence-based approaches. So I feel that as a clinician it's my responsibility to become familiar with the evidence-based practices with what works with
certain population and certain scenario,” and “I like to stick to what I'm good at… and EBPs is what I have been using.”

As mentioned previously, being ethical was mentioned several times. Participants were concerned about doing no harm and abiding to their professional guidelines. Th7 stated, “I think it’s ethical for me to start with something that is evidence-based.” This same participant went on to say that “the evidence-based practice is a benefit to the clinician because it helps you—you have a path. You have a destination.” The statements made by participants indicated that their sense of professionalism is connected with what approaches they are using to treat their clients. Th3 expressed that “there is some safety in that structure being given to you, and it can keep the sessions moving along.” Th10 also spoke about the structure of safety related to EBPs by expressing that “It's a little scary to be out on your own just narrating things, I think.” Some participants related to “doing the right thing” to ensuring they are following what is requested by insurance companies, as stated by Th4: “that's the approach that the insurance company wanted us to use. So I was kind of forced to get into it.” A sense of obligation to use only EBPs was expressed in this statement by Th9: “The insurance company has a managed care officer, and once a month we have to give a comprehensive report on where we're at with that child through the treatment protocol.” Research has discussed the pressure to use only EBPs (Borntrager, Chorpita, Higa-McMillan, & Welsz, 2009). There appeared to be a feeling of fear and resentment among some participants who felt affected by the pressure imposed by agencies as well as insurance payers in general. Essentially, I found through this research that trauma-focused therapists identified the strengths of EBPs and related those to protective factors, such as “scientific research,” “ethics”, “outcome”, and “symptom decrease.” However, the sense of
dislike stemming from the rigid structure characteristic of EBPs caused these clinicians to speak of EBPs from a place of apprehension.

**Theme #7 “Being careful”**

From participants’ responses, risks factors were also related to ethics and consequently to doing no harm. One of the participants also spoke about her concern regarding using only EBPs and not knowing other approaches that can be beneficial for a client’s treatment. Th1 said, “I'm always concerned, if TF-CBT is, did we open something and then not give them the skills they need to be able to deal with the trauma?” This same participant discussed feeling “stuck at that moment” if the approach is not effective for the client; without knowing other techniques or interventions that work for sexual trauma, “then I feel very incompetent and feel like I’m not helping the person.” This statement indicates that the structure of EBPs can lack elements to help survivors develop skills to cope with processing sexual trauma.

Three of the participants talked about professionalism and the risks of not using EBPs with observations such as the following: “But I think to do no harm is equally as important as helping, and to not just start grabbing for straws to try and help, because that can actually do a lot of harm.” “It's not a matter of me giving an opinion, as to whether this is good or bad. It's just as a professional.” “Your clients would not be receiving the best possible care that’s available.” These statements indicate that trauma-focused therapists feel compelled to use treatments that are research based and having the evidence that they can help clients. Th2 stated, “There could be therapists out there who are just sort of doing their own practice, which I think could be unethical.” Th2 explained that “clients might suffer by not having evidence-based practices that they're benefiting from. So it might be hurting the therapist and might be hurting the client as well.” In the same context, Th6 voiced, “I don't think that any organization or any therapist in
general should just wing it,” and Th2 indicated, “Many therapists don't fully know how to deliver sexual trauma interventions, and that they aren't educated on it.” There seemed to be recognition among the participants that survivors of sexual violence need to be counseled by trauma-focused therapists who understand the complexity of trauma work. Their reports of thinking about professionalism and being ethical, indicates that they value their work and clients. There also seemed to be awareness that deviating too much from EBPs can be a potential risk to a client’s treatment. As Th3 observed, “I guess once you start manipulating it, then you're no longer following the evidence-based model.” It is interesting to note that many of the participants that expressed concerns with treatment fidelity, ethics, and following EBP structure were those that had fewer years of experience in working as a trauma-focused therapist. These clinicians seemed to feel more secure with the structure of EBPs, though they emphasized their dislike of rigid approaches. For instance, Th7 mentioned her experience with EBPs: “So even though I may have also been a little bit not rigid with it, I was more on point with it; you forget the training a little bit as you go along, and you make it your own.”

Participants also felt there are potential risks for not following third party payers’ requirement for using EBPs. Th5 stated, “They want to see whatever it is that we're working on in the treatment plan, if it's matching up with what we're doing in session, and if those sessions are, in fact, related to some kind of evidence-based practice.” Th6 spoke about honesty when reporting notes and the treatment used during sessions, which should comply with health insurance requirements. “Being careful” and decreasing potential risks in a client’s treatment seem to be the ultimate goal of participants in this study.
Theme #8 Lack of preparation for trauma

In the context of risk factors, a theme related to participants’ preparation for trauma in graduate school emerged. Participants were asked whether they had been adequately prepared for trauma work during graduate school. Seven out of the 10 participants reported that their graduate school programs had not required a course in trauma. Four of these seven participants took an elective class related to trauma, typically in the context of addiction or crisis intervention. Whereas most asserted that they had received adequate training in counseling theories, techniques, and counseling skills, almost all acknowledged that they wish there had been more emphasis on trauma work. Th1 stated that in her master’s program they offered a trauma course, “but it wasn't required… I didn't take it because it clashed with another class that I was taking… I very much had very minimal education in working with trauma.” Th8 also revealed, “No one mentioned [about trauma]… there were no—there was nobody doing a trauma course, even a voluntary one or an optional one. Nobody mentioned trauma.” Th10 seemed cautious as he stated, “I don't want to offend anybody in the community. I just don't remember any courses on trauma.” These statements speak about training during graduate school and provide insight on issues that should be addressed to help professionals in training feel more confident about their skills. Of course, a certain degree of unpreparedness is to be expected; however, it seems that some programs are offering minimum training on an aspect that therapists report they deal with the most.

Th4 revealed that her experience in graduate school with regard to learning and being trained to do trauma work was highly significant. She went on to talk about the professor who taught the course and even shared a remarkable experience she had with this professor, who she said “was great.” Th7 also reported that she had a large amount of trauma work training during
graduate school. She noted that she did everything she could to acquire experience in working with trauma and that she was fortunate to have it available within the university program. Other participants seemed less enthusiastic about their graduate programs’ focus on trauma work. Since mental health programs seem to be deficient in their focus on students’ preparation to work with trauma related issues, accreditation boards and institutions should improve their efforts to include trauma work and interventions as a requirement course.

**Theme #9 Lack of preparation for EBPs**

In addition to lack of preparation for trauma work, the curricula for many of the participants in grad school did not seem to include training in using EBPs. This is clear from the fact that all participants mentioned *hearing about* EBPs at some point during graduate school. Th10 shared that he purposefully chose a program that would have a humanistic approach instead of a focus on EBP. He stated, “I had no [preparation for EBPs], but I actively chose schools and programs that wouldn't do that.” Two other participants shared, also, that their training did not focus on EBPs. Th8 stated, “I was in a psychology program and they were very existential. No EBPs there. And I don't even remember that as being a—EBPs. I don't even remember it until what, the late 90s? Early 2000s. When it actually became a term.” It is important to note that participants who attended graduate school in the 90s and/or early 2000s expressed hearing about EBPs but with no focus on them yet. The efforts put forth by the American Psychological Association Division 12 Task Force on Promotion and Dissemination of Psychological Procedures (Task Force, 1995) resulted in comments like the following: “When I was in graduate school, evidence-based practices, that was the big buzzword,” and “I remember my adviser in grad school saying that this was the way of the future, and billing would be based on evidence-based practice, and we should definitely be in tune with that.”
Th7 explained that at her school they talked about EBPs and she “remember[ed] some discussion. It always comes back to this argument of whether it's the relationship with the clinician or the practice, and that discussion is old as time.” This statement illustrates accurately the predicament in the mental health field with regard to EBPs. The rise of EBPs has challenged clinicians to become aware of it whether they want them or not. Evidently, some mental health settings, more than others, demand that EBPs be used when delivering treatment to clients. Surprisingly, academic institutions have not shifted their focus to making future mental health professionals informed in terms of implementation and dissemination of EBPs in treating sexual trauma.

**Research Question #4**

The fourth and last research question was “How do trauma-focused therapists understand their experiences of using EBPs, within the context of Bronfenbrenner’s bio-ecological model (1979) and Levers’ (2012) ISAT model, particularly relating to issues of context and systems?”

The bio-ecological framework furthered the understanding of subsequent dynamics that affect trauma-focused therapists’ experience with EBPs when delivering sexual trauma interventions to clients. The following common themes captured aspects of trauma-focused therapists’ systems that have influenced their experiences with EBPs.

**Theme #10 Flexibility/adaptation**

All participants spoke about flexibility and adaptation with regard to sexual trauma interventions. The work setting was certainly regarded as a determinant of treatment flexibility and adaptation. Although five of the participants are currently working in private practice, they all have experience practicing in different settings. Participants working in private practice indicated that they could use any approach in which they feel competent: “It’s really what I want
to do”; “Private practice is very casual. If I were in an agency, specifically for sexual violence, I would imagine that there would be a lot more structure”; “I can use as much of something as I want to.” These statements indicated that trauma-focused therapists working in private practice could adapt their treatment because they work independently. Some related flexibility to their experience: “I think if someone’s been practicing with that population for a really long time using those and feels that it’s safe, [it’s ok] to be a little more flexible.” Several participants emphasized the importance of adapting EBPs if needed: “I feel that's where the therapist can step in and kind of mold it or make it their own for the particular client that they are seeing”; “I have used EMDR in all kinds of non-classic ways”; “I'm using CBT for the most part, but there are days where I'm very psychoanalytic and I just allow them to explore”; “So that's one thing that I noticed that happens, and you know that's where that flexibility comes in.” Participants who worked in agencies, health centers, and hospitals, expressed less flexibility and treatment adaptability: “We can certainly take an eclectic approach to things, but the core of the treatment is CBT”; “Although, there was an expectation that I would definitely offer”; “Even though it doesn't look exactly like the model and there are pieces and parts of the particular practice involved within the sessions, that it's still very effective”; “I felt like the agency was okay with exceptions. I didn't feel like this is, ‘Give them these 12 sessions and they're out the door.’”

These professionals seem to perceive EBPs positively as long as they could adapt their treatment to meet clients’ stages in their recovery.

**Theme #11 Structure/rigid**

Except for Th9, all of the participants related EBPs with structure and expressed their feelings regarding inflexible approaches. To describe their perceptions and experiences with EBPs, participants used such words as “workbook,” “pretty rigid,” “box,” “manual,”
“structured,” “mechanized,” “protocol.” The participants were very vocal about feeling restricted when pressured to use only EBPs: “Sometimes evidence-based practices, we have to stay in a box and can only work within that box”; “you have to do it despite of the clients themselves”; “and going by this very rigid box with CBT or any other approach”; “I don't feel comfortable just going by a step-by-step process in a book”; “it became very clear to me that it felt too mechanized to them”; “if you're trying to get some trauma survivor to follow a protocol, forget it.” There appeared to be a sense of aversion as participants spoke about their experiences with the structure inherent to EBPs. Th8 expressed, “When I looked at the whole protocol for CPT, I wanted to gag.” I sensed that it can be a challenge for trauma-focused therapists, especially more experienced clinicians, to follow the structure that is usually demanded by approaches under EBPs. These clinicians often endorsed flexibility and integration of approaches. They believe that freedom to choose from any approach is a strength rather than a limitation. Some of the participants expressed that structure can be helpful for some clients, as observed by Th4: “I started noticing that was so helpful to her, because she was actually doing the homework, the exercises in the book”; “there is some safety in that structure being given to you, and it can keep the sessions moving along. I think for some, it means there can be a beginning and an end.”

There were some differences among participants with regard to how they used and perceived EBPs from their experience in delivering sexual trauma interventions to clients. Some participants displayed displeasure and frustration, whereas others described different ways of using or adapting EBPs to fit their practice: “I wonder how much my version of CPT matches a pure version of CPT, and how much does that matter as far as outcomes.” Trauma-focused therapists who had more experience in the field appeared more likely to integrate approaches and adapt interventions to attend clients’ needs. Overall, participants use EBPs when delivering
sexual trauma interventions to clients, but prefer flexibility and integration of approaches in treating their clients.

**Limitations of the Study**

This qualitative study derived its data from 10 participants, all of whom have used EBPs when delivering sexual trauma interventions to clients. The participants in the study were selected using purposeful sampling and chosen because of their experience with counseling survivors of sexual violence. In addition, the majority of the participants were Caucasian females. Thus, as typical of limitations in qualitative studies such as this one, the findings cannot be generalized to all contexts or settings of trauma-focused therapists who deliver sexual trauma intervention to clients.

I may have also been a limitation in this study because of my preconceived perceptions about EBPs when delivering sexual trauma interventions to clients. Participants were aware of my work as a trauma-focused therapist. According to Patton (2002), the researcher is an instrument, and this feature can influence how the researcher is perceived by participants, especially when they share a similar experience. I was careful to counterbalance any influence my perception and experience might have exerted on the findings. I constantly reminded myself of personal biases and ensured trustworthiness by constantly reflecting on my field notes and consulting with the dissertation chair.

**Implications for the Field**

The data derived from this interview may illuminate the understanding of trauma-focused therapists’ perceptions and lived experiences with EBPs when delivering sexual trauma intervention to clients. Although the use of EBPs has become more common in the mental health field, limited research has been done in clinicians’ perceptions and lived experiences of EBPs,
especially when treating survivors of sexual violence. This study’s findings contribute to
knowledge that can be used to inform and direct efforts to implement and disseminate EBPs
more effectively in the field of trauma. Additionally, the results from this study can provide
mental health professionals including counselors, social workers, and psychologists with
knowledge on EBPs when delivering sexual trauma intervention to clients.

The findings of this research suggest that although participants identify EBPs as
structured and rigid, they also perceived the structure as a protective factor. Th3 stated that there
is some safety in that structure because “it means there can be a beginning and end.” In contrast
to the previous statement, Th10 expressed that the therapy room is “flexible and open” and that
“it's a dance [referring to work with treating survivors of sexual violence], and the dance floor
goes on forever.” These participants discussed the benefits and challenging aspects of using
EBPs. When asked about their perception of EBPs and non-EBPs some participants, especially
those with more years of experience, expressed that if the approach is safe for the client, they do
not see it as harmful. They also commended flexibility when integrating modalities and reported
experiencing more success when using a multimodal approach.

The majority of participants in this study supported the use of EBPs as an ethical
responsibility. The results of this study indicate that the use of EBPs in practice is intrinsically
connected with “doing the right thing.” However, some participants expressed using EBPs out of
fear instead of from a belief that it is the best clinical choice. As stated by Th4, “that's the
approach that the insurance company wanted us to use. So I was kind of forced to get into it.”
Another participant expressed “overall being trained with evidence-based practice, and this is the
only protocol I've really ever known to do this kind of work, [so] it's really difficult for me to
think of anything else but using an evidence-based treatment protocol.” To some extent, the
differences in theoretical orientation and work settings explain participants’ perceptions and experiences with EBPs. However, participants appeared confident that using EBPs is ethically responsible and that the research behind these practices is a solid protective factor.

Each participant’s experience of using EBPs when delivering sexual trauma intervention to clients was situated within and unique to his or her context. The ecological system a trauma-focused therapist exists within provides the context for his or her lived experience. When applying Bronfenbrenner’s bio-ecological systems theory and Levers’ ISAT to the participants, I pondered the ecological systems in which they had experience practicing as well as their current work settings. Notably, the systems where participants do trauma work affect their perceptions of how they practice trauma-focused therapy. As stated by Th9, “With our contracts and our different accreditation bodies that come in to the hospital, and the insurance companies that are paying for the children to be in care, everything has to be evidence-based.” His working setting has affected his clinical decision-making process. The findings in this study have revealed that all the ecological systems in which a trauma-focused therapist practices affect their perceptions and experience of EBPs when treating survivors of sexual violence. On the microsystem level, practitioners’ experience with EBPs varies, as some participants seemed to follow a structure that characterizes EBPs with more fidelity. However, the vast majority of participants try to adapt their treatment to meet clients’ needs, as Th5 observed: “whenever you're sitting down across from somebody, and they have a million and one things that they need to say to you, and you're trying to be structured and … it doesn't work.” Because the microsystem is the most intimately involved systems, this study suggests that considering clinicians practice’ experience can help research develop interventions based on real experience, which consequently benefits survivors’ healing process.
The study findings have also revealed the important role of trauma-focused therapists, and their prime position in delivering interventions for posttraumatic issues stemming from sexual violence. Other systems have great influence in clinical decision making, therefore affecting the therapist and client dynamics. As demonstrated in this study, the participants’ exosystems have compelled clinicians to use EBPs whether they wanted it or not. What needs to be explored further is the effect of decisions made by those at the exosystem level. The participants in this inquiry revealed themes emerging from their perceptions and lived experiences working as trauma-focused therapists when treating survivors of sexual violence. These themes suggest areas for further research that can be more focused on specific lived experiences and ecological factors.

**Implications for Future Research**

Findings from the study revealed several areas related to trauma-focused therapists perceptions and lived-experience with EBPs when delivering sexual trauma interventions to clients. Participants’ descriptions of the context in which their therapeutic performance occurs can contribute to the field of mental health and trauma work as researchers and clinicians gain a better picture of the reality of clinical practice. Thus, the lived experience of trauma-focused therapists seems to provide an essential component when one attempts to understand EBPs and the treatment of sexual violence. Further research into the lived experiences of professionals who work with psychotherapies related to sexual trauma is necessary.

As clinicians in the mental health field feel more compelled to use EBPs, it is essential that a balanced way of delivering sexual trauma interventions to clients become available. Aspects characteristic of EBPs seem to be disapproved by clinicians such as protocols and/or manualized treatments. Trauma-focused therapists welcome approaches that allow them to
integrate and individualize treatments to attend clients’ needs, especially when treating sexual trauma survivors. Therefore, a study that explores public and private health care systems’ perceptions of cognitive-behavioral trauma therapies adaptation to the unique needs of sexual violence survivors would be beneficial, as would a study of how frequently clinicians modify/adapt protocols to attend clients’ needs. Further study on whether non-EBPs nurture the therapeutic relationship more compared to EBPs would also be helpful. Participants seemed to emphasize the lack of attention to building therapeutic relationships within EBPs protocols. One participant alluded to the fact that counseling and psychology pay little attention to the holistic approaches that gestalt, existential, and psychodynamic approaches offer. An inquiry regarding trauma-focused therapists’ use of non-EBPs could lead to a more accurate assessment of interventions being delivered to survivors of sexual violence. Future research could also focus on the common factors theory, which proposes that different approaches and EBPs share common factors that contribute to the effectiveness of an intervention or treatment (Laska & Wampold, 2014).

Although this study did not focus on preparation to work with trauma survivors and the delivering of treatment specifics for posttraumatic stress issues during graduate school, it appeared that further exploration in this area could be beneficial for academic institutions’ program development. As elucidated through the findings, lack of preparation for trauma work and EBPs during graduate school posed a risk factor, as the majority of participants seemed not to have had adequate groundwork to practice. Finally, a qualitative study exploring female trauma-focused therapists’ experiences with vicarious traumatization and secondary traumatic stress while delivering sexual trauma interventions to women survivors, could further the knowledge of issues related to trauma treatment.
Questions Generated by the Research

The following research questions were generated from this study:

1. What type of sexual trauma interventions do trauma-focused therapists integrate when delivering sexual trauma interventions to clients?
2. Do novice counselors rely more on following the structure of EBPs than more seasoned therapists?
3. Are inpatient settings stricter with the use of EBPs compared to outpatient settings?
4. What methods of self-care do trauma-focused therapists use to prevent vicarious trauma, secondary trauma stress, and burnout?
5. How do clinical supervisors perceive supervisees’ use of EBP when delivering specific treatments to clients?
6. What are supervisors’ perceptions of supervisees’ being flexible and adapting treatment protocols when delivering sexual trauma-interventions to clients?
7. What are trauma-focused therapists’ attitudes toward alternative treatments for sexual trauma issues?
8. Are EBPs more beneficial than non-EBPs when treating survivors of sexual violence? What makes a sexual trauma intervention effective?
9. How can mental health related programs perceive and educate counselors-in-training about EBPs?
10. What expressions, analogies, and metaphors do trauma-focused therapists use when speaking about their experience with trauma work?
11. How does personal experience with sexual trauma affect therapists who work with survivors of sexual violence?
Conclusion

The purpose of this study was to explore trauma-focused therapists’ perceptions and lived experiences with EBPs when delivering sexual trauma interventions to clients. A qualitative study guided by a phenomenologically oriented approach was used to gain an understanding of the lived experience of therapists who use EPBs. The use of a phenomenological approach illuminated the development of 11 common themes that shaped trauma-focused therapists’ perceptions of and experience with EBPs when delivering sexual trauma interventions. The robust descriptions shared by 10 trauma-focused therapists about their experiences working with survivors of sexual violence offered rich understanding of the phenomenon.

The findings included trauma-focused therapists’ most-used EBPs; their lived experiences; ecological factors, including systems that influence their use of EBPs; and risk and protective factors related to the use of EBPs. Participants in this inquiry recognized that staying flexible and adjusting their approaches to meet clients’ needs is beneficial. It is also apparent from the participants’ statements that abiding by EBPs is an ethical obligation. Most participants recognized the importance of using treatments that have been researched, but not limiting practice to using only evidence-based approaches.

The discussion on the findings that emerged from the collected data indicates that trauma-focused therapists endorse integrative approaches to treating survivors of sexual violence. Participants spoke about flexibility and adaptation in attending to clients’ needs, and generally expressed their perception of EBPs as being structured and rigid. This finding may offer insight for researchers and clinical practices that use EBPs on how clinicians feel about the approaches they use when treating trauma survivors.
Participants demonstrated positive feelings toward using approaches that have a great deal of research and support. However, they also supported flexibility in terms of adapting modalities to work with the unique issues presented by survivors, which might deviate from the structure inherent in EBPs’ protocols. As EBPs continue to influence clinicians’ decision-making process, this investigation’s findings added to the existing knowledge base regarding trauma-focused therapists’ perceptions and lived experiences in the trauma field. It also contributed to an advanced comprehension of EBPs in treating sexual trauma.
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Appendix A

Semi-Structured Interview Guide
Appendix A

Semi-Structured Interview Guide

Prior to the interview, the participant will be asked to sign a consent form that presents all of the important information about the participant’s consent to participate in the proposed study. Such information consists of the title of the study, the investigator’s name and contact details, the advisor of the co-investigator, the rationale for conducting this study, the purpose of this study, the risks and benefits, the lack of compensation, the confidentiality, the right to withdraw, the summary of results, and the meaning of the voluntary consent. The following protocol questions are designed as open-ended prompts to elicit information about the phenomenon under investigation.

Protocol Questions

1. What has been your experience working as a trauma-focused therapist?
2. What has it been like for you to have treated survivors of sexual violence?
3. What approaches have you used in counseling trauma survivors of sexual violence?
4. How have you used sexual trauma interventions or how do you currently use sexual trauma interventions?
5. How were you trained to provide evidence-based practices (EBPs) to treat clients’ survivors of sexual violence?
6. How do you perceive EBPs and non-EBPs approaches when delivering sexual trauma interventions to your clients?
7. Have you dealt with any challenges using EBPs? If yes, can you elaborate on how you dealt with these challenges?
8. Explain, in as much detail as possible, your lived experience of using EBPs to treat clients’ survivors of sexual violence.
9. How has your environment affected your clinical decision to use EBPs with your clients?

10. What are the benefits of using EBPs?

11. What are the risks of not using EBPS?

12. Overall, how do you feel about your experience using EBPs when delivering sexual trauma interventions to your clients?

13. Are there other questions that I have not asked that would enhance my understanding of your perceptions and lived experience of EBPs when delivering sexual trauma interventions to clients?
Appendix B

Recruitment Letter
Appendix B

Recruitment Letter

Dear Participant:

I am a doctoral candidate under the direction of Lisa Lopez Levers, Ph. D., in the Department of Counseling, Psychology, and Special Education at Duquesne University. I am conducting research, *Trauma-Focused Therapists’ Perceptions and Lived Experiences of Evidence-Based Practices (EBPs) When Delivering Sexual Trauma Interventions to Clients*, to develop a better understanding of clinicians’ lived experiences. This research is partial fulfillment of my studies for a doctoral degree in counselor education and supervision.

I invite individuals to participate in this study who meet study requirements, that is, the participants must have over one year of experience working in agencies or self-identify from an evidence-based approach. If you decide to participate, you will be asked to complete a demographic questionnaire, and participate in a face-to-face, telephone/cell, or other electronic or Internet-based interview for approximately one hour to one-hour-and-thirty-minutes, to talk about your perceptions and lived experiences of EBPs when delivering sexual trauma interventions to clients. After the completion of the interview and at a later date, you will have the opportunity to review the transcript from our interview and make any corrections if you identify errors or wish to clarify an idea.

Your participation in this study is voluntary and you may withdraw from the study at any time, without any penalty. The results of this study may be published, but your identity is kept anonymous. There is minimal risk involved in your participation of this study. The potential benefit to participating in this study is the contribution that this investigation may make to professional understandings about trauma-focused therapists perceptions of and experiences with EBPs.

If you are interested in participating in this study, please contact Carlos Golfetto, M.S. Ed., NCC, ACS, LPC at 412-779-7078 or cgolfett@duq.edu to confirm the interview method (face-to-face, telephone/cell, or other electronic or Internet-based interview) that are convenient to you and to answer any questions that you may have. The consent form is attached for your review. We will review the consent form again at the time of the interview and you will be asked to read and sign the consent form prior to the interview. If you have any questions concerning this research or your participation in the study, please contact me, Carlos Golfetto, M.S. Ed., NCC, ACS, LPC, cgolfett@duq.edu, or Dr. Lisa Lopez Levers at (412) 396-1871 or levers@duq.edu.

Sincerely,

Carlos Golfetto, M.S. Ed., NCC, ACS, LPC
Appendix C

Consent to Participant in a Research Study
CONSENT TO PARTICIPATE IN A RESEARCH STUDY

TITLE: Trauma-Focused Therapists’ Perceptions and Lived Experiences of Evidence-Based Practices (EBPs) when Delivering Sexual Trauma Interventions to Clients

INVESTIGATOR: Carlos Golfetto (PhD Candidate)

ADVISOR: Dr. Lisa Lopez Levers, Ph. D.
School of Education
412-396-1871

SOURCE OF SUPPORT: This study is being performed as partial fulfillment of the requirements for the doctoral degree in Counselor Education and Supervision at Duquesne University.

PURPOSE: You are being asked to participate in a research project that seeks to investigate trauma-focused therapists’ perceptions and lived experiences when delivering sexual trauma interventions to clients. In order to qualify for participation, you must have over one year of experience working in agencies or self-identify as using an evidence-based approach. You will be asked to participate in an individual interview, which will take approximately 60 to 90 minutes. The interview questions will focus on your counseling experiences. There will be only one interview. In addition, you will be asked to allow me to audiotape your interview. The interview will be audiotaped and transcribed; all subject identifiers will be deleted during the transcription process. You will receive a draft of the transcription; if you find the need to clarify your responses to the questions, or to ask further questions, you can contact the investigator via telephone or e-mail. These are the only requests that will be made of you.

RISKS AND BENEFITS: There is no risk to participating in this study, as you are being asked only to discuss your experiences and your perceptions of evidence-based practices when delivering sexual trauma interventions to clients. There are no more
risks to participating in this study than you would encounter in everyday life. The potential benefit to participating in this study is the contribution that this investigation may make to professional understandings about trauma-focused therapists’ perceptions of an experiences with EBPs.

COMPENSATION: There will be no compensation for participation in this study. However, participation in the project will require no monetary cost to you.

CONFIDENTIALITY: Your participation in this study and any personal information that you provide will be kept confidential at all times and to every extent possible. Your name will never appear on any survey or research instruments. All written and electronic forms and study materials will be kept secure. Your response(s) will appear only in summarization of report findings. Confidentiality will be maintained with the use of audiotapes. All materials related to the study will be stored in a locked cabinet to which only the investigators have access. Any electronic data will be password protected. Any study materials with personal identifying information and transcribed interviews will be maintained for five years after the completion of the research and then destroyed.

RIGHT TO WITHDRAW: You are under no obligation to participate in this study. You are free to withdraw your consent to participate at any time by informing the investigator, via email or at the interview, that you wish to withdraw. Any data collected prior to withdrawal will be destroyed and not used in this study.

SUMMARY OF RESULTS: A summary of the results of this research will be supplied to you, at no cost, upon request.

VOLUNTARY CONSENT: I have read the above statements and understand what is being requested of me. I also understand that my participation is voluntary and that I am free to withdraw my consent at any time, for any reason. On these terms, I certify that I am willing to participate in this research project. I understand that should I have any further questions about my participation in this study, I may call Carlos Golfetto or Dr. Lisa Lopez Levers (412) 396-1871 or if I have any questions regarding protection of human subject issues, I may call Dr. David Delmonico, Chair of the Duquesne University Institutional Review Board, at (412) 396-4032.
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<th>Participant's Signature</th>
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<td>Researcher's Signature</td>
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Appendix D

Demographic Information
DEMOGRAPHIC INFORMATION

Name:_____________________________________________________________________

Age: ______ Gender:_______ Race: __________

Occupational Position: ______________________________________________________

Current Employer: ___________________________________________________________

Professional Credential: _____________________________________________________

(B.A., M.A., Ph.D., Ed.D., L.P.C., L.S.W., L.C.S.W., etc.)

Have you worked with victims and/or survivors of sexual violence?

________________________________________________________________________

Have you attended training(s) on evidence-based practices?

________________________________________________________________________

How many years have you worked in the field as a mental health professional?

________________________________________________________________________