PAPER ONE: SYSTEMATIC REVIEW

Coping with Secondary Trauma: A Systematic Review of Qualitative Research

PAPER TWO: EMPIRICAL PAPER

"You're going to connect with the stories" – A Qualitative Analysis of Secondary Traumatic Stress and the Role of Clinical Supervision.

Submitted by Mr. Edward Copestake, to the University of Exeter as a thesis for the degree of Doctor of Clinical Psychology, September 2021

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SCHOOL OF PSYCHOLOGY

DOCTORATE IN CLINICAL PSYCHOLOGY

LITERATURE REVIEW

Coping with Secondary Trauma: A Systematic Review of Qualitative Research

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Abstract

Background: There has been an increasing awareness of the effects of caring for traumatised individuals on therapists. The phenomena of vicarious trauma (VT) and secondary traumatic stress (STS) have emerged in the literature that have suggested that continued vicarious exposure to trauma can have significant influences on the wellbeing and practices of therapists. There has been no formal synthesis to date, however, of the qualitative literature investigating the coping strategies therapists use to cope with indirect trauma exposure. This represents the focus of the present systematic review.

Objectives: This review summarises and synthesises the literature investigating the use of different coping strategies among therapists to manage the negative effects of VT and STS in clinical practice.

Method: Systematic review of all qualitative literature to date that investigates the role of coping with VT or STS using OVID, Medline, PTSD Pubs, and CINAHL Complete. Of 613 papers found, 84 papers were full-text reviewed. Twelve papers were included in the final synthesis for discussion.

Results: Findings demonstrated a range of coping strategies used by therapists to deal with the challenges associated with VT and STS. These are categorised as self-care practices, professional coping strategies (e.g., emotional detachment, seeking informal colleague support) and organisational strategies (e.g, individual/peer supervision, team meetings).

Conclusions: A range of coping strategies are used by therapists at individual, professional and organisational levels to mitigate the potentially negative effects of VT

and STS in clinical practice. The influence of therapists' own trauma histories in the availability of effective and sustainable coping strategies is unknown and warrants further investigation. Further research is required to determine whether the constructs of VT and STS contribute meaningful understanding of the effects of working in trauma practice, or pathologically describe normal distress associated with this work.

Keywords: vicarious trauma, secondary trauma, secondary traumatic stress, coping, vicarious resilience.

Introduction

Awareness of the challenges that therapists face when supporting traumatised individuals has increased in recent years. The impact of being exposed to trauma was first observed in emergency and rescue workers in the late 1970s, who displayed similar symptoms to the trauma victims they supported (Moulden & Firestone, 2007). The effects are dependent on the nature of exposure (Stamm, 1995), whereby those working with acute trauma (trauma occurred due to a single event), such as ambulance workers, are said to be exposed to primary trauma while people supporting those who have been traumatised, such as therapists, are indirectly exposed to trauma defined as secondary trauma (Mitchell & Everly, 1995). Primary trauma refers to trauma that occurs by directly witnessing the original traumatic event(s), whereas secondary trauma describes the trauma associated with indirectly learning of the original traumatic event(s). The terms secondary traumatic stress (STS) and vicarious trauma (VT) then emerged from the secondary trauma literature. STS refers to the experiencing of symptoms in the trauma worker that are akin to those displayed by people with post-traumatic stress disorder (PTSD) (Figley, 1995; Sabin-Farrell & Turpin, 2003). VT,

meanwhile, was first coined in 1990 and refers to a transformation in how one views themselves, others and the world that have resulted from repeated empathic engagement with another's traumatic experiences (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995).

Figley (1995) suggested that "there is a cost to caring. Professionals who listen to clients' stories of fear, pain and suffering may feel similar fear, pain and suffering because they care" (p.1). Here, ill health is influenced by the type of work, and not purely organisational or workplace factors, such as a lack of resources, colleagues, and supervision. This distinguishes STS and VT from work-related stress that does not involve trauma exposure. Pearlman and Saakvitne (1995) asserted that "the effects of vicarious traumatisation are widespread; its costs are immeasurable" (p.281). The clinician may experience higher levels of stress, distressing images of trauma material, sleep disturbance, and anxiety (Cunningham, 2004). According to research, the signs of secondary trauma can decrease if the clinician uses commonly recommended coping strategies to help control the unwanted disturbances of working with traumatised clients (Bober & Regehr, 2005).

The Role of Coping

The transactional theory of stress is a useful framework for evaluating processes of coping with stressful events (Lazarus, 1999; Biggs et al., 2017). Two types of appraisals, primary and secondary, are central to the theory. Primary appraisal evaluates the potential threat or relevance of the encounter and is based on how benign, threatening, harmful, or challenging the stressful situation is deemed by the individual (Dillard, 2019). Perrewe and Zellers (1999) suggest that "an individual can

experience a stressful encounter, which is considered to be harmful, threatening, or challenging toward an individual's well-being" (p.740). An example of a stressful encounter includes the therapist re-living a client's traumatic narrative in clinical practice. According to Perrewe and Zellers (1999), "if the individual determines they have a stake in the encounter, the theory proposes that they will engage in a secondary appraisal" (p. 741). If the therapist has been psychologically impacted by the traumatic material, then they are likely to engage in a secondary appraisal. Here, the therapist evaluates their interpretation of the event and the effects of hearing the client's traumatic story (Perrewe & Zellers, 1999). A secondary appraising, based on coping self-efficacy, is the result of the degree to which an individual feels capable of dealing with the threat, harm, or challenge (Dillard, 2019). The emotional and functional effects of primary and secondary appraisals are then mediated by coping strategies.

The transactional model has been supported by research by demonstrating that, "the way people evaluate what is happening with respect to their well-being, and the way they cope with it, influences whether psychological stress will result, and its intensity" (Perrewe & Zellers, 1999, p.740). The transactional theory of stress and coping offers a suitable theoretical framework for this review because it specifically emphasises that "it is the perception that the event is stressful, rather than the event itself, that determines whether coping strategies are initiated and whether the stressor is ultimately resolved" (Biggs et al., 2017, p. 352). An important insight of transactional theory of stress is that the same trauma narrative may engender different reactions from different individuals depending on how individuals assess and cope with it.

Although Lazarus's (1999) transactional theory of stress and coping provided a comprehensive theoretical approach for examining stress and emotion process, critics have cited a reliance on subjective interpretations of an event and emphasised the role of loss of resources as an objective measure of situational constraints. In addressing this criticism, Lazarus (2012) contended that critical views fail to acknowledge that subjective determination of stress provides context for loss or event. Loss or event cannot be deemed distressing until after examining the extent of distress and suffering, making such examinations reliant on subjective appraisal.

Understanding how therapists cope with indirect trauma exposure is vital for informing what strategies can be implemented at individual and organisational levels to support employees. Pearlman (1999) discovered that therapists benefited from discussing cases with colleagues and attending workshops. Social support with friends (Schauben & Frazier, 1995) and peer support (Ennis & Horne, 2003) have been associated with fewer symptoms of STS. Moulden and Firestone (2007) found that collegial support decreases the risk for VT in therapists working with sexual offenders. Job role variety and supervisor support are common tools used to reduce job-related trauma amongst treatment providers working with torture victims (Akinsulure-Smith et al., 2012). The authors did not determine if the reported coping strategies were related to STS scores, which was a limitation of these studies. Moulden and Firestone (2007) argued that it was the interplay between the work setting, professional experience, and personal coping strategies that relate to secondary stress.

Way et al. (2004) found that both positive methods of coping (e.g., exercise and social support) and negative strategies (e.g., use of alcohol) were related to increased

levels of STS. The authors used a cross-sectional model that prevented them from determining if coping methods were used before or after the stressors occurred. If the latter occurred, the results may be more attributable to respondents' desperate attempts to "put out fires" by using any and all coping mechanisms available to them (both positive and negative) and may not be a valid indication that certain coping strategies are ineffective. The authors noted that additional research is needed in this area to empirically examine coping effectiveness.

Related Literature Reviews

Sabin-Farrell and Turpin (2003) suggested the existence or prevalence of VT is debatable and the evidence base requires accumulation and critical evaluation. They conducted a systematic review of VT in healthcare workers who were exposed to narratives of traumatic events. A strength of this review was the inclusion of quantitative and qualitative data, although the methodology used for study selection is unknown. Inclusion/exclusion criteria was also not evidenced, which makes review replication problematic. Some evidence was found for emotional responses to hearing trauma narratives (Knight, 1997). Physical effects (Iliffe & Steed, 2000) and behavioural responses during sessions (Steed & Downing, 1998) were also identified, although it is unclear whether such responses go beyond what could be expected in this field (Sabin-Farrell & Turpin, 2003). It was unclear, therefore, if these responses were significantly different in nature to the longer-term effects described as VT or STS.

Sabin-Farrell and Turpin (2003) highlighted that most VT research has featured quantitative methodology, where construct validity of VT questionnaires has been questioned. For example, the MBI (Maslach Burnout Inventory) has been used to

assess VT (Johnson & Hunter, 1997; Schauben & Frazier, 1995), yet it was originally designed to measure the concept of burnout (Maslach & Jackson, 1997). Burnout describes the general experience of psychological stress and emotional exhaustion not specific to trauma work (McCann & Pearlman, 1990). Indeed, Pearlman and Saakvitne (1995) acknowledged that VT measures are limited, with the strongest assessment tool being one's own ability to reflect on experience.

Sabin-Farrell and Turpin (2003) concluded that the quantitative evidence for VT is inconsistent and ambiguous. That said, some qualitative research has identified negative aspects of working with traumatised clients, such as feeling less secure in the world, increased sensitivity to gender power issues (Iliffe & Steed, 2000), negative changes in the relationship with self and isolation from others (Benatar, 2000). Identifying the associated factors which predict or maintain VT has been challenging, as well as how they interact with each other. Some workers may use effective coping strategies that inhibit the negative impact of working with trauma and this is likely to influence research findings. It is unknown, however, whether the use of effective coping strategies is due to individual differences in knowing how to devise and carry out such strategies or a result of access to coping strategies that can be maintained. Incorporating a more longitudinal design may be useful in the identification of VT processes and coping styles to mitigate its negative effects (Sabin-Farrell and Turpin, 2003).

Sheen et al., (2014) reviewed the impact of indirect trauma exposure in HCPs and reported symptoms of STS and VT common across the 42 studies included in the review. Their review identified symptomatic responses that were potentially enduring

(Alexander & Klein, 2001) and damaging to home life and relationships (Benoit et al., 2007; Udipi et al., 2008). Quantitative studies showed that some professionals could experience STS symptoms in response to indirect trauma exposure, even at clinical levels (Sheen et al., 2014). They also explored HCPs' perceptions of their own responses to indirect trauma. Work-related stress and empathic engagement were key triggers identified. The authors noted that further exploration of these associations is required, as it was unclear whether these factors precipitated or moderated STS. Unsurprisingly, correlational studies indicated that professionals experiencing STS tend to also report a high degree of work-related stress, although the direction of this effect remains unclear (Sheen et al., 2014).

Empathic engagement refers to the cognitive and affective ability to recognise and experience the emotions and mental states of clients (Lawrence et al., 2004). Sheen et al. (2014) discovered that some HCPs focused on 'technical care' or reducing their level of empathic engagement with clients to protect themselves (Benoit et al., 2007; Austin et al., 2009). It was concluded that indirect trauma exposure can have negative implications for empathic care; a vital tool for establishing trust, safety, and containment in therapeutic relationship with clients.

Vicarious Resilience

A phenomenon receiving increasing focus in trauma research is vicarious resilience (VR). VR is embedded in resilience theory as the vicarious learning process by which therapists can be positively influenced by exposure to the resilience demonstrated by their clients (Hernandez-Wolfe et al., 2015). Resilience is the ability to withstand and rebound from disruptive life challenges, involving dynamic processes that

foster a positive adaptation in the context of a significant adversity (Walsh, 2016). The concept of VR identifies how clients may influence therapists in ways that enhance growth.

Measures of Coping

Measurement of the effectiveness of coping behaviours for trauma practice is lacking (Bober et al., 2006). The Coping Strategies Inventory (CSI) was a new tool devised by Bober et al. (2006) to assess whether engaging in commonly recommended strategies for stress management leads to lower distress in trauma workers. Although therapists of violence victims generally believed in the usefulness of recommended coping strategies, including self-care, leisure activities and supervision, there was no association between the belief that self-care and leisure were useful and time allocated to engage in these activities (Bober & Regehr, 2006). Crucially, no association was found between time devoted to self-care, leisure, research and development, or supervision and traumatic stress scores. They concluded there was no evidence that using recommended coping strategies is protective against symptoms of acute distress. Like Way et al. (2004), the researchers used a cross-sectional design, thus, it was not possible to determine whether leisure activities protect against disrupted belief systems or whether those with less negative beliefs are able to better engage in leisure activities (Bober & Regehr, 2006). They suggested that further research is urgently needed regarding individual coping strategies and workplace conditions that would prevent, identify, or reduce secondary trauma among trauma therapists.

Rationale

Governmental initiatives in the UK (Department of Health, 1998) and other countries across the world including the USA (National Institute for Occupational Safety and Health [NIOSH], 1999) have highlighted the importance of protecting employees from the harm to their health that certain jobs can cause. Research has found that when appropriate coping strategies are in place, the negative cognitive changes associated with vicarious trauma occur less frequently (Canfield, 2008). Some research exists examining coping strategies employed by therapists to deal with the negative effects of indirect trauma (e.g., Way et al., 2004), although no formal synthesis of the qualitative literature in this field has yet been conducted.

This review aims to collate the findings of existing qualitative literature to identify how people cope with the adverse effects of being vicariously exposed to client trauma. Specifically, the experiences of therapists have been underrepresented in secondary trauma literature, a gap in the evidence base that this review aims to address by including therapist and psychologist samples, as well as more commonly used samples of physical health professionals, (e.g., nurses, outreach workers). Whilst this approach ensures that the underexplored experiences of therapists and psychologists can be better understood, the analysis of reviewed study findings will inevitably be based on experiences of a range of professionals working with traumatised clients. A drawback of this methodological approach is that the nuances of differing health professions may not be fully captured when considering the clinical implications of reviewed findings.

Given the qualitative evidence that exists for the presence of VT and STS in those who are exposed to trauma narratives, this could suggest that the in-depth nature

of qualitative methods may enable participants to elaborate, clarify and reflect on their experiences in ways that quantitative measures do not allow. Indeed, Pearlman and Saakvitne (1995) suggested the strongest assessment tool is one's own ability to reflect on experience. Previous literature reviews have focused primarily on coping strategies at an individual level to protect therapists working in trauma. However, greater focus has been made in recent years of the role that healthcare providers can have in promoting social support and connection within their teams (Best, 2016). As such, this review will seek to explore strategies that can be implemented at an organisational level as well from an individual perspective to support employees to cope with VT and STS.

Literature Review Question

This review aims to address this gap by asking the following question: What are the known strategies used by therapists to cope with secondary trauma?

Methodological Approach

A narrative review was conducted to answer the stated review question and provide qualitative discussion of the subject with no stated hypothesis. This approach was adopted to enable broad coverage and a comprehensive review of existing evidence in this research area (Collins & Fauser, 2005). Analysis of reviewed studies are partially objective based on empirical evidence, although such analysis is inevitably shaped by the author's subjective interpretations (Pae, 2015). This review adhered to the Preferred Reporting Items for Systematic Review and Meta-analysis guidelines (PRISMA-P; Moher et al., 2015) to enhance its scientific rigour and to minimise bias. Themes were extracted using a thematic analysis (TA) approach, (Braun & Clarke, 2006; Clarke et al., 2015). Although accessing participant transcripts was not possible,

aspects of Braun and Clarke's six-step process of TA (2006, 2015) was used to familiarise myself with the data as reported by the authors, before generating initial ideas and sorting them into overarching themes (see Appendix C). This provided a framework for the review findings presented here (Braun & Clarke, 2006; Clarke et al., 2015). The categories used to describe the review findings were based on the types of coping strategies reported within the studies to capture the systemic influences of coping strategy use.

Search Strategies

A scoping review was carried out and used to modify the search terms included in the review. Search terms described the range of therapists (participants) who have been exposed to traumatised clients (exposure) and experienced secondary trauma responses (outcome). Four electronic databases of peer-reviewed publications were searched; OVID (to access PsychINFO and PsychARTICLES), Medline, PTSD Pubs, and CINAHL Complete. These databases were selected following consultation with a University of Exeter librarian who specialised in searching psychology-related content. All search terms were searched within the 'title' and 'abstract' fields to filter relevant literature, which took place on 21st February 2021. EndNote 20 software was used to identify duplicate results. Appendix A illustrates the final search terms and appropriate wildcards and truncation used to conduct the review, as well as Boolean operators (AND between sections; OR within sections).

Eligibility Criteria

This review focused on literature about therapists who had experienced secondary trauma and their coping strategies. This included qualitative studies

published in peer-reviewed journals only. Relevant studies were written in English and published since the term 'vicarious trauma' was first coined in 1990 (McCann & Pearlman, 1990). The population, exposure, comparator, outcome, and study design (PECOS; Methley et al., 2014) inclusion and exclusion criteria for the studies are outlined in Table 1.

Table 1.

Inclusion and exclusion criteria of review studies.

	Inclusion	Exclusion
Population	Therapists, psychotherapists, psychologists, counsellors, psychoanalysts, healthcare professionals.	
Exposure	Vicarious traumatisation (cognitive changes following indirect experience of trauma victims' emotional reactions, e.g., attitudes towards trust, safety, intimacy, and own sense of self). Secondary traumatic stress (natural and consequential behaviours and emotions resulting from knowing about a traumatising event experienced by a client and the stress resulting from helping or wanting to help them).	Burnout only (general experience of psychological stress and emotional exhaustion that individuals of any profession may experience, not necessarily related to trauma narrative exposure). Compassion fatigue only (generalised fatigue that professionals experience by supporting clients who are suffering in some way, not necessarily related to trauma narrative exposure).
Comparison	Not applicable	Not applicable

Outcomes	Discussion of coping strategies for STS/VT	Studies that do not report outcomes relating to coping strategies for STS/VT.
Study designs	Peer-reviewed articles, qualitative studies, published since 1990.	Review papers, abstracts, case studies, pilot studies, 'grey literature' (due to time restrictions), discussion or opinion papers, book chapters, non-English papers with no available English translation, quantitative or mixed method studies

Study Selection

All articles (titles and abstracts) were initially screened using the PECOS criteria outlined in Table 2. Studies deemed appropriate were then included for full text screening for assessment of eligibility against the inclusion and exclusion criteria. Quantitative studies were excluded either at the initial screening stage or during full text screening. As recommended by Moher et al. (2015), six studies were reviewed by a second-rater at the full text stage to assess study selection reliability. Using the PECOS criteria, they were required to make a yes/no decision about whether the study should be included or excluded. Inter-rater reliability was calculated using Cohen's Kappa. This yielded total agreement between raters (Cohen's $K = 1$).

Evaluation Criteria

Quality appraisal of research is key for promoting transparency, precision, and evaluation of psychological research. Differing quality appraisal tools can lead to differing conclusions (Protogerou & Hagger, 2019). No single tool, therefore, is fully

adequate to assess the quality of studies (Alderson et al., 2003) and raises questions regarding the reliability and validity of the appraisal process.

The Critical Appraisal Skills Programme (CASP) was the standardised tool used to critically appraise the quality of the studies included in this review (Critical Appraisal Skills Programme, 2018). It was used as it provides a clear structure that allows a comprehensive appraisal of qualitative research. It is a ten-item questionnaire that considers three broad issues that need to be considered when appraising qualitative studies:

1. Are the results of the study valid?
2. What are the results?
3. Will the results help locally?

A scoring system developed by Butler et al. (2016) was used to identify papers that are of adequate quality for inclusion in the systematic review (see Appendix B). Additionally, inter-rater judgements were gathered for three full-text articles and used to gauge the reliability of article screening and quality evaluation. Inter-rater reliability was 1.0 that suggested a complete agreement (McHugh, 2012).

Results

The search procedure and review process are detailed in Figure 1. The database search yielded 613 potentially suitable records. Following duplicate removal (n= 91), 522 articles were screened using the pre-set PECOS criteria. Title and abstract screening resulted in 84 records, which were full-text reviewed to assess for eligibility. This process resulted in a total of 12 studies included in this review. The extracted information specific

to the PECOS criteria, outlined review question, and critical appraisal is summarised in Table 2 below.

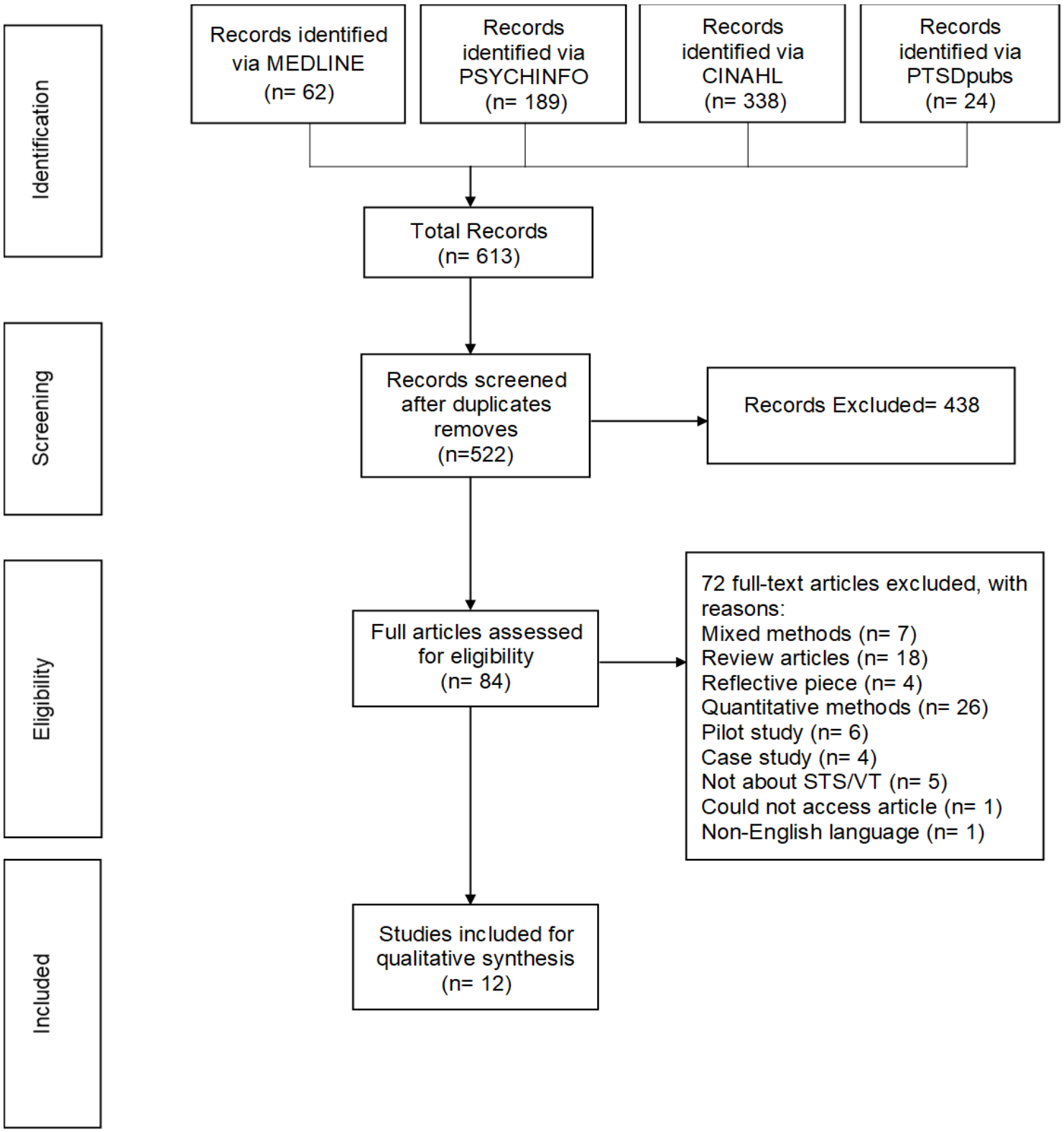

Figure 1. Results of search strategy and screening process using PRIMSA flow diagram.

1 **Table 2.**

2 *Summary of studies included for analysis.*

No., Authors, and Country	Method/ Theoretical Approach	Sample	Main Findings and Conclusion	Critical Appraisal	Quality Rating
1. Beckerman & Wozniak (2018). United States of America (USA).	3 focus groups. 3-4 participants (pts) per group. Thematic analysis.	Convenience sample of female (n= 11) DV shelter counsellors, recruited from 3 different shelters. Ethnicity: 5 pts identified as African American, 3 pts identified as	4 key themes emerged: 1) Hypervigilance/ fear of harm – afraid of being identified, tracked down and harmed by the abuser. 2) Impact on personal life – counsellors' experiences with client' violation intruded into their personal lives, causing discomfort, or questioning of events in their own lives.	**Strengths:** Study was piloted to refine interview guide. Consistent approach using same interview guide across groups. **Weaknesses:** Small sample size cannot be generalized to this area of social work.	**9/10**

	biracial, 3 pts identified as white. Education: MSW entry level (n= 9), MA in mental health counselling (n= 2). 10 pts <5 years' experience.	3) Shift in worldview – pts struggled to remain positive about the world, adopting stance of wary mindfulness about pervasiveness of violation. 4) Methods of coping – involving self-care to balance draining nature of work with comforting/ stress-reducing experiences e.g., exercise, meditation, garnering support from co-workers.	Convenience sample represents counsellors interested in focus group, therefore may have been eager to have opportunity to vent or gain support. No further details of racial and ethnic breakdowns of pts.

2. Bell (2003). USA.	Incorporated strengths perspective. Grounded theory with data collection and analysis occurring simultaneously. Counsellors from five different settings interviewed twice, nearly	30 counsellors working with female victims of DV recruited using snowball sampling. 29 female pts, 1 male pt. Diverse age ranges (20-29 yrs, n= 9, 30-39 yrs, n= 9, 40-49 yrs, n= 7, 50yrs+, n = 5). Ethnicity: African American (n= 1), White (n= 22), Hispanic (n= 7).	Pts generally presented picture of strength and positive coping under stress. 40% of pts felt their work had had positive effect on them, 10% felt a negative effect. 43% named both positive and negative effects on them or were unsure. Low stress group (n= 6) described fewer extremely stressful situations in their work and personal lives, no lasting reactions. Medium stress group (n= 19) identified positive and negative reactions, with adequate resources to cope with stress.	**Strengths:** Incorporating strengths perspective facilitates qualitative exploration of participant experience. Provides insight into processes that allowed counselors to maintain their health and continue to provide quality services to victims of domestic violence. Inclusion of specific percentage of respondents considered traumatized (unlike much previous research in this field).	**9/10**

one year apart. Semi-structured interviews used, second set of interviews conducted via phone.	Professional affiliation: no degree (n= 8), bachelor's degree (n= 5), master's degree in social work (n= 8), other master's degree (n= 7), doctorate in clin psy (n= 2).	Would eventually recover without long-lasting effects. High stress group (n= 5) described themselves as extremely stressed/reporting somatic symptoms of stress. Counsellors' experiences of stress changed between interviews. Five counsellor strengths identified: having sense of competence about coping, maintaining objective motivation, resolving personal traumas, drawing on positive role models of coping, having buffering personal beliefs.	**Weaknesses:** No acknowledgement of study limitations. Homogeneity of sample gender. Five interviews were not transcribed verbatim due to equipment problems – only handwritten notes available for analysis for these interviews. No measure outlined re participant stress at time of contact.

3. Butler et al. (2018). Australia.	In-depth semi-structured qualitative interviews. Framework approach to thematic analysis.	Six female and five male pts (n= 11). Age range 40-65 yrs (ave. = 53yrs). Non-clinical admin workers based in head office (n= 3), outreach workers employed by organization (n= 3), workers in TC program (n= 5). Median term of employment – 2 yrs (max 22 yrs).	Three main themes identified: 1) Challenges of working in an AOD TC – effects of vicarious trauma, isolation and safety of outreach workers, lack of connection between teams within the organization. 2) Individual strategies to cope and facilitate employee wellbeing – family, friend and partner support, self-care practices including exercise and meditation. 3) Organisational facilitators of employee wellbeing – formal staff supervision, employment conditions, and the ability to	**Strengths:** Provides indication of possible factors that influence worker wellbeing and coping in a TC setting. Respondent validation employed. Incorporation of multiple viewpoints from staff employed by different teams of the TC organisation. **Weaknesses:** Small sample size in one AOD TC organisation (particularly invested in wellbeing of its workers)	**8.5/10**

	Median duration of AOD treatment sector employment – 5 yrs (max 22 yrs). Three pts with lived experience of AOD problems, in long-term recovery.	communicate openly about stress. Value of the promotion of social connection and support within organisations.	so findings may not be generalizable beyond this context. Sample may not be representative of all workers in that organisation. Self-care strategies may be related to age, strategies and wellbeing needs may differ for younger/newer cohort.

4. Cohen et al. (2015). Israel.	Focus groups (n= 65; groups= 11). Findings analysed using content analysis. Therapy narratives voluntarily shared by all therapists (n= 70) at end of first year of interventions. Individual phone interviews	33 therapists (clinical and/or school psychologists), 37 art therapists (n= 70). Average length of work experience: 10yrs (range 2-35 yrs).	Four generated themes from content analysis: 1) Effects of the war on therapists. 2) Effects of the therapists' double exposure on the nature of the therapy. 3) Effects of the clinical work with the children on the therapists. 4) Coping strategies employed by the therapists. Clinical work empowered therapists and even helped them cope with their challenges. Supervision, training, therapy and consultation were seen as	**Strengths:** Method triangulation – several research tools used to study VT. Investigator triangulation – views of research team members compared before reaching agreement. Participant validation achieved by asking pts extent to which they agreed with researcher conclusions. **Weaknesses:** Little information provided re participant demographics.	**9/10**

	conducted randomly with therapists (n= 30) following recent termination of therapists' involvement in the project.	key sources of support. Additional resources included prior experience, a balanced work load, team work peer support, self-care, internal resources, family support, religion and spirituality.	Questionnaires administered re therapists' accreditation, seniority, type of in-service trainings and frequency of supervision but findings not reported in paper.

5. Hunter & Schofield (2006). Australia.	In-depth, individual, face-to-face interviews. Grounded theory approach.	Counsellors (n= 8) recruited from 5 general counselling agencies in Sydney through personal networks of first author. One male, seven female counsellors, age range 30-66 yrs. Masters' degree in counselling or related subject (n= 5), undergraduate	Four core themes identified: 1) Self-care – balancing the personal and the professional, relaxation, meditation and self-nurturing, close relationships, social activities & social support, and physical activity. 2) Professional – becoming more experienced and seeing patterns, gaining more knowledge, becoming more detached, having a positive outlook, creating pre- and post-session rituals, using within session coping strategies, structuring weekly loads and holidays, becoming an	**Strengths:** Adds to previous research by highlighting the personal, professional and organisational responsibilities for caring for counsellors who work with high loads of traumatised clients. **Weaknesses:** Small purposive sample of Australian counsellors. Sampling strategy not explicitly outlined.	**7/10**

	degree (n= 1), two-year undergraduate diplomas in therapy and no further qualifications (n= 2). >10 yrs experience (n= 3) 5-10 yrs experience (n= 3) <2 yrs experience (n= 2)	advocate, using personal therapy & group work. 3) Organisational – supervision, formal and informal debriefing, balancing workloads, supporting therapists who are not coping. 4) Encouraging personal therapy.

6. Ciydem et al. (2020) Turkey.	Employed descriptive phenomenological approach. Face-to-face interviews conducted via the internet due to safety measures implemented within scope of the outbreak. Colazzi's seven step	Nurses (n= 10) who cared for patients diagnosed with COVID-19. Pts selected using snowball sampling method. Two males, eight females, ranging 24-40yrs of age. Bachelor degree education (n= 7), master's degree education (n= 3).	Three core themes identified: 1) Effects of the outbreak – working conditions, psychological effects, social effects. 2) Short-term coping strategies – normalisation, refusal to dwell on their experience, avoidance, expression of feelings, distraction. 3) Needs – psychosocial support, resource management. Nurses caring for COVID-19 patients in Turkey were negatively affected psychologically and socially by the pandemic. They used short-term coping strategies and	**Strengths:** Pilot interviews used to revise the interview process and questions appropriately. Steps outlined to ensure trustworthiness of data obtained, including credibility, transferability, dependability and confirmability. In-depth details of sampled pts included. **Weaknesses:** Precise and generalisable results could not be attained due to qualitative	**10/10**

	method used for analysis.	required psychosocial support and resource management. Health workers sampled in this study were mostly supported by society but sometimes encountered stigmatising attitudes.	design and restricted sample size. Long-term experiences of pts could not be attained due to time-limited nature of study.

7. Maier (2011). USA.	Phone interviews with pts who were compensated with gift cards e.g. Starbucks. Inductive approach used to identify recurring phrases or common "threads" in informants' accounts.	SANEs (n= 40) 21-62 yrs (mean = 45 yrs). Some also served as directors or co-ordinators of programs (n= 17). Caucasian (n= 38) and African American (n= 2) interviewees. Nurse practitioner (n= 1), bachelor's degree in nursing (n =7). Mixture of part-time (n= 24) and	When asked about their difficulties as a SANE and the hardest part of their job, the majority (67%) discussed vicarious trauma, worrying about victims after they leave the hospital, the emotional demands associated with the job, and burnout. 46% indicated they have experienced burnout at least to some degree and more than half (51%) of SANEs interviewed specifically indicated that they have experienced vicarious trauma as a result of treating rape victims. All SANEs, regardless of whether they believe they have	**Strengths:** Study reveals important information regarding experiences of vicarious trauma and burnout based on perceptions of Sexual Assault Nurse Examiners, many of whom are in leadership positions. Multiple implications for clinical practice result from this study. **Weaknesses:** Based on self-reports - SANEs may not be aware that they experience vicarious trauma or burnout or may want to	**8.5/10**

	full-time SANEs (n= 16). Some pts had personal experience of rape (n= 16).	experienced vicarious trauma or burnout, have ways to cope after hard cases, e.g., finding relaxing activities, talking to family members, reaching out to other SANEs, program coordinators or rape victim advocates and detectives, and participating in meetings with other SANEs where the focus is on problems after difficult cases.	deny or minimise such experiences. Only one researcher coded the data in its entirety - possible that others would interpret SANEs' responses differently. SANEs were asked whether they experienced vicarious trauma or burnout, but they were not specifically asked to describe their symptoms.

8. Marriage & Marriage (2005). Canada.	Semi-structured interviews. "Answers abstracted" from videotaped interviews for analysis.	Clinicians (n= 7) in Department of Psychiary, BC Children's Hospital. All pts in full-time practice in university teaching hospital, including psychiatrists (n= 3), psychologists (n= 2) and psychiatric social workers (n= 2). Age range 40-60 yrs.	No pts reported burnout or secondary post-traumatic stress, although vicarious traumatisation was present in all accounts. These experienced therapists managed stress by self-monitoring their emotional responses, continuing professional education, the employment of collegial support networks, formal and informal, interests outside of the work environment, and the support of significant others.	**Strengths:** Clear distinction made between constructs of burnout, secondary traumatic stress and vicarious traumatisation. **Weaknesses:** No outline given re method of data analysis. No discussion of study limitations. Very little discussion of study implications for clinical practice. No justification provided re selection of clinicians with most experience.	**6.5/10**

9. McCall (2020). USA.	Structured interviews conducted approx. 18 months post shooting incident, 3 interviews performed via internet. Framework method used for analysis – transcription, familiarisation, coding, analytic framework	Emergency nurse pts (n= 7) ranged from 30-41 years. Six female, one male. Researcher known to four pts prior to interview.	Three key themes identified: 1) Preparation and preparedness – emergency nurses reported being in "nurse mode" and taking immediate actions to promote readiness. 2) Coping and support mechanisms – importance of maintaining self-care routine to foster personal wellbeing and promote emotional recovery. Strategies included cooking, walking, exercising, kayaking, hiking, humour and talking with peers. 3) Reflections and closure – each pt provided recollections of patients and their interactions	**Strengths:** Study findings yield implications for emergency nurses that may mitigate the negative psychosocial effects of providing care to patients from multiple-victim, school-associated shootings. Various potential avenues of future research provided e.g. inclusion of clinicians beyond emergency dept. **Weaknesses:** Limitations exist in transferability of findings	**9/10**

	development and application, data charting into framework matrix, and data interpretation.	despite passage of 18 months between the event and interview participation. Described reflecting on patients while away from work and lack of achieving closure because patient outcomes often unknown.	to community settings with fewer specialty resources. Emergency nurses from Level 1 comprehensive trauma centre would typically have more experience caring for patients injured by gun violence, therefore, likely affording emotional and clinical benefits that supported nurses' abilities to cope during and after roles in care of victims from this event.

10. Middleton et al. (2021). USA.	Descriptive phenomenological approach used. Demographic questionnaire, semi-structured interviews. Colazzi's approach used for data analysis.	FIs (n= 9) predominantly female (78%) with mean age of 38 yrs. Majority were Euro American/ Caucasian (n= 7), and some (n= 4) were parents. Education: 4-year degree (n= 5) and Master's degree (n= 4). Average 5.5 yrs forensic interviewing experience	FIs shared common intrinsic responses brought on by vicarious trauma, were working within context of an inadequate "system" which led to feeling unsupported by structures which were meant to protect children. This created barriers to syncretism, and having work-related stress and trauma "spill out" into their personal lives. FIs who had years of experience commonly turned to disengagement from the emotional intensity of the work as a self-protection strategy. FIs described that over time, they developed very specific	**Strengths:** Study outlines implications beyond those for FIs themselves, including organisational and policy implications for all first responders and their agencies. Acknowledgement made of researcher subjectivity and reflexivity. **Weaknesses:** Sample represents 100% of FIs in the state, but only represents one state. Homogeneous ethnicity of pts.	**9/10**

	(range 0.5-18 yrs).	coping responses to the stress that they experienced in their work role. These responses included (a) shifting into a mode within the interview setting, (b) becoming hyper-competent within their professional role as a forensic interviewer, (c) engaging in high-risk behavior as a way to cope with stress outside of their work role, and (d) disassociating from reality outside of their workplace.	Pts not asked about their own trauma histories, therefore, unable to suggest how previous trauma impacts vicarious trauma.

11. Günüşen et al. (2019). Turkey.	Descriptive phenomenological approach used. Semi-structured, in-depth interviews. Content analysis.	Purposeful sampling with oncology nurses (n= 13). Exclusively female sample, average age of 31 yrs. Bachelor's degree (n= 12) and Master's degree (n= 1). Mean total work experience: 9 yrs. Mean oncology experience: 4 yrs.	Three main themes identified: 1) Cycle of desperation – deep feelings experienced by nurses during process of care. Reach a limit when they think they cannot provide sufficient care. Feelings of frustration followed by helplessness. Nurses cannot spend sufficient time with patients due to work overload, resulting in feelings of guilt and desperation when they realise they're powerless to change the situation. 2) Coping – avoidance, seeking social support, balancing social and professional life, and spirituality.	**Strengths:** Impact of being inexperienced, nurse insufficiency, and caring for young patients to the occurrence of STS has been revealed. Recognition made of positive impact of stress experiences e.g., making their perspectives on life more positive. **Weaknesses:** Nurses shared several things after the audio recordings were stopped that were not shared during data collection.	**10/10**

	3) Change – personal maturation and psychological fatigue. Changing priorities, positive effects of stress e.g., developing communication skills, strengthening coping skills. Physical and emotional effects of stress including burnout, hypertension, weariness, depression	Difficult to ascertain extent to which findings are attributable to gender, given absence of male pts in the study.

12. Woolhouse et al. (2012). Canada.	In-depth, individual interviews. Iterative and interpretive process used for data analysis.	Family physicians (n= 10). Male (n= 6) and female (n= 4) physicians with average age of 42 yrs (range 32-58 yrs). Ethnicities identified as white (n= 8), asian (n= 1) and black (n= 1).	Two major themes identified: 1) Emotional impact – challenges, joys and sorrows they experienced as they struggled to care for patients with significant mental, physical and psychosocial needs. Sub themes of tragedy and death, difficult behaviours and isolation from mainstream medical community. 2) Coping mechanisms – sub themes of adaptation and evolution, teamwork, and modification of expectations. Evolving from 'rescuer' and problem-solver to simply bear witness and sit with patients'	**Strengths:** Further interviews conducted to ensure no new themes emerged from the data, despite indications that data saturation had been achieved. Methodological rigour ensured by including investigators who did not work in the field of interest and who reviewed transcripts and analysis to support bias identification. **Weaknesses:** Findings limited to restricted geographical	**8.5/10**

	suffering. Turning to colleagues for support when demands of work took their toll. Changing expectations of what their patients could accomplish – if the only measure of success was full recovery then constant disappointment would result.	location of pts to Ottawa and Toronto, Ontario and narrow focus of patient demographic. Evaluation of coping strategies would provide further implications for clinical practice.

Study Aims

All papers featured in this review offered evidence of the experiences of working with traumatised people. Studies explicitly examined concepts of VT and/or STS, often using such terms interchangeably which is a feature of wider research in this area (Newell et al., 2016). To answer this review's research question, only findings directly related to the coping strategies used by participants will be reported. Table 3 provides a summary of aims that were explicitly outlined by the study researchers.

Table 3.

Summary of study aims as stated by researchers.

Study authors	Stated Aims
1. Beckerman & Wozniak (2018).	"Though STS has been researched among DV workers, there has not been a qualitative study to examine the nuances and subtleties of their lived experiences and the impact of this work in a more textured way than testing the existence of STS in this cohort. This qualitative study is a first step in trying to identify the range of experiences of STS and other related psychosocial sequelae."
2. Bell (2003).	"The present study focuses on whether the unique stresses of this work contribute to secondary trauma among counselors who work with battered women. It also addresses a broader question of how counselors experience their work, both positively and negatively, by asking open-ended questions about a number of work and personal experiences."
3. Butler et al. (2018).	"We conducted an exploratory qualitative study of the individual and organisational strategies employed to facilitate wellbeing in an AOD TC organisation in Australia. In particular, this study aimed to address the following research questions: • What are the factors that potentially negatively affect the wellbeing of workers at an AOD TC organisation? • What worker and organisational strategies are employed to enable workers to cope with work related stress and facilitate worker wellbeing?"
4. Cohen et al. (2015).	This paper aims to address the experience of therapists working with children under conditions of a shared traumatic reality of war

	and to learn about the challenges, risks, and positive gains involved in their experience. It is based mainly on analyses of the therapists' own accounts and reflections related to two research questions: 1. How did therapists, exposed to a war, experience their work with traumatized children, both personally and professionally? 2. What were the challenges to the therapy work and the therapists' ways of coping?
5. Hunter & Schofield (2006).	"The current study was designed to explore how both early career and more experienced Australian counsellors, coped with the impact of their clients' traumatic experiences, and how they developed those strategies. The study sought to elicit responses ranging from self-care, professional development and organizational support strategies, to develop a more holistic picture of how counsellors coped with the challenges of their work and balanced their personal and professional lives."
6. Ciydem et al. (2020).	"This study, therefore, aims to determine the experiences and opinions of nurses working in psychiatric wards regarding the assessment of patients' sexual health."
7. Maier (2011)	"While previous research has explored the vicarious trauma experienced by counselors, advocates and social workers who assist rape victims, little is known about SANEs' vicarious trauma or the psychological consequences and burnout they experience as a result of their exposure to victims' traumatic experiences. This qualitative research is an attempt to fill the void in the literature."
8. Marriage & Marriage (2005)	"Although a number of authors e.g. (Rabin et al, 1999; Arvay et al, 1996) have discussed institutional factors and interactions that may protect clinicians from the stress of working with traumatized patients, relatively little has been written about the strategies employed by the therapists themselves. We were prompted to conduct a qualitative study of experienced clinicians in a Child & Family Psychiatry Clinic, asking about their work experiences, responses, and coping methods."

9. McCall (2020)	"The purpose of this study was to learn how emergency nurses describe their experiences to identify themes and findings that may translate to practices for improving the mental health and wellness of emergency nurses who care for patients from a multicasualty, school-associated shooting incident."
10. Middleton et al. (2021).	"This study aims to provide an exploratory context to understand and describe the experiences of vicarious trauma through the lens of forensic interviewers. Therefore, the primary research question guiding this study is, "How do forensic interviewing professionals experience vicarious trauma?" The secondary question is, "What is the textual and structural experience of the phenomenon of vicarious trauma?"
11. Günüşen et al. (2019).	"The aim of this study was to explore the experiences of STS among nurses caring for cancer patients."
12. Woolhouse et al. (2012).	"This qualitative study set out to explore the phenomenon of VT in a group of inner-city family physicians caring for a patient population known to experience high levels of trauma: women using illicit drugs. Although there has been much research exploring VT and CF in non-physicians caring for similar populations, little literature was found to explore these phenomena in family physicians."

Study Method and Analysis

All the papers adopted a qualitative approach to data collection and analysis. All but two of the studies used semi-structured interviews to gather data; papers one and four relied on focus groups. Five papers (1, 3, 7, 9, 12) used thematic analysis to analyse participant data. All themes reported and discussed within the papers were coherent and related closely to the study aims and research questions. Two papers (2, 5) used a grounded theory approach; two (4, 11) analysed data using content analysis; two (6, 10) used Colazzi's seven step method for analysis and one study (8) did not indicate what method of data analysis was used.

Study Sample

This review considered data from a total of 226 participants. Most studies took place in the USA (1, 2, 7, 9, & 10), two were conducted in Australia (3, 5), two in Turkey (6, 11), two in Canada (8, 12) and one in Israel (4). Variability was noted in study sample sizes, ranging from 70 participants (4) to 7 participants (7, 8). Four papers (5, 8, 9, 10) included fewer than 10 participants; five papers (1, 3, 6, 11, 12) had 10-15 participants; and three papers (2, 4, 7) had 30 or more participants. Of studies where the gender status of participants was stated, they featured a higher representation of women than men in their samples (83% women, 17% men). Papers four, seven and eight did not publish details of participants' gender. The imprecise and incomplete information in the studies regarding participant age, ethnicity and years of experience mean that obtaining accurate averages of this data is not possible.

Quality Appraisal

Most papers scored well on stating study aims and ensuring the research design was appropriate to address the research aims (see Table 3). The level of detail in outlining recruitment strategy was mixed, and it was therefore unclear at times whether such a strategy was appropriate. All the studies included samples that were relatively small and non-representative of the population. Recognition of this limitation was made by some studies, such as study three, where the research was conducted with a small number of workers in one therapeutic community organisation that was particularly invested in the wellbeing of its employees. Even those papers with larger samples included homogeneity of gender (2) or ethnicity (7). It is important to consider the experiences and needs of racialised minority staff in the context of recent world events,

such as the ‘Black Lives Matter’ movement from 2020. Most studies that reported participant ethnicity included predominantly Caucasian samples (2, 7, 10, 12), therefore, drawing comparisons of resilience and access to coping strategies across ethnic groups is problematic. Researchers in five of the twelve papers (2, 4, 6, 10, 11) considered the role of reflexivity and their relationship with participants. The other seven papers did not address this issue when discussing the limitations of their research. It is not known, therefore, the extent to which the research process and narratives created by the researchers were influenced by their own outlook, interest, and experience. Detailed findings were provided by most studies, where the value of the research was made clear.

Findings

The review discovered several methods of coping, including self-care practices, strategies related to their individual professional practice and organisation-level influences. Appendix C illustrates these strategies and their prominence across the reviewed studies.

Self-care.

All studies reported the need to balance the draining work of supporting trauma victims with experiences that intentionally reduce stress. Establishing this type of balance was viewed as crucial for maintaining emotional stability and restoring a sense of perspective. Key self-care practices included exercise and mindful meditation to release work-related stress and maintain wellbeing. Interestingly, study eight revealed that physical activity is viewed as an effective stress reducer even amongst those that performed little exercise, which could be suggestive of a functional coping strategy

rather than simply a lifestyle choice. Some participants referred to meditation as a fundamental method of centring themselves and ensuring they remain present for their clients (1, 3, 5). Self-reflection and relaxation practices, such as reading escapist literature, were central to this anchoring process and contributed to their perceived coping ability. The value of holding buffering personal beliefs was another source of strength for participants (2, 4, 5, 11). For example, counsellors in study two shared their beliefs in a higher power and a higher call to do counselling work that played out as a sense of 'rightness' in their work. The function of their personal beliefs was seen as a source of comfort and positivity to better cope with trauma and to help find meanings in their experiences.

Accessing social and emotional support from family, partners, and friends outside of work was identified as vital (1, 2, 3, 4, 5, 6, 7, 8, 11). This included confiding in loved ones and accessing support through spiritual communities. Participants commonly expressed that family support made it easier to process and cope with the work pressures. Interestingly, a partner was often cited as a helpful source of support, but the confidentiality of clients had to be respected and any specific discussion needed to be contained. That said, some participants suggested that partners may not fully appreciate or understand the complexities of the trauma work and the secondary traumatic resonance.

Professional Coping Strategies.

Multiple professional strategies were identified by participants to manage the emotional burden of their work. Emotional detachment was discussed by many participants (5, 6, 7, 8, 9, 10, 11), which often involved a gradual learning process of not

taking on board their clients' problems. To facilitate this process, some participants described adaptations to their practice style. For example, they evolved from 'rescuer' (someone with an overwhelming responsibility to fix all their clients' difficulties) to someone who learned to simply contain and bear witness to their clients' suffering. Although a challenging process for many, this was reportedly a key survival skill learned through experience and necessity. Such experience helped participants to become more philosophical and desensitised (5, 8), which they believed was necessary to help their clients feel that therapists were accepting of and resilient enough to hear their trauma stories.

Receiving emotional support from colleagues was another key coping strategy discussed by participants. Such support could come via "blowing off steam" with co-workers outside of work (1) and informal debriefs within work. For instance, study 12 suggested that turning to colleagues for support when the daily demands of work were challenging allowed participants to take brief moments during the day to vent and process a troubling case, whilst also decreasing feelings of isolation. A psychiatrist in study eight reported that sharing and reflecting with colleagues on experiences is an empathic exchange that can help to understand that the times clients share their most traumatic narratives are also times of potential growth for the client. Similarly, the role of humour with colleagues was expressed (1, 8, 9) as a means of effective stress reduction.

Participants recognised the unique aspects of working with this challenging population and described modifying their expectations of what they and their clients could accomplish (5, 7, 10, 12). For example, it was noted that if full recovery was the

only measure of success, then he would be continually disappointed (12). Other participants discussed the process of "shifting into a mode" to help meet the differing expectations of their work roles. They described shifting into a disengaged mode to be able to cope effectively as a practitioner hearing about violent and sexual trauma, or a cognitive mode to gather information from child clients to disseminate evidence to investigative team members (10).

Organisational Coping Strategies.

Many participants felt that supervision offered by the organisation facilitated wellbeing and was a meaningful source of coping with the therapeutic process and their personal experiences (1, 3, 4, 5, 8, 10). One-to-one supervision was described by some participants as akin to personal therapy, whereby discussions could be held regarding their functioning and the factors in their roles and personal lives that were impacting their functioning. Indeed, personal therapy was reportedly used by several participants, noting that it was also beneficial to have a sense of being "the other" for helping to experience greater empathy for their clients. Being able to discuss themselves and their feelings in the context of client cases was deemed an effective coping strategy for dealing with secondary trauma.

The value of positive supervisor attributes was outlined in study five, including trustworthiness and enabling supervision sessions that felt safe and dedicated to their needs. Parallels with the therapeutic work they hoped to offer trauma clients were described by participants. For example, they felt that supervisors needed to foster a sense of safety and be able to challenge and provide both positive and constructive feedback. In addition, good supervision defined by reassurance, direction, and

providing a containing platform to debrief from any traumatic or personal responses to their clients' narratives enabled effective caseload management. Conversely, supervision was seen as inadequate if the supervisor failed to offer useful advice or support. A participant described coming to rely on "self-supervision" because she didn't feel that she could trust her current supervisor.

Group supervision was also identified as a useful space to share coping strategies with colleagues and to keep supervision group members grounded (1, 3, 5, 8). Participants expressed the value of group supervision for fostering informal debriefing between colleagues. For example, one participant suggested that it meant she did not have to feel alone with dilemmas about her clients (8).

Team meetings were invaluable for coping with secondary trauma reactions (1, 3). This involved sharing advice and training about how to support trauma survivors and instil therapeutic boundaries to prevent being 'pulled into' their clients' lives too much. Communicating safely and openly about stress experienced in the organisation was key for some participants. This organisational ethos was deemed important for participants in study three, to allow them to express and share in the same manner as clients to mirror the values and philosophy of the organisation.

Discussion

This systematic review set out to discover the known strategies used by therapists to cope with indirect trauma exposure, specifically VT and STS. The review highlights a range of potential individual strategies and organisational supports that promote wellbeing among therapists working in trauma practice. The qualitative methodology of the reviewed studies enabled deep exploration of therapists'

experiences of secondary trauma and their coping strategies. It also reiterates the importance of bolstering organisation-wide strategies to facilitate practitioner wellbeing by implementing further strategies targeted at “at-risk” teams within an organisation. Further research is required to understand the coping strategies that are most effective in managing the negative effects of secondary trauma exposure versus general clinical practice, as well as how therapists’ personal trauma histories influence accessibility and maintenance of effective coping.

The selected participants in the studies typically comprised convenience samples that represented therapists who were interested in attending interviews or focus groups. They may, therefore, have been eager to have an opportunity to gain support or vent about their experiences. Self-reported experiences may have been shaped by social desirability or a perception of the study as a form of evaluation, with participants tailoring their responses accordingly. Acknowledgement of this potential bias in reported participant experience was lacking in the reviewed studies. Furthermore, it was often unclear whether participants were invited to discuss their own trauma histories. Paper ten highlighted this as a study limitation and suggested further research is necessary to understand how previous trauma impacts experiences of indirect trauma exposure.

Given that participants were predominantly female and Caucasian, the review lacks consideration of the experiences and needs of ethnic minority groups and men. Those cultural contexts could have provided insight on issues of countertransference with trauma survivors, for example. The accessibility and effectiveness of coping

strategies across different cultural and racial contexts are difficult to examine using homogenous samples included in this review.

Inconsistent and imprecise distinction between concepts of indirect trauma exposure was observed in some papers, including VT, STS, burnout, and compassion fatigue. Researchers highlighted that such phenomena have been used interchangeably in previous research, despite the conceptual differences that exist between them (Sabin-Farrell & Turpin, 2003). This interchangeability and lack of empirical specificity also represents a limitation within the overall literature base that seeks to understand the pathologies of these conditions (Newell & MacNeil, 2010).

Prior research infers that disengagement is a negative outcome of VT (Perron & Hiltz, 2006). However, findings from this review suggests that disengagement, when utilised intentionally, may in fact have a positive impact on the therapist's experience of VT. Indeed, the theme of learning about coping with adversity from their clients is suggestive of effects on therapists that are positive, even if not pain-free. This is consistent with the phenomenon of VR, whereby trauma professionals learn about overcoming adversity through witnessing and participating in trauma survivors' own recovery processes (Hernandez-Wolfe et al., 2015). Hernandez et al. (2007) hypothesised that VR is a common and unique consequence of trauma work that may coexist with VT.

Limitations

The reviewed articles failed to provide adequate evidence that participants could distinguish between the terms used to describe indirect trauma exposure (e.g., during research interview). It is unclear, therefore, whether the reported findings are based on

the target phenomenon researchers aimed to investigate. As a result, the findings and subsequent implications presented in this review are rather generalised and lack specific focus on VT and STS as mutually exclusive concepts. Perhaps adopting a narrower focus on one key phenomenon associated with secondary trauma (e.g. vicarious traumatisation only), would have prevented overlapping of constructs described in the analysis and discussion of reviewed papers. In addition, the concepts of coping and resilience are difficult to quantify and are rather arbitrary and subjective in their definition. This review has assumed a universal definition of coping that implies a dichotomy between 'coping' and 'not coping' and fails to recognise how one's resilience to secondary trauma can vary greatly according to a myriad of internal and external factors e.g., access to internal and external resources of support. The strategies outlined also suggest that they are effective for all therapists. This generalisation fails to account for individuals who may find certain coping strategies more or less effective depending on variables such as current mental health status, personal trauma experiences and ability to access said coping strategies.

The development of review themes presented here relied on the findings discussed by the authors of the reviewed studies. Access to original transcripts of participant narratives was not possible, thus, this review's themes are based on other researchers' subjective interpretations of participant data. It cannot be known, for example, whether other coping strategies were discussed by participants but were omitted from the final edit of the reviewed papers due to perceived lack of importance or prevalence in the original dataset.

A narrative review was conducted for the present review, which involved familiarisation with the data and developing subsequent themes. However, the development of initial codes from which themes were derived lacked thoroughness and reliability. The inter-rater used to evaluate the quality of the reviewed studies could have been consulted with when reviewing the data themes to improve the reliability and robustness of the findings presented in this review.

Implications for Clinical Practice

Given the degree of exposure to human-based trauma increases the intensity and probability of VT and STS (Beckerman et al., 2018), supporting those who work in this field is paramount.

Recommendations for Therapists.

Actively establishing and maintaining self-care strategies should be accepted as fundamental to practice when working with people who are traumatised. This review shows that therapists often organically enacted self-care as a counterweight to their work, for instance, through meditation or exercise. The role of informal debriefing with colleagues that facilitates a culture of collegial support is also noteworthy. Informal debriefing involves telling one's story and being heard emotionally, with no analysis of the situation from a therapeutic lens and without recommendations for future action. Meaningful consideration of the methods of promoting an organisational culture in which this occurs is vital.

Recommendations for Supervisors.

Supervisors have a key role to play in supporting therapists to manage the difficulties associated with VT and STS. Considering that the therapeutic relationship is

both a source of healing and pain for therapists working with trauma survivors, supervisors are encouraged to address therapists' internal and external responses and the possibility of VT (Etherington, 2009; Sommer, 2008). A safe and supportive supervisory environment is required to explore the range of thoughts and feelings that arise in response to trauma work (Etherington, 2009; Trippany et al., 2004). Advance preparation of therapists of the likelihood of VT and STS within clinical practice should be recommended (Cohen et al. (2014). Monitoring through supervision of the natural experiences of blurred boundaries between the personal and the professional, self and other, may reduce distress from encountering these phenomena (Cohen et al., 2014). This may raise their awareness should these feelings interfere with the process of therapy.

Recommendations for Service Managers.

Work systems at an organisational level were highly influential in the reviewed studies. Hence, institutionalised self-care may better ensure that care is routinely implemented and conveyed as an agency expectation. As therapists' exposure to trauma narratives and their risk of developing negative secondary trauma responses increased, measures for clinician wellbeing protection would already be in place.

It is important for service managers to take a proactive role in helping therapists to develop coping strategies for dealing with secondary trauma during a global pandemic. Team meetings, training opportunities and a supportive team culture that fosters safe communication of secondary trauma experiences were all valued by participants. According to Perez et al. (2010), leadership at organisational levels can lessen VT experienced by employees by rotating them to different positions to take a

break from viewing graphic images, reducing workloads, and increasing leaderships' support regarding employee stress.

In summary, therapists can develop coping strategies for dealing with the complex repertoire of emotional responses to trauma work. Many therapists in this review adopted professional and self-care strategies to protect themselves from the intense and common pressures of client contact. They also valued the organisational strategies implemented by management figures, such as supervision, formal and informal debriefing. Therapists and their service managers will need to continue to educate themselves and each other about the importance of managing stress associated with secondary trauma and work to reduce the stigma attached to being seen as not coping.

Conclusion

To date, there has been limited qualitative research investigating the use of coping strategies to manage the potentially negative effects of VT and STS. This systematic review highlights the specific means of coping therapists use to deal with the challenges of indirect trauma exposure, and demonstrates the influence that organisations can have on therapists' ability to cope and practice effectively. Limitations exist regarding the unknown influence of one's own trauma histories to access and maintain effective coping strategies for trauma work. Considering the challenges posed by clinical work during a pandemic, such as exposure to trauma narratives whilst working from home, prioritising therapist wellbeing seems a particularly important initiative that service managers should pursue to facilitate effective coping and resilience towards traumatic client narratives.

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Appendix A: Search terms for the review

Search	Therapist	Secondary Trauma	Coping
Individual search terms	"therapist*" OR "psychologist*" OR "counsellor*" OR "counselor*" OR "psychotherapist*" OR "clinician*" OR "doctor*" OR "psychiatrist*" OR "nurse*" OR "health worker*" OR "healthcare worker*" OR "health professional*" OR "healthcare professional*" OR "psychoanalyst*" OR "analyst" OR "trainee" OR "student" OR "in-training")	"secondary trauma*" OR "secondary traumatic stress" OR "STS" OR "VT" OR "vicarious trauma*" OR "indirect trauma*"	"coping" OR "coping style" OR "coping strategy" OR "coping mechanism" OR "coping strategy" OR "coping technique"
Combined search	Section 1 AND Section 2 AND Section 3		
Filtered	English language and human sample, peer-reviewed and carried out 1990		

Appendix B: Scoring system using CASP checklist

CASP Scale	Scoring System	Description of Quality
Was there a clear statement of the aims of the research?	Yes: 1 point	High: 9-10 points
Is a qualitative methodology appropriate?	Unsure: 0.5 points	Medium: 7.5-9 points
Was the research design appropriate to address the aims of the research?	No: 0 points	Low: <7 points
Was the recruitment strategy appropriate to the aims of the research?		Exclude: <6 points
Was the data collected in a way that addressed the research issue?		
Has the relationship between the researcher and participants been adequately considered?		
Have ethical issues been taken into consideration?		
Was the data analysis sufficiently rigorous?		
Is there a clear statement of findings?		
How valuable is the research?		

Appendix C: Summary of coping strategies

Table 4.

Themes and components of coping strategies for VT and STS provided in reviewed studies.

Theme	Components	Study number	Studies including theme (n= total number of studies)
Self-care	Social/ emotional support	1, 2, 3, 4, 5, 6, 7, 8, 9, 11	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11 (n=10)
	Meditation	1, 3, 5, 11	
	Holding buffering beliefs	2, 4, 5, 11	
	Seeking work-life balance	1, 4, 5, 8, 10	
	Exercise	1, 3, 5, 8, 9	
Professional coping strategies	Emotional detachment	5, 6, 7, 8, 9, 10, 11	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12 (n=12)
	Colleague support	1, 3, 4, 8, 9, 12	
	Use of humour	1, 8, 9	
	Addressing personal traumas e.g., therapy	2, 4, 5	
	Altering goal expectations	5, 7, 10, 12	

Organisational coping strategies	Individual supervision	1, 3, 4, 5, 8, 10	1, 3, 4, 5, 6, 7, 8, 10, 12 (n=9)
	Group supervision	1, 3, 5, 8	
	Team meetings	1, 3, 7, 12	
	Training	4, 6, 8	
	Positive working culture	2, 5, 6, 12	

SCHOOL OF PSYCHOLOGY

DOCTORATE IN CLINICAL PSYCHOLOGY

EMPIRICAL PAPER

"You're going to connect with the stories" – A Qualitative Analysis of Secondary Traumatic Stress and the Role of Clinical Supervision.

Trainee Name: **Edward Copestake**

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Abstract

Objective: There has been increasing recognition of the effects of vicarious exposure to client trauma on healthcare professionals working with trauma survivors. The role of supervision has been suggested as key for supporting practitioners, but little evidence exists exploring how supervision is experienced by psychologists in their practice. This study, therefore, aimed to qualitatively examine psychologists' experiences of secondary traumatic stress (STS) and of supervision specifically related to trauma practice.

Methods: Thirteen individual semi-structured interviews were conducted with practising psychologists. Interviews took place via phone or Skype and were audio-recorded, transcribed verbatim and analysed using thematic analysis.

Analysis: Participants' descriptions of their STS experiences were largely based on physical responses to exposure to trauma narratives, e.g., intrusive thoughts and images, physiological arousal and avoidant behaviours. Some participants shared positive influences that STS have had on their clinical practice. Three major themes were analysed: normalisation of STS as a response to trauma narratives, development of the therapeutic relationship to connect with trauma narratives, and significance of supervisor attributes in understanding STS experiences.

Conclusion: STS should be viewed as a set of normal responses to secondary exposure to traumatic material. Supervisors play a significant role in how STS is experienced, understood and processed, which has implications for supervision practices, including the delivery of trauma-informed supervision in particular. Further research should examine the role of the type and amount of secondary trauma exposure and personal

trauma histories in how STS is experienced. This study suggests that the current conceptualisation of STS may unhelpfully pathologise normal distress.

Introduction

The effects of psychotherapy that focuses on the impact of the process on the client's life have long been researched (Cuijpers et al., 2010). In contrast, the influence of the therapeutic process on the therapist that is of great importance for the therapeutic relationship, has been less investigated (Cavanagh et al., 2015). Specifically in trauma therapy, the trauma therapist must be very aware of their feelings and beliefs to provide effective client care, therefore, understanding the countertransference process and exploring therapists' feelings and responses to traumatic accounts is of significant clinical importance.

In recent years, the concepts of secondary traumatic stress (STS) and vicarious traumatisation (VT) have been theoretically developed, and these constructs have captured the interest of many professionals working in the field of trauma support (Devilly et al., 2009). Many simply assume that such traumatisation inevitably exists, but there has been some difficulty in building a body of quality empirical support. Considering that 'vicarious trauma treatments' are being offered to therapists who work with trauma populations (e.g., British Medical Association, 2022), an empirical base for these assumptions is becoming more urgently needed.

Supervision practices that actively address the secondary traumatic effects of trauma work have been encouraged (Trippany et al., 2004; Pearlman & Maclan, 1995). Traditionally, supervision has been viewed as a central component of professional

practice that provides a safe and reflective space to explore the clinician's work and to arrive at conclusions regarding the most appropriate course of action for client presentations (Joubert et al., 2013).

Recent campaigns in mental health services (e.g., The King's Fund, 2017) have attached greater significance to the roles of compassion and self-care to ensure staff wellbeing that indirectly facilitates positive client outcomes. These professional values are linked to improved staff wellbeing, lower staff absenteeism and patient satisfaction (West et al., 2011). There has been a push to identify the factors that may protect therapists from the impact of STS (Bober & Regehr, 2006), and a call for future research to examine the interaction between STS and potential protective factors (Sabin-Farrell & Turpin, 2003). The present study aims to address this call by examining the STS experiences of psychologists who have been exposed to trauma narratives and the role of clinical supervision in disclosing and processing such experiences.

Secondary Trauma Constructs and Terminology

Various constructs have been used in research to describe the emotional and psychological responses professionals may experience to clients and their narratives, especially for clinicians involved in trauma practice (Newell, et al., 2016). Given the intensity of working therapeutically with trauma survivors, therapists involved in such work may be more prone to STS, VT, burnout and compassion fatigue (Bride, 2004; Pearlman & Saakvitne, 1995). A recent shift has occurred in the literature, however, that places a greater emphasis on recognising the positive experiences that take place in trauma practice (Newell et al., 2016).

The concept of ‘posttraumatic growth’ was introduced by Calhoun and Tedeschi (1998, 2006) to describe the client’s experience of growth after a traumatic experience. Growth among therapists involved in trauma work is also present, characterised by various rewards (Herman, 1995), including increased therapist appreciation of life (Steed & Downing, 1998), enhanced understanding of others and themselves, and improved existing relationships (Herman, 1995). This parallel growth process has been referred to as ‘vicarious posttraumatic growth’ (Arnold et al., 2005).

Charles Figley (1995) is widely credited for developing the concept of STS based on his work that investigated the psychiatric symptoms related to post-traumatic stress disorder (PTSD). He defined STS as the “natural and consequential behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other (or client) and the stress resulting from helping or wanting to help a traumatized or suffering person” (Figley, 1995, p. 7). STS includes symptoms akin to those experienced by individuals exposed directly to trauma (Chrestman, 1999), including intrusive imagery linked to clients’ disclosures of traumatic experiences (McCann & Pearlman, 1990), physiological arousal (Figley, 1995) and avoidant responses (Haley, 1974). STS reactions may manifest through the engagement in an empathic and therapeutic relationship with a client suffering from a traumatic experience and exposure to the painful or intense experiences of that specific person’s trauma (Figley, 1995).

A term frequently associated in the literature with STS is VT, first described by Laurie Pearlman in the early 1990’s. Pearlman suggested that the therapist’s collective frame of reference may undergo cognitive changes following indirect experience of

trauma victims' emotional reactions and cumulative empathic engagement in the trauma treatment process (McCann & Pearlman, 1990; Pearlman & Maclan, 1995). Such changes could include the therapist's attitudes towards trust, safety, intimacy, and their own sense of self, which could deplete the psychological resources needed for the clinician to provide client care and self-care (Rothschild & Rand, 2006). The theoretical model of VT suggests that the development of disrupted beliefs is gradual, progressive, and long-lasting.

'Compassion fatigue' and 'burnout' are commonly discussed terms used interchangeably with STS and VT in the literature to describe clinicians' psychological reactions to their clients (Newell & MacNeil, 2010). Burnout describes the general experience of psychological stress and emotional exhaustion that individuals of any profession may experience (McCann & Pearlman, 1990). Burnout is typically associated with occupational influences, such as autonomy and workload, rather than relationships with others (Whitebird et al., 2013). Compassion fatigue refers to a more generalised fatigue that professionals experience by supporting clients who are suffering in some way (Stamm, 2005). The concept of compassion fatigue also posits that clinicians may not necessarily experience a secondary traumatic stress reaction should they experience significant stress from treating traumatised persons.

Empirical evidence that supports the concepts of STS and VT is limited and reported to be unclear and inconsistent (Bride, 2004; Sabin-Farrell & Turpin, 2003; Elwood et al., 2011). That said, such concepts do provide helpful descriptors of symptoms associated with working with trauma survivors, which distinguish from more generalised and non-specific constructs of emotional exhaustion e.g., burnout. Whilst

literature has cited increased awareness of the impact of client trauma on clinician wellbeing, measurement of these constructs is problematic. The level to which stress linked to trauma practice contributes to trauma symptoms exceeding exposure to high work stress in general remains unclear.

Influence of Psychoanalytic Theory

Literature first depicting the concept of emotions being 'transferred' from client to therapist occurred in the early 20th century as a component of psychoanalytic practice (Hayes et al., 2011; Freud & Strachey, 1954). The Freudian construct of 'transference' describes the client's unconscious projection of thoughts, feelings, and emotions onto the therapist (or significant others), based on their past experiences. Latterly, Freud posited that it is not possible for the therapist to supress all unconscious and conscious feelings and thoughts about the client (Freud, 1964; Hayes et al., 2011). He coined the term 'countertransference', by which information presented to the therapist by a particular client activates the therapist's own unconscious or unresolved conflicts.

The process of countertransference has been described in two ways. One description refers to the collective unconscious response a therapist has towards their client, the client's narrative, transference, and re-enactments based on the therapist's past life events. The other description suggests the therapist demonstrates unconscious and conscious defences against the presentation of material by the client, including responses such as detachment, avoidance, and overidentification with the client and their circumstances (Pearlman & Saakvitne, 1995; Wilson & Lindy, 1994). This distinction between the two types of countertransference responses has been referred to as Type I and Type II countertransference (Wilson & Lindy, 1994).

Similar developments in psychoanalytic theory and process, such as projective identification, have been influenced by Freud's identification of the countertransference relationship between the client and the therapist (Newell et al., 2016). Projective identification (Klein, 1946) describes the therapist's similar emotions or feelings to those of the client due to the client's projection of these emotions onto the therapist (Newell et al., 2016). The occurrence of projection identification has been suggested as an antecedent behavior to countertransference (Greatrex, 2002; Rothschild & Rand, 2006).

Particular consideration must be given to trauma therapists who are themselves trauma survivors. If the therapist is still recovering from their own trauma experiences, there are risks of confusing personal healing with clients' healing or overidentifying with clients, which may be harmful to both the client and the therapist (Yassen, 1995). Survivor therapists may hear a client's experience and relive feelings and memories linked to their own experiences of trauma. Trauma therapists with similar experiences to their clients may start to dissociate during sessions, causing serious disruption in the therapeutic process (Pearlman & Saakvitne, 1995).

If traumatic material presented by clients to trauma therapists can lead to painful experiences and feelings for these therapists, such feelings could emerge in the therapeutic relationship (Hesse, 2002). Even skilled and well-trained therapists may be unable to remain empathic towards clients if they are suffering from STS. STS responses that are manifested as countertransference in sessions present a serious ethical dilemma for therapists, as clients can be harmed or possibly even re-traumatised by such responses (Pearlman & Saakvitne, 1995). For example, the therapist may try to avoid feelings or topics that produce anger, anxiety, fear, or other strong feelings in

them. The therapist may become authoritarian or argumentative with clients, which can confuse or hurt the client, causing them to disconnect from the therapist (Hesse, 2002).

Given the lack of empirical evidence in a clinical psychologist population, the present study aims to explore the effects of supporting trauma survivors on trauma therapists' and to understand how such responses may influence the countertransference process and therapeutic relationship with trauma clients.

Trauma-Informed Practice & Supervision

Trauma-informed practice refers to the practitioner's understanding of a client's current difficulties in the context of past victimisation (Knight, 2015). According to Knight (2015), the implications of being a trauma survivor on the client's ability and willingness to engage in a working alliance are also considered. This may be particularly challenging for trauma survivors, given common difficulties forming positive attachments and core beliefs that can be characterised by hostility towards others (Monahan & Forgash, 2000; Stovall-McClough & Cloitre, 2006). Trauma-informed practice helps trauma survivors to develop their ability to manage distress and participate in more effective daily functioning (Gold, 2001). Its basic assumptions are trustworthiness, safety, choice, collaboration, and empowerment (Harris & Fallot, 2001; Quiros & Berger, 2013).

In their Guidelines for Supervision, The British Psychological Society (BPS) Division of Counselling Psychology describes supervision as an 'activity', a 'process', a 'relationship' and a 'practice' (BPS, 2007). Supervision is an ethical and professional activity for reflection on the work that enables 'playful reflection' for future action and is distinct from therapy. Supervision is a process of 'ongoing collaborative, experiential

and transformational learning' that draws on research-based knowledge and practice. It is a 'flexible' relationship of 'mutual trust, respect and integrity' that considers the learning needs of the supervisee. Finally, it is a practice that is bounded by an explicit contract and draws on 'shared and explicit models of supervision' (BPS, 2007).

Numerous models of supervision have been developed and implemented in clinical practice, although data figures for the most prevalent approaches to clinical supervision are unknown (Smith, 2009). Psychotherapy-based supervision models have been described as a natural extension of the therapy itself, where there is an uninterrupted flow of focus, terminology, and technique from the therapy session to the supervision session, and back again (Falender & Shafaanske, 2008). These models include feminist (Feminist Therapy Institute, 1999), cognitive-behavioural (Haynes et al., 2003), and person-centred (Haynes et al., 2003) supervision. Developmental models of supervision, including the integrated development model (Falender & Shafaanske, 2004) and Ronnestad and Skovholt's (2003) model define progressive stages of supervisee development from novice to expert, with each stage comprising of discrete skills and characteristics. Integrative models of supervision rely on several theories and techniques (Haynes et al., 2003) and are widely practiced given the number of integrations that are possible (Smith, 2009). Examples of integrative models include Bernard's (1979) discrimination model, Ward and House's (1998) reflective learning model and Holloway's (1995) systems approach model.

A comprehensive description of each supervisory model goes beyond the scope of this paper, but salient defining characteristics of the psychodynamic approach to supervision will be discussed as it pertains most closely to countertransference and

STS reactions. Psychodynamic supervision is a psychotherapy-based model of supervision that has been classified into three categories: patient-centred, supervisee-centred and supervisory-matrix-centred (Frawley-O'Dea & Sarnet, 2001). In patient-centred psychodynamic supervision, the supervisor's role is didactic, with the aim of supporting the supervisee to understand and treat the client's material. As the name suggests, the client's presentation and behaviours represent the focus of the supervision session (Smith, 2009). Conversely, supervisee-centred supervision focuses on supervisee growth, where the supervisee can learn about their own psychological processes and reactions to client content. This seems particularly relevant to working with trauma survivors, where understanding of one's own emotions and behaviours in response to vicarious exposure to traumatic material is key for a healthy therapeutic relationship to be established and maintained. The supervisory-matrix-centred approach not only attends to client and supervisee material, but also examines the supervisor-supervisee relationship (Smith, 2009). Supervision is, therefore, relational and the supervisor's role is to "participate in, reflect upon, and process enactments, and to interpret relational themes that arise within either the therapeutic or supervisory dyads" (Frawley-O'Dea & Sarnat, 2001, p. 41). This includes exploration of parallel process, defined as "the supervisee's interaction with the supervisor that parallels the client's behavior with the supervisee as the therapist" (Haynes et al., 2003, p.12).

Specific challenges and risks to practitioners in learning and executing trauma-informed practice may include personal attitudes and resistance (Berger & Quiros, 2014). Theoretical and empirical literature has suggested that supervision is a key strategy in supporting therapists to address such challenges and to prevent, mitigate,

and heal STS (Bell et al., 2003; Cohen & Gagin, 2005; Pulido, 2007). Ongoing supervision has been recognised as a significant protective factor by serving as a buffer against STS (Yassen, 1995), in addition to perceived social support (Iliffe & Steed, 2000), humour (Mesmer-Magnus et al., 2012) and clear workplace policies (Begic et al., 2019).

Aims and Research Questions

Research into STS and VT has predominantly employed surveys, measuring the degree or level of disrupted beliefs and/or trauma symptoms, in relation to indirect exposure to client trauma (Bride et al., 2007; Cunningham, 2003; Pearlman & Maclan, 1995; Schauben & Frazier, 1995). The present research focuses on the subjective interpretations of psychologists' own experiences of STS, rather than empirically measured STS ratings to capture the richness, nuance, and variability of participant experience. A lack of empirical evidence exists investigating psychologists' experiences of supervision and how supervision can be used to potentially mitigate the negative effects of STS. Accordingly, the present study explores the following research questions:

1. What are psychologists' experiences of secondary traumatic stress (STS)?
2. What are psychologists' experiences of using supervision to disclose and process STS?

Methodology

This study incorporated a social constructionist framework proposing that the social world is continually defined and transformed and challenges the idea of a single, fixed perception of the world (Bryman, 2012). The social constructionist position

assumes that knowledge about the reality of psychologists' experiences of STS is not objective, but subjective and socially constructed by those experiencing it (Schwandt, 2003). Here, knowledge is accessed by personal accounts and meanings that are influenced by social contexts and described through language (Braun & Clarke, 2013). In this way, knowledge and the realities of experiences of STS are constructed by the participants and the researcher throughout the research process. Using a qualitative approach enables an in-depth exploration of the nuances of participants' experiences and provides context to meanings and interpretations.

Researcher Reflexivity

Researcher reflexivity and disclosures about the researcher's identity are key for contextualising co-constructed meaning between researcher and participants (Clarke et al., 2015; Barker et al., 2016). Researcher reflexivity relates to the researcher's critical self-evaluation of how they situate themselves in the research process and the creation of knowledge (Bradbury-Jones, 2007).

I am an English, white male trainee clinical psychologist with an interest in psychological trauma. I have clinical experiences of working with traumatised clients and families and worked alongside colleagues who have been exposed to many trauma narratives. I have maintained awareness of my position throughout the analysis to manage my subjectivity in the research process. For example, regularly reviewing my reflections and preconceptions prior to and during the data collection phase ensured that I remained open to the varying experiences of participants to enable new themes to develop naturally. I have used NVIVO-12 (see Appendix G) to identify the frequency of

references to such themes as a means of ensuring that any personal biases do not compromise the authenticity of research findings.

Design

Individual semi-structured interviews were carried out to understand psychologists' experiences of STS. Due to COVID-19 restrictions, participants were given the choice of being interviewed via phone or Skype. Focus groups were considered, however, a one-to-one format was chosen given the sensitive and personal nature of the topic.

Procedure

Ethical Considerations.

Prior to commencing participant recruitment, ethical approval was granted by the University of Exeter Ethics Research Committee (Appendix A). A key ethical consideration concerned the potential emotional impact of study participation for interviewees. Participants were encouraged to safely share details of their experiences within the boundaries of what they were comfortable disclosing during interview. Breaks were offered if participants wished to pause the interview at any time. All participants were given the opportunity to debrief with the researcher following interview completion and contact information was provided for local counselling services via the participant debrief sheet (Appendix F).

Piloting of Interview Schedule.

Five psychologists in current clinical practice were consulted to support the development of an ethically sound interview schedule. The research aims were explained and ideas for questions were discussed. Questions were edited and revised,

which provided a flexible interview framework to elicit insight into participants' narratives and meanings (Appendix B).

Recruitment.

The study was advertised through a private online group on Facebook (Appendix C). The group is exclusive to members who are qualified psychologists or psychologists in training. Participants were required to be currently practising psychologists, in receipt of regular, formal clinical supervision and with experiences of STS. UK-based respondents were invited to contact the researcher to discuss the study and to read the participant information sheet (Appendix D). Participants needed to read and sign the study consent form (Appendix E) before interview.

Thirteen participants were interviewed (October-November 2020). Twelve of the 13 participants were female and one of the participants required a British Sign Language interpreter due to hearing difficulties. The interpreter was privately briefed about the study prior to the research interview to minimise the risk of translation issues during interview. The participant verbally communicated responses to me directly once study information and interview questions had been translated by the interpreter. Six interviews were conducted via phone, seven used Skype. Interviews lasted 76 minutes on average (max = 108 mins; min = 55 mins) and were audio recorded using a Dictaphone. Recordings were transcribed verbatim and anonymised using an online transcription service.

Data Analysis

To enable a rigorous and systematic approach to coding and theme development, thematic analysis was used to analyse the participant transcripts (Braun &

Clarke, 2006; Clarke et al., 2015). Thematic analysis is the process of identifying patterns or themes within qualitative data and is a method rather than a methodology (Braun & Clarke 2006; Clarke & Braun, 2013). This means that, unlike many qualitative methodologies, it is not tied to a particular epistemological or theoretical perspective and is, therefore, a very flexible method (Maguire & Delahunt, 2017). It should be noted, however, that TA can never be conducted in a theoretical vacuum (Braun & Clarke, 2020), with the present study adopting a social constructionist perspective for data analysis. According to Holloway and Todres (2003), TA should be viewed as a foundational method for qualitative analysis given the high complexity, diversity and nuance of qualitative approaches. TA provides core skills that are useful for conducting many other forms of qualitative analysis, with 'thematizing meanings' being one of several shared generic skills across qualitative analysis (Holloway and Todres, 2003). Considering this and following consultation with my research supervisors, TA was felt to be the most suitable method of data analysis for the present study.

Using Braun and Clarke's (2006) six-step process of TA (Table 1), data analysis adopted an inductive approach by using participants' narratives rather than existing theoretical concepts as the primary framework for analysis. Although emergent codes and themes were data driven, analysis was inevitably partly shaped by the researcher's prior experience, knowledge of the field and personal standpoints (Clarke et al., 2015). Theoretical labels and ideas were used by participants to describe their experiences and narratives; however, these were not intended to determine the framework for analysis (akin to deductive TA) (Clarke et al., 2015).

Table 1.

Steps for Thematic Analysis (Braun & Clarke, 2006)

Step	Description	Examples
1. Familiarisation with the data	Transcribing, reading, and re-reading data. Producing initial ideas.	
2. Generating initial codes	Systematically working through whole data sets to create initial codes and identify features of relevant data. Attended thematic analysis workshop with other qualitative researchers to share ideas and ensure process for generating initial codes adhered to Braun and Clarke's framework (2006).	*Sometimes I am very, very tired especially if it is something heavy, I'm tired and I have this cloudy mind or sometimes I have hearing problems.* – P7 Initially coded as *"clouded thinking from tiredness"* and then recoded as "*very tired especially if it is something heavy" a*nd "*cloudy mind or sometimes I have hearing problems"*

3.	Searching for themes	Sorting codes into potential overarching themes.	Validation of STS experiences was initially a theme and was recategorised as a feature of a more overarching theme "normalisation of STS as a response to trauma narratives" "*he just said some very reassuring, validating things*" – P.12 "*people were sharing similar sort of feelings of doubt, which helped, which was very validating*."– P.8
4.	Reviewing themes	Identifying if themes are appropriate and coherent with coded extracts. Codes and themes were reviewed by qualitative researcher and clinical psychologist (objective third parties) who noted that grouping of codes in themes were not self-explanatory, i.e., context	For example, participants discussed positive and negative aspects of supervisors and this was categorised as "supervisor attributes". However, this failed to adequately consider why these supervisor traits were significant in the context of disclosing and processing STS experiences. "*He was just extremely boundaried, which again, it can feel a bit colder."* – P2.

		was needed to provide clarity to meanings.	"*That's maybe reflected back or modelled by the supervisor as well that they also experience some of this stuff and they normalise it."* – P6
5.	Naming and defining themes	Refining selected themes and defining the story the analysis tells.	By referring to Braun and Clarke's notion of "identifying the essence of what each theme is about" (Braun & Clarke, 2006 p. 92) and consultation with research supervisors, "supervisor attributes" was renamed to "significance of supervisor attributes in understanding STS experiences".
6.	Producing the report	Final analysis of data extracts in line with the research questions and literature. Production and report of the analysis.	Consultation with research supervisors, peers and members of TA workshop group helped to prioritise the data to include and analyse in the final report. This ensured that data analysis continued to be in line with the original aims and research questions.

Once the interviews had been transcribed, NVIVO-12 software was used to code the transcripts (QSR, 2020). Audio recordings were listened to, to consider the emotional content and processes and the researcher's responses during interview. Reflexive notes made by the researcher during the interview process contributed towards the co-construction of themes. A systematic and iterative process of data coding was conducted to identify key themes relevant to the research questions. Codes were assessed and evaluated to inform key themes, until no additional codes or themes were generated.

According to Braun and Clarke, a theme "captures something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set…ideally there will be a number of instances of the theme across the data set, but more instances do not necessarily mean the theme itself is more crucial. As this is qualitative analysis, there is no hard-and-fast answer to the question of what proportion of your data set needs to display evidence of the theme for it to be considered a theme" (Braun & Clarke, 2006, p. 82).

Quality of Analysis.

Promoting credible, trustworthy, and authentic analysis was fundamental for ensuring good quality of data analysis (Nowell et al., 2017). In addition to engaging with several psychologists in the field of psychological trauma in the interview design phase, maintaining an open and curious standpoint during interview helped to establish rapport. Authenticity was ensured by representing the variety and idiosyncrasy of participants' experiences, whilst a reflective journal featuring thoughts and assumptions aided

researcher reflexivity. Sections of transcripts were discussed with and jointly coded by three independent researchers and the research supervisor. Figure 1 illustrates the steps that were carried out from conducting the research interviews to the organisation and reporting of themes in this report.

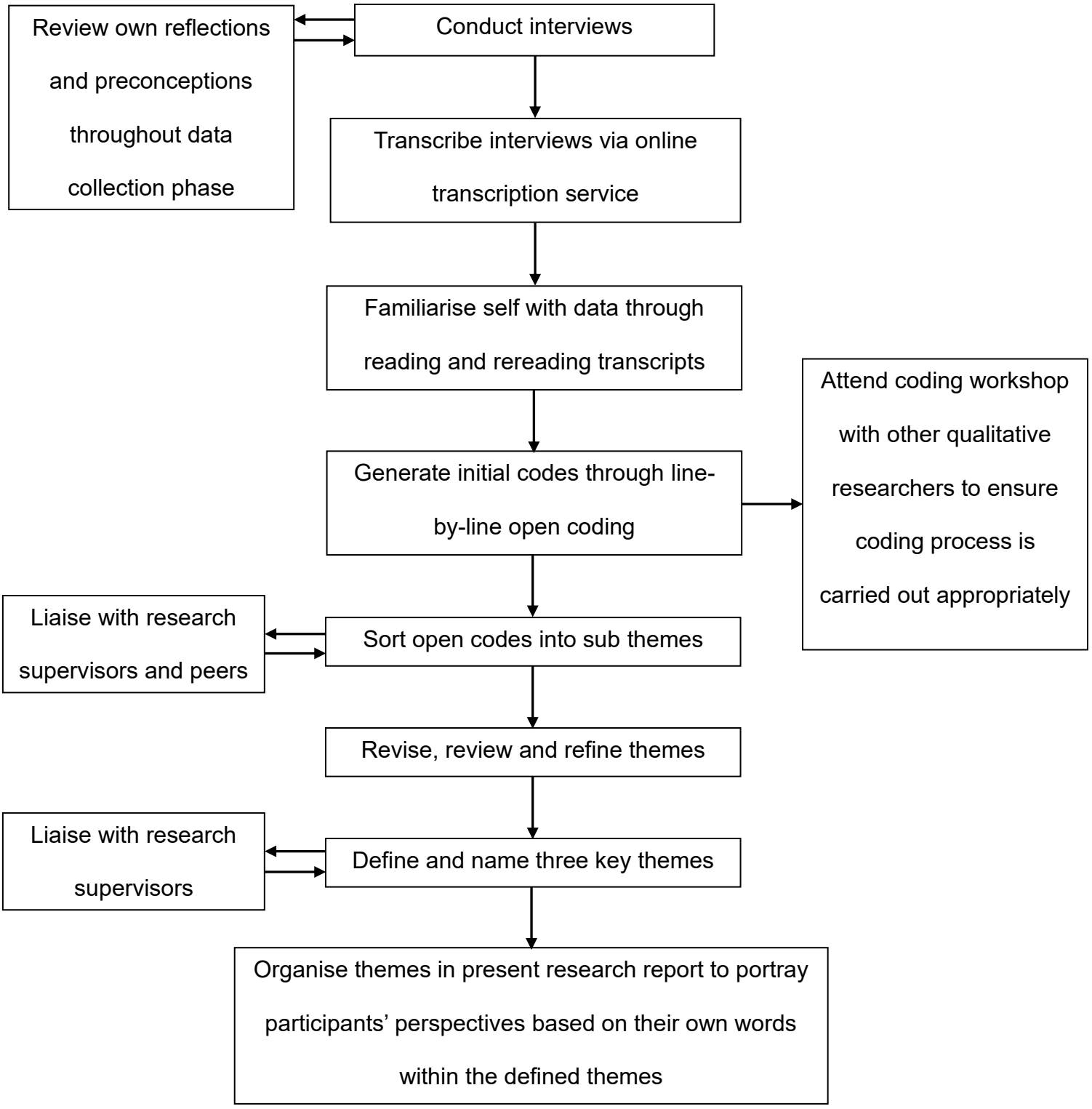

Figure 1. Data collection and analysis process.

Analysis

An overall summary of participants' experiences of STS is provided here to answer the research question 'What are psychologists' experiences of secondary traumatic stress (STS)?'. As participants were directly asked for their STS experiences, their responses cannot be defined as a theme, but will be included separately as it pertains to the aims of this research.

Table 2.

Participants' reported experiences of STS

STS experience	Description of experience
Intrusion	"Thinking and the rethinking, or maybe the dreaming…when I'm feeling a lot, I'm visualising it, and then I'll be replaying it" (2) "A couple of times, I've had intrusive thoughts…I may think about it or dream about it. Occasionally images pop into my mind." (3) "All my intrusive thoughts were always about the children who've been abused by their parents." (3) "I have experienced intrusive thoughts where I've had a session with the client, they've disposed quite horrific things and I haven't been able to get that off my head for much longer than it should." (4)

	“I just couldn't get the image out of my head. It just kept recurring, kept coming back, involuntarily.” (5)
Physiological arousal	“Increased heart rate and feelings of panic or anxiety, physical symptoms, and joint pain, tension” (2) “Sometimes when I have memories, I know I get some of the physiological arousal. I can feel myself getting hot” (3) “The hairs just stand up on the back of my arms. I suppose it's very weird. I'd get this kind of autonomic nervous-- I call it a womb-clench.” (3) “Feel like your heartbeat went faster or something like that. Just noticed that it has some reaction.” (9)
Avoidant responses	“I guess it made me feel a bit avoidant, maybe, of putting myself in that position of hearing those kinds of very graphic details again.” (5) “Definitely avoidance symptoms, which to an extent's still with me” (8)
Hypervigilance	“Hypervigilant, the whole increased heart rate, and can't stop thinking” (2) “Quite some vigilance” (5)

Other physical sensations	"I also started to have panic attacks in the mornings before going into work." (10) "Coming out of a session with him and immediately, within two minutes, having a migraine" (12) "Very, very tired especially if it is something heavy, I'm tired and I have this cloudy mind or sometimes I have hearing problems" (7) "I had quite a few gastrointestinal symptoms when I'm not normally that way inclined" (8) "Sometimes I feel sick over the session, and I know that this is not my sickness that is happening." (7)

Participants' accounts of their STS experiences were largely based on physical responses to exposure to trauma narratives, particularly intrusive thoughts and images, physiological arousal and avoidant behaviours. Some participants also shared experiences of being hypervigilant of their surroundings and with other loved ones, for example, looking out for their child's welfare having listened to patient accounts of child abuse. Interestingly, participants identified some adverse reactions e.g., nausea that were unique to STS, rather than a response to generic workplace stress or related to underlying health issues. This would suggest that being exposed to trauma narratives can evoke visceral reactions that may affect a psychologist's mental and physical well-being, which has clearly significant implications for their clinical practice and staff absenteeism. That said, some participants discussed positive responses they

experienced when working with traumatised clients, including feeling “inspired” by clients’ resilience, “moved” by the person’s story and “resonating with their joy and gratitude”. Whilst participants’ experiences of STS were largely viewed negatively and damaging of their health, some participants reflected on how they have benefited from such experiences and the positive influences that STS have had on their clinical practice.

Three key themes were generated from in-depth analysis of the data. Here, themes were conceptualised as meaningful stories about specific patterns of shared meaning across the dataset underpinned by a core concept (Braun & Clarke, 2020). Through a rigorous and continuous process of data immersion, themes were generated based on concepts that were not simply reflective of data collection questions. Instead, themes were derived from accounts volunteered by several participants, were directly related to the research questions that offered meaningful insight and were of clinical interest and importance. Researcher subjectivity was viewed as a resource, not a potential threat to the credibility of theme development (Gough & Madill, 2012). In this way, data analysis was not concerned with discovering the ‘truth’ that could be found in the dataset, rather, analysis represents the product of interpreting and creating meaning from participants’ stories through active and thoughtful reflection. Discussions took place between researcher and supervisors regarding theme names to best capture the conceptual meanings portrayed by participants. These themes will be described and illustrated using extracts from interviews.

Theme 1: Normalisation of STS as a response to trauma narratives.

Participants reflected on STS experiences, which they viewed as normal and a natural, human response to trauma narratives. Questioning of the construct of STS was made, and whether it provides a helpful understanding of the distress that can arise through indirect trauma exposure:

I think responses to stress should be normalised. I don't think I frame it as traumatic stress. (Participant 3)

And

It feels like I'm not abnormal and that it is a thing. (5)

Participants were invited to reflect on their experiences of STS and to suggest what they felt was important for others, including colleagues and supervisors, to know about STS. Participants emphasised the value of receiving validation of their difficult experiences from clinical supervisors with whom they have shared their accounts of STS. The power of being seen and heard was also discussed by participants, a process mirrored by that found in the therapist-client relationship:

That brief acknowledgement that, yes, this has been a tough piece of work. (6)

And

The acknowledgement of what you're experiencing is understandable and proportionate. (12)

Participants were asked if there was anything about their experiences of STS that they would like people to know. Some participants suggested that STS was not only normal, but to be expected amongst health professionals working in trauma. Maintaining an awareness of this fact was described as essential:

We need to be aware that it's going to happen. (7)

And

Probably most of (us) go through this as we develop as therapists. (8)

Participants outlined the value of talking about responses to trauma narratives and that such responses are not indicative of a failure to cope with distress, a recognition that can help to manage STS experiences:

It's like a normal reaction to that. It doesn't indicate that you're not coping or that you're not resilient. (4)

There was suggestion that being invited by supervisors to discuss the challenges linked to hearing traumatic material may have helpful in processing and overcoming them:

If it had just been a thing that was talked about and if any of my supervisors had asked, that would have been good. (11)

Indeed, sharing and discussing experiences of STS was seen as vital in the context of clinical practice:

I think it makes us better and more aware and more attuned therapists to be able to talk about it. (8)

That said, when asked about what it was like disclosing their experiences of STS to others, several participants described this as very difficult and akin to talking about a 'taboo' subject. Such discussions emphasised the importance participants placed on the need for STS to be normalised and spoken about in supervision:

Saying it out loud is really horrible, so it's really hard to share content. (4)

And

We never talked about being re-traumatised, it was more like taboo. (7)

Theme 2: Development of the therapeutic relationship to connect with trauma narratives.

The presence of transference and countertransference processes were concepts raised by participants, particularly when describing the nature of their STS experiences. These processes were often discussed within the therapy context, as well as the impact of such responses on clinical practice:

You're picking up on the transference and the countertransference in your feeling and thinking some of what they're feeling and thinking. (12)

Participants discussed the importance of developing a therapeutic relationship with clients to enable connection with their trauma narratives:

You are going to connect with these people, you're going to connect with the stories. (6)

And

If they feel understood or heard or seen… they feel relieved. (7)

As therapists, being transparent about one's own emotional responses to clients' stories was seen as a key facet of the therapeutic relationship.

I'm very transparent about what people tell me. (5)

And

It needs to be articulated, sometimes for them it's surprising that I can feel something like that. (7)

These reflections are indicative of the importance of self-awareness and reflexive capacity as a clinician. Clinical supervision often provided the platform to develop these

clinical skills and a reflective space to acknowledge and process emotional responses to clients' trauma narratives:

> *I use supervision a lot to reflect on this. There's points during therapy where I have to be careful not to let my own instincts of avoidance come into the room. (6)*

And

> *He's traumatising me…that's really difficult to acknowledge, but I had to. I've spent a lot of time in supervision talking to my supervisor. (12)*

Participants expressed an awareness of the roles that can be adopted within the therapeutic relationship, and how they may link to the personal experiences or tendencies of participants:

> *There was a lot of no one understands, you're the only one who understands me dynamic. (11)*

Similarly, the importance of recognising one's own triggers within their clinical practice and the countertransference that may subconsciously play out within the therapeutic context:

> *It's helpful to separate what's yours, what belongs to the patient, and better understand the patient. (7)*

And

> *It was a good thing to spot where countertransference or your own stuff could potentially cloud your understanding. (2)*

Theme 3: Significance of supervisor attributes in understanding STS experiences.

When discussing the role of clinical supervision in disclosing, processing, and reflecting on experiences of STS, a common discussion point was the traits and behaviours demonstrated supervisors. A prominent positive supervisor attribute was the ability to provide containment for participants:

My supervisor at that point was very good. He was very, for the most part, very containing. (12)

And

She was very containing about that, very non-judgemental and very constructive. (5)

Participants were asked what helped them to disclose their experiences of STS. They typically valued the incidents where supervisors disclosed their own challenges and experiences, a process of supervision that seemed to provide validation for participants' own difficult experiences of clinical practice:

That's maybe reflected back or modelled by the supervisor as well that they also experience some of this stuff and they normalise it. (6)

And

She was very open about her experience of doing trauma work, and some of the anxieties and worries and things that she'd had. (3)

Disclosing experiences of STS to supervisors without feeling that they were being judged for doing so was also important to participants:

Emotions were being spoken about and they felt like they were spoken in a non-judgemental way. (2)

And

She's my boss, but I don't think she's going to judge me. (3)

Participants described the supervisor responses they received following disclosures of STS and associated difficulties they were facing. Some participants expressed gratitude that their supervisor did not immediately adopt a problem-solving approach towards such disclosures:

She was just very good at sitting and reflecting and tolerating the difficult stuff. (12)

And

Able to offer empathy and sit with the distress and not jump in, but sit with the feelings I was bringing. (1)

Such responses highlight the value of empathy, and they support the idea that empathy helps to create and sustain social relationship. When asked whether they were in receipt of trauma-informed supervision, however, several participants expressed uncertainty regarding its definition:

Umm, I'm not entirely sure what that means…what do you mean exactly, trauma-informed? (1)

And

By trauma-informed, do you mean that they knew about trauma? (4)

Other participants demonstrated familiarity with the concept of trauma-informed supervision, such as describing the trust and empowerment that characterised their

supervision. The differences observed in participants' knowledge of what constitutes trauma-informed supervision were unexpected and noteworthy.

Supervisors' perceived level of knowledge and experience in the same field played a key role in how some participants reflected on sharing their experiences of STS:

My supervisor was very, very experienced. He was very good. (12)

And

There's something very, very helpful about having a very knowledgeable supervisor with a lot of experience. (6)

In contrast, several participants noted negative behaviours or traits of the supervisor which prevented them from having their experiences validated or normalised. Some participants suggested that their supervisor was dealing with their own difficult experiences which left participants feeling uncontained or unseen:

Supervisor was pretty useless…he was going through his own stuff so he wasn't the most containing. (11)

And

Our supervisor, I think, she was having quite a lot of things going on outside of work and wasn't really there as well. (9)

A lack of interpersonal warmth from supervisors was also cited by participants as an obstacle for opening up about STS responses in supervision:

She couldn't show warmth, which I now know was due to her own insecurities and labours. (8)

And

He was just extremely boundaried, which again, it can feel a bit colder. (2)

Accounts were found in interview that indicated a lack of validation and feeling dismissed by supervisors when divulging details of STS, which affected participants' trust in their supervisor to support them:

"Please, don't tell me, I don't want to know," yet they're in positions of trust like supervisors. (5)

And

My heart dropping in that judgment having been made about me so quickly, "You're just not cut out for this." (12)

Discussion

This study aimed to address a gap in the literature, investigating how psychologists experience STS and the role of clinical supervision to disclose and process STS experiences. Participants typically viewed STS as a normal set of emotional and physiological responses to client trauma narratives. According to Pearlman and Saakvitne (1995), recognising and accepting that vicarious exposure to trauma narratives is a normal part of doing trauma work is vital. If a trauma therapist is embarrassed, ashamed, or in denial of painful feelings that emerge when hearing clients' stories, they are not likely to take measures that can reduce the stress or pain (Pearlman & Saakvitne, 1995). Participants perceived these reactions as a complex, yet normal or expectable feature of working with trauma. Normalisation of STS as a response to trauma accounts was seen as important, with participants querying whether STS as currently defined is a useful descriptor of affective distress that is typically experienced in this field. Development of the therapeutic relationship to connect with

trauma narratives was commonly discussed by participants, often citing the role that countertransference reactions play in this therapeutic process. To facilitate this connection, participants referred to the importance of therapist reflexivity and self-awareness of one's own experiences that could interfere with the maintenance of the therapeutic relationship.

When using supervision to disclose and process STS, participants valued supervision experiences of supervisors demonstrating understanding, validation, and empathy for their secondary traumatic responses. This supports literature that suggests empathy is key for effective clinical practice and positive therapeutic outcomes (Elliott et al., 2011; Gibbons, 2011; Neumann et al., 2009). Participants described generally positive examples of sharing troubling experiences with their supervisors, especially when supervisors demonstrated active listening and the ability to sit with supervisees' distress. Bion's (1962) theory of container and contained provides useful understanding of how the supervisee makes unconscious use of the supervisor and how the latter can help. According to Bion, supervisees will sometimes expel challenging and unprocessed parts of their experience into their supervisor. Such experiences may occur through working with trauma survivors who divulge details of their trauma that can be difficult for the therapist to hear. When the supervisor can respond sensitively and digest these elements of the supervisee experience, they will be able to re-present them to the supervisee in a manageable form. Problems may arise, however, when the elements being expelled are particularly toxic, or when the supervisor has personal experiences which are interfering with this process (Bion, 1962).

The importance participants placed on receiving empathy and validation was emphasised by those reporting supervision experiences whereby supervisors were emotionally unavailable or dismissing of their experiences. A degree of self-disclosure from the supervisor was also valued, helping participants to feel that their affective responses to secondary trauma were not unusual or indicative of a failure to cope. That said, debates exist regarding the necessity for empathy and detachment in psychoanalytic literature. Freud (1922) posited that the therapist cannot rely on the client's direct responses and engagement with the therapeutic process as they are unconsciously re-enacting early childhood themes in the transference relationship. Freud suggested that the therapist must attempt to feel, understand, and even maintain clients' subjective experiences, but to also represent them in a clinically accurate and objective way where the therapist's empathic involvement becomes limited (Kaluzeviciute, 2020). As such, Freud viewed empathy as simultaneously the drive and the challenge of psychoanalytic practice (Freud, 1912). Considering the value of clinical objectivity as discussed in psychoanalytic literature, it is noteworthy that empathy was perceived by participants as an exclusively desirable behaviour in both therapist and supervisor roles.

Trauma-Informed Supervision

Frawley-O'Dea and Sarnat (2001) describe supervision as relational and involving the parallel process of the supervisee's interaction with the supervisor mirroring the client's behaviour towards the therapist. Recent literature has recommended that the parallel principles that guide trauma-informed practice (trustworthiness, safety, choice, empowerment, and collaboration) should be exercised

in supervision for trauma-informed practice (Berger & Quiros, 2014). To create an environment in which effective trauma-informed supervision can take place, therapists must not only be safe but feel safe, and feel empowered and trusted. Reference was made by participants to the value of these core principles, including trust and safety that was facilitated by supervisors that were seen as containing and empowering.

Some participants reported receiving trauma-informed supervision, for example, they shared feelings of safety and trust including supervisors regularly checking the personal impact of the work on supervisees and ensuring the environment felt safe and containing. These participants reported the benefits of these features of supervision for helping to process their STS experiences. This was evident among several participants who reported how trauma-informed supervision helps to process the trauma narratives of clients to understand and contextualise their stories. This process was viewed as reflexive and collaborative with the supervisor to help sit with distress and to consider how to best support the client.

Other participants expressed unfamiliarity with its conceptual definition and were unsure whether the supervision they received was trauma-informed. Drawing links between participants' experiences of STS and the role that trauma-informed supervision can play in supporting psychologists with STS symptoms is, therefore, problematic. Specifically, it is unknown whether trauma-informed supervision can help cope with or even prevent the negative effects of STS. This uncertainty is consistent with the relative lack of available literature for supervisors to guide them in providing knowledgeable supervision to those directly and indirectly engaged with trauma work (Knight, 2018).

Clear challenges exist regarding the ongoing need for mental health professionals (including supervisors) to be educated about the nature and principles of trauma-informed care and practice. Appropriate training is needed to ensure that supervisors are equipped with suitable tools to provide and monitor trauma-informed supervision characterised by safety, trust, choice, collaboration, and empowerment (Berger & Quiros, 2014). Service demands and capacity also require attention, specifically, the common issues regarding the duration and frequency of supervision. The depth with which individual client cases can be discussed may be compromised given that infrequent, e.g., monthly supervision sessions, will typically involve discussion of multiple clients. In this way, supervision may involve more patient-centred content (Smith, 2009) to ensure necessary and appropriate management of clients displaying the most significant risk issues, for instance, at the relative cost to discussion of the supervisee's own psychological processes and reactions to client content.

Countertransference

The findings regarding the role of countertransference reactions support previous work in this area. Defence mechanisms to counterbalance effects of the reactions, including avoidance and affective disconnection by some supervisors towards emotional aspects of trauma narratives, were evident in this study and are reportedly experienced by many who practice in trauma (Cavanagh et al., 2015).

Parallel processes may take place in the supervisory relationship where empathic responses towards supervisees and their traumatic stories may be disrupted by these countertransference responses exhibited by supervisors. This may lead to empathic strain and ruptures in the supervisory relationship. Empathy refers to "the

capacity to understand and enter into another person's feelings and emotions or to experience something from the other person's point of view" (Colman, 2009, p. 248). Considering the importance participants placed on the validation and normalisation they received from supervisors, acknowledging and normalising countertransference responses from supervisors could help to sustain an empathic supervisory relationship. According to Freud (1912), a paradoxical balance needs to be struck whereby a substantial detachment from the client (supervisee) is required to be able to observe and interpret their unconscious, subjective experiences. Perhaps then, a degree of candor between supervisee and supervisor is needed to ensure that both parties are aware of this subjectivity/objectivity paradox. This could support the maintenance of a safe and trusting environment for supervision to take place – cornerstones of trauma-informed supervision.

Post-Traumatic Growth

Participant acknowledgment of the positive aspects of working with trauma survivors, including becoming more attuned as therapists, was a feature of the findings and relates to the concept of 'post-traumatic growth' (PTG) (Tedeschi et al., 2007). Greater levels of STS have been linked to greater PTG in therapists (O'Sullivan & Whelan, 2011; Putterman, 2005). This indicates that indirect trauma exposure may drive therapists to search for and subsequently find positives from their work. Indeed, participants in this study reflected on their clinical practice, including learning how to cope with affective distress, and developing their awareness of and being able to communicate their emotional responses to traumatic material.

Strengths

This study provides original insight into the value of having a dedicated space to reflect upon and make sense of experiences that can be challenging and impactful on one's professional and personal life. For instance, some participants reported how being invited to talk about their experiences was interesting and helpful for making sense of them. The interview represented a meaningful opportunity to discuss participants' stories, with many stating that this was their first invitation to explore and dissect their STS experiences. Several participants discussed the value of raising awareness of this phenomenon in clinical settings as a vehicle for implementing protective measures for psychologists supporting traumatised individuals. Previous literature typically focusses on the nature of participant experience related to the researched phenomenon e.g., VT but lacks discussion of the interview experience itself from researcher and participant perspectives. This study contributes novel understanding that extends beyond the content of people's STS experiences and emphasises the benefit of participating in a reflexive discussion to process and understand one's own experience.

This research highlights the usefulness of the interview schedule used for psychologists to reflect on their experiences of STS. This type of tool could be used in clinical supervision settings to initiate discussions of STS in a sensitive and person-centred manner. This could be of real benefit in recognising and understanding STS experiences and supporting the wellbeing of those who are vicariously exposed to trauma in their clinical practice. In line with principles of trauma-informed supervision (Berger & Quiros, 2014), this process is likely to rely on supervisees feeling a sense of

trust and safety in the supervisory relationship. Given the value participants placed on the interview questions used to facilitate discussion of their STS experiences, this represents a key recommendation from this research.

Limitations

Several participants expressed uncertainty regarding the term 'trauma-informed supervision'. Although the trauma-informed principles of supervision as outlined by Berger and Quiros (2014) were explained to those participants in doubt, knowledge of these principles was assumed in participants who did not ask for clarification. In hindsight, participants could have been provided with information explaining what constitutes trauma-informed supervision, in a similar way to how the concept of STS was defined explicitly towards the start of every interview. The importance placed on trauma-informed supervision being made accessible to trauma workers has been cited as key for providing a trauma-informed system of care (Berger & Quiros, 2014; Harris & Fallot, 2001). Without explicitly outlining the principles of trauma-informed supervision during interview, uncertainty exists regarding whether those participants unsure of its definition did receive trauma-informed supervision when working with trauma survivors.

The findings presented here could arguably be more generally expected of many psychologists working therapeutically. For example, the importance of receiving normalising and validating supervisor reactions in response to disclosing experiences of distress and maintaining an awareness of one's own beliefs, histories, biases etc. could be argued to be important when working with any client, not just with trauma survivors. However, there are critical differences in the level of secondary trauma exposure according to the nature of psychological assessment or intervention. For instance, the

affective demands for psychologists performing stabilisation work primarily based on empowering clients to practise grounding and distress tolerance techniques are likely to differ from those associated with carrying out psychological interventions more directly linked to the client's traumatic memories, such as EMDR (Eye Movement Desensitisation and Reprocessing) therapy or trauma-focussed CBT.

The lack of clarity regarding causal factors for participants' STS experiences could reflect the uncertainty regarding the terminology used to describe indirect trauma exposure (Sabin-Farrell & Turpin, 2003). It is possible that if STS does exist, it may not be restricted to those who specialise in trauma work. Siegel (1999) posits that everybody has a range of physiological arousal that enables them to function effectively. It is vital, therefore, for psychologists to be in tune with their own windows of stress tolerance when exposed to potentially emotion-charged trauma narratives. One of the crucial factors distinguishing STS from general work stress are the reported intrusive trauma symptoms (Sabin-Farrell & Turpin, 2003), which were described by most participants in this study. This, along with the reflections of participants, raises the question of whether the construct of STS, as currently defined, is a useful conceptualisation of the experiences one may face when vicariously exposed to trauma, or an unhelpful pathological descriptor of normal distress.

Implications

Future Research.

The present study highlights the need to conduct further research into the role of the type and amount of secondary trauma exposure and personal trauma histories in experiencing STS. Although participants were invited to share their experiences of STS

and their reflections of supervision in the context of such experiences, they were not asked about the traumatic material they had been exposed to. It is unclear, therefore, whether there is a relationship between the nature of STS symptoms (e.g., intensity, duration, frequency) and the type of trauma experienced. For instance, is a trauma where a client has been deliberately harmed by another person more likely to lead to STS than a natural disaster or accident? Further research could invite participants to explore the origins of their STS experiences more explicitly, as it cannot be inferred from this study whether factors such as therapeutic specialities or career stage significantly influence psychologists' responses to secondary trauma.

Other risk factors, including the personal trauma histories of participants and the level of indirect exposure to traumatic material, are difficult to measure but are important when examining coping strategies for STS. The ethical issues of exploring this, however, would require significant consideration. Further research to clarify the significance of these risk factors will enable clarity on whether we should pathologise or normalise secondary responses to trauma.

Implications for Supervision Practices.

Supervisors are often required to serve as a consultant, teacher, counsellor, and evaluator to supervisees in addition to being an evaluator of their work (Knight, 2018). It is possible, therefore, that the need to adopt a 'quality control' role may inhibit supervisors' ability to sit with and validate the difficult emotions brought by supervisees in relation to STS. Similarly, supervisees' ability and willingness to openly discuss difficulties in their work may be compromised. Recent literature has suggested the potential benefits of separating the clinical function of supervision from the evaluative

function and competence assessment (Mehr et al., 2015). The BPS (2012) recommends that managerial supervision is carried out by the line manager whilst clinical supervision is provided by someone with expertise within the model of working. The pragmatic issues of separating line management from clinical supervision, including staff capacity, require consideration. Transparent guidelines agreed upon between supervisee and supervisor would help to ensure appropriate separation of these elements of supervision in the event that staff availability is limited.

Conclusion

This study explored how psychologists experience STS and the use of clinical supervision to disclose and reflect on such experiences. Three key themes were developed from participant data. Firstly, STS was typically viewed as a natural set of responses to indirect trauma exposure that should be normalised and validated by clinical supervisors. Secondly, the development of the therapeutic process involving self-awareness of one's responses and recognition of countertransference processes was key. Thirdly, the traits and actions of supervisors, including the presence or absence of warmth, validation, containment, and self-disclosure were seen as vital in participants' ability to share their STS experiences and to feel trust and safety in the supervisory relationship.

The research interview schedule provided a valued tool for disclosure and reflection of participants' experiences of STS and supervision, which could be utilised as a meaningful tool in clinical practice for assessing STS experiences and wellbeing in psychologists and other HCPs. This practice could reduce the perceived stigmatisation

that some participants suggested was associated with talking about difficult emotional responses to vicarious exposure to client trauma.

The value participants attributed to the normalisation of STS responses is a key finding of this study and questions how STS is defined in research. Whether the present conceptualisation of STS helps to make sense of the experiences one may face when vicariously exposed to trauma, or poses an unhelpful pathological descriptor of normal distress, is debatable and represents an avenue for further investigation.

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Appendix A: Ethical Approval

Dear Edward Copestake,

Application ID:	**eCLESPsy001480 v6.1**
Title:	**How do psychologists manage secondary traumatic stress in their clinical practice?**

Your e-Ethics application has been reviewed by the CLES Psychology Ethics Committee.

The outcome of the decision is: **Favourable**

Potential Outcomes

Favourable:	The application has been granted ethical approval by the Committee. The application will be flagged as Closed in the system. To view it again, please select the tick box: View completed
Favourable, with conditions:	The application has been granted ethical approval by the Committee **conditional** on certain conditions being met, as detailed below. Unless stated otherwise, **please resubmit the requested amendments** via the online system before beginning the research.

Provisional:	You have **not** been granted ethical approval. The application needs to be amended in light of the Committee's comments and re-submitted for Ethical review.
Unfavourable:	You have **not** been granted ethical approval. The application has been **rejected** by the Committee. The application needs to be amended in light of the Committee's comments and resubmitted / or you need to complete a new application.

Please view your application here and respond to comments as required. You can download your outcome letter by clicking on the 'PDF' button on your eEthics Dashboard.

If you have any queries please contact the CLES Psychology Ethics Chair:

Nick Moberly n.j.moberly@exeter.ac.uk

Kind regards,

CLES Psychology Ethics

Appendix B: Interview Schedule

Intro:

"We're interested in learning about psychologists' experiences of secondary traumatic stress and supervision within clinical practice. Your responses will inform how secondary traumatic stress is experienced and the factors that may mitigate its negative effects. I anticipate this interview to last up to 1 hour approximately, but I am happy to take breaks during the interview if you would like. You can ask me to pause the interview at any time, at which point I will pause the Dictaphone. From reading the participant information sheet and consent form, did you have any questions? (answer questions). Let's begin."

1. Can you tell me what working with traumatised clients is like for you?

Prompts - *Have there been times when it has felt more challenging than at other times? In what ways? What factors do you think made this more challenging?*

NATURE OF STS

2. Secondary Traumatic Stress has been defined as the "natural behaviors and emotions resulting from knowing about a traumatizing event experienced by a client and the stress resulting from helping or wanting to help the traumatized or suffering person". Would you say that you have ever had symptoms of secondary traumatic stress? What were your experiences?

3. What did it feel like to experience this?

4. What felt different here to when you felt stressed or burnt out at other times in your life?

5. In hindsight, what did you notice that was happening in the client relationship you had?

IMPACT OF STS

6. Do you think STS impacted your clinical practice and if so, what impact did it have? (e.g. therapy with clients, work with colleagues/supervisors)

7. Do you think it impacted your personal life and if so, what impact did it have?

MANAGING STS

8. What, if anything, has helped you to manage the difficult experiences you've talked about?

9. What, if anything, has made it harder to cope with the difficult experiences you have talked about?

SUPERVISION

10. What type of supervision did you receive during this time (e.g. 1:1 with senior staff member, peer supervision with other MH professionals)?

11. Were you able to discuss your experience of STS in supervision?

YES: - What enabled you to share your experiences in supervision? What was it like?

NO: What made it difficult to discuss your experience of STS in supervision?

12. Would you describe the supervision you received as trauma-informed? In what ways?
13. Specifically, what has been effective about supervision you've received?
14. What has been less effective about supervision you've received?

REFLECTIONS

15. Do you have any thoughts about how supervision could/should look to mitigate the effects of STS?
16. Upon reflection, have your experiences of STS had any positive impact on you?
17. Is there anything about your experiences of STS that you would like people to know, or that I have missed that feels important to you?

Appendix C: Study Advertisement

Hello everyone!

I am a trainee clinical psychologist seeking participants for a study that examines psychologists' experiences of Secondary Traumatic Stress (STS).

What is STS?

STS refers to the observation that people who come into continued, close contact with trauma survivors may also experience emotional distress and become indirect victims of trauma. STS is the stress resulting from supporting a traumatised or suffering person (Figley, 1995).

This study is being conducted as part of a Doctorate of Clinical Psychology at the University of Exeter.

Am I eligible?

To be eligible for participation you must be a qualified psychologist who is currently in clinical practice and receiving regular, formal, clinical supervision. If you are not eligible for this study but you know someone who might be, please share this with them!

What does taking part involve?

Taking part involves participating in a 1:1 interview with me (via Skype or phone) and will last approximately 60 minutes. Together, we will explore what your experiences of STS have been, reflect how they have impacted you and if you have found anything

helpful for managing them. You will also be invited to talk about your experiences of supervision in the context of experiencing STS.

What are the benefits of taking part?

With your help, this research will inform how STS is experienced in a psychologist population and, crucially, what can be done to mitigate the negative effects of STS working in a profession that is emotionally demanding.

If you are interested in taking part, please contact me via Messenger or by email at ec601@exeter.ac.uk. I look forward to hearing from you!

Appendix D: Participant Information Sheet

Participant Information Sheet

Title of Project: How do psychologists manage secondary traumatic stress (STS) in their clinical practice?

Researcher name: Edward Copestake, Janet Smithson, Alicia Smith

Invitation and brief summary:

We are inviting you to take part in this research project but before you decide whether to participate, it is important for you to understand what participation will involve and why this research is being conducted. Please take time to consider the information carefully and to discuss it with family or friends if you wish, or to ask the researcher questions.

Purpose of the research:

Research suggests that empathy for traumatised patients can leave psychologists affectively vulnerable. This vulnerability may lead psychologists to experience symptoms akin to those of their trauma survivor clients. We are looking to explore participants' past and/or present experiences of Secondary Traumatic Stress (STS) and the role of clinical supervision in mitigating the effects of STS. This research project

aims to identify strategies that health professionals can utilise to help cope with the negative impact of STS in their clinical practice.

Why have I been approached?

You have been invited to take part in this study because you have been identified as a currently employed psychologist who receives individual, formal, clinical supervision and has past and/or present experiences of STS.

What would taking part involve?

Your participation in this study is entirely voluntary. If you choose to take part, you will be contacted via email to ask whether you would like to be interviewed via Skype. You will be given the choice whether you would like the video link turned on or off during interview. If connectivity issues are likely then we can carry out the interview via telephone, where you will let me know the best number to contact you on. Please see attached 'Additional Information- Skype/Telephone interviews' for further guidance.

The one-off interview will last approximately 60 minutes, where you will be asked about your experiences of STS and clinical supervision. You will have the opportunity to avoid discussion of any given topic at your request. The interview will be audio-recorded and then transcribed for the purposes of analysis. However, your name and identifying details will be omitted and will not be included in the report completed by the researcher. The study is being conducted in partnership with the University of Exeter. All data will remain anonymous and no identifiable information (e.g. your name) will be included in

the report. A copy of the report will also be submitted by the researcher, Edward Copestake (Trainee Clinical Psychologist), to the University of Exeter as part of a doctorate in clinical psychology.

What are the possible benefits of taking part?

There are no direct benefits to you for taking part, although you will have the opportunity to receive a summary of the findings following study completion. You may benefit from the experience of sharing your reflections about the experiences you have had and the knowledge that you have contributed to research that will increase our understanding of STS and how to cope with its negative effects.

What are the possible disadvantages and risks of taking part?

In order to take part in this study, you will have to give up some of your time to be interviewed. The researcher will endeavour to make you feel comfortable, supported and relaxed. However, it is possible that some of the discussion may make you emotional, since it invites you to consider your experiences of STS that may have been difficult for you. You can take a break from the interview if you want to, or you can talk to the researcher after the interview. If you wish, you can also talk to:

- Your GP
- Janet Smithson (Project Supervisor)
- A telephone support service, such as The Samaritans (116 123)
- If relevant, you can contact your mental health team.

If the researcher becomes concerned about your safety or that of someone else, they may need to contact an outside agency in order to ensure that you are provided with the support you need to keep you safe.

What will happen if I don't want to carry on with the study?

If you decide that you do not want to continue with the study, you can withdraw at any time without having to give a reason. You can ask to withdraw at any point during the interviewing process and up to 7 days after you have been interviewed, and your data can be destroyed. After 7 days, the information that you have provided will have already been anonymised with no link to individual participants. There will be no information identifying you as a participant that will be included in the write-up of the study.

How will my information be kept confidential?

The University of Exeter processes personal data for the purposes of carrying out research in the public interest. The University will endeavour to be transparent about its processing of your personal data and this information sheet should provide a clear explanation of this. If you do have any queries about the University's processing of your personal data that cannot be resolved by the research team, further information may be obtained from the University's Data Protection Officer by emailing dataprotection@exeter.ac.uk or at www.exeter.ac.uk/dataprotection

Your participation in this study and any personal information you provide will be kept anonymous and confidential. Personal information, including consent forms, will be

accessible only to the researcher, and will be stored safely in a locked filing cabinet at the home of the researcher. Such information will be destroyed by the end of the research (approximately September 2021). Any audio recordings collected will be transcribed and then erased within 28 days of interview completion. These anonymised data will be stored in a password-protected database in the United Kingdom for 5 years following collection, after which they will be destroyed. Some of the anonymised data may be shared with the other researchers to support data analysis by identifying themes and implications of the data.

Your responses during the interview will be associated with a unique number, but not your name. This means that your participation and your discussions will be kept confidential at all times. Confidentiality might need to be broken if you disclose a risk to yourself or others, but we will let you know if this needs to happen.

Will I receive any payment for taking part?

Unfortunately, you will receive no payment for taking part in this study.

What will happen to the results of this study?

The results of this study will be written up and submitted to the University of Exeter as a Clinical Psychology Doctoral Thesis. We intend to disseminate the results of this research study by publishing in academic journals, presenting the findings at conferences and meetings, as well as deposit the anonymised data in a password-protected archive. Quotations from the interviews may be used in written reports but

identifying information will be removed. If you are interested in receiving a summary of the results of the study, please provide us with an email address and we will endeavour to contact you once the project is finalised.

Who is organising and funding this study?

This study is funded by The University of Exeter as part of the Clinical Psychology Doctorate programme.

Who has reviewed this study?

This project has been reviewed by the Psychology Research Ethics Committee at the University of Exeter.

Further information and contact details

If you have any further questions, please feel free to contact us.

Edward Copestake

Trainee Clinical Psychologist

(ec601@exeter.ac.uk)

Janet Smithson

Project Supervisor

(j.smithson@exeter.ac.uk)

Gail Seymour

Research Ethics and Governance Manager

(g.m.seymour@exeter.ac.uk, 01392 726621)

Nick Moberly

Chair of Psychology Ethics

(n.j.moberly@exeter.ac.uk)

Thank you for your interest in this project.

Appendix E: Participant Consent Form

Participant Identification Number:

CONSENT FORM

Title of Project: How do psychologists manage secondary traumatic stress (STS) in their clinical practice?

Name of Researcher: Edward Copestake, Janet Smithson, Alicia Smith

Please read the following statements and initial in the boxes at the end of each statement.

Please initial box

I confirm that I have read the information sheet dated 1st June 2020 for the above project. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without my legal rights being affected. ☐

I understand that relevant sections of the data collected during the study may be looked at by members of the research team where it is relevant to my taking part in this research. ☐

I give permission for the researchers to have access to any information I provide. ☐

I understand taking part in this study involves answering interview questions that will be audio-recorded, which will be used for the purposes of reports and publications in academic
journals. This data will be archived for 5 years, then destroyed. ☐

I understand that I will be asked about my mental health and I consent to the researchers
breaking confidentiality if I indicate I am currently at risk of harm from myself or others. ☐

I agree that my contact details can be kept securely ☐

☐

I agree to take part in the above project.

If you would like to receive a summary of the findings once the study is completed (in approximately September 2021), please provide us with an email address:

_____

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of researcher taking consent	Date	Signature

Appendix F: Participant Debrief Sheet

Participant Debrief Sheet

Thank you for taking part in the study.

We hope you have enjoyed the interview experience. This study aims to explore participants' past and/or present experiences of Secondary Traumatic Stress (STS) and the role of clinical supervision in mitigating against the effects of STS. It is hoped that strategies to help cope with the negative impact of STS in clinical practice will emerge from this research. Your responses will be invaluable to help achieve these research aims.

If you decide that you wish to discontinue from the study, you can withdraw up to 7 days after you have been interviewed without having to give a reason, and your data can be destroyed. After 7 days, the information that you have provided will have already been anonymised with no link to individual participants. There will be no information identifying you as a participant that will be included in the write-up of the study.

Should you have any further questions about the study, please feel free to contact us.

Edward Copestake

Trainee Clinical Psychologist

(ec601@exeter.ac.uk)

Janet Smithson

Project Supervisor

(j.smithson@exeter.ac.uk)

Gail Seymour

Research Ethics and Governance Manager

(g.m.seymour@exeter.ac.uk, 01392 726621)

Nick Moberly

Chair of Psychology Ethics

(n.j.moberly@exeter.ac.uk)

If you experience discomfort or distress because of this study, you can contact the following for further support:

Your GP

If you have been experiencing low mood most of the day for several days or weeks, you should consider consulting your GP, who can provide professional guidance and help.

EXETER SAMARITANS

Samaritans provides confidential emotional support, 24 hours a day for people who are experiencing feelings of distress or despair. Samaritans are there if you're worried about something, feel upset or confused, or you just want to talk to someone.

10 Richmond Road

Exeter

Devon EX4 4JA (open every day from 10:30-21:30)

24 hour telephone helpline: 01392 411711 (Exeter branch) / 116123 (free)

Email: jo@samaritans.org

Website: http://www.samaritans.org/branches/samaritans-exeter-mid-east-devon

https://www.nhs.uk/conditions/stress-anxiety-depression/

For information, help, and support for people who are depressed please visit **Mind** at https://www.mind.org.uk/

If you would like more information on general mental health support, please visit **SANE** at http://www.sane.org.uk/

For information on what you can do to help cope with mental health and useful information on mental health treatment from a UK perspective visit **Royal College of Psychiatrists** at https://www.rcpsych.ac.uk/

To find the nearest cognitive behavioural therapists to where you live visit **British Association of Behavioural and Cognitive Psychotherapy (BABCP)** at https://www.babcp.com/Default.aspx

Healthline provides a very comprehensive overview of bipolar disorder as a critical starting point for individuals and/or their loved ones. For more information visit https://www.healthline.com/

Young minds provide mental health support for young people and parents. Please go to https://youngminds.org.uk/

Rethink is a national mental health charity: information, services & a strong voice for everyone affected by mental illness - challenging attitudes and changing lives. For more about them visit https://www.rethink.org/

Outlined below is a list of resources specifically regarding COVID-19:

Government Advice

NHS website: https://www.nhs.uk/conditions/coronavirus-covid-19/

Government website: https://www.gov.uk/government/topical-events/coronavirus-covid-19-uk-government-response

General Tips and Resources for Mental Health and Covid-19

Mind – Coronavirus and Your Wellbeing: https://www.mind.org.uk/information-support/coronavirus-and-your-wellbeing/

BBC News – Coronavirus: How to protect your mental health: https://www.bbc.co.uk/news/health-51873799

General CBT based self-help: https://www.getselfhelp.co.uk/

World Health Organisation – Mental health considerations: https://www.who.int/docs/default-source/coronaviruse/mental-health-considerations.pdf

FACE COVID - How to respond effectively to the Corona crisis - by Russ Harris

FACE COVID - How to respond effective

Disorder Specific Resources

Anxiety (including health anxiety):

https://www.anxietyuk.org.uk/blog/health-and-other-forms-of-anxiety-and-coronavirus/

https://www.anxietyuk.org.uk/blog/covid-19-and-anxiety-part2/

OCD:

https://www.ocduk.org/ocd-and-coronavirus-top-tips/

Managing Uncertainty and Worry

Uncertainty: https://www.getselfhelp.co.uk/apple2.htm

Worry: https://www.getselfhelp.co.uk/gad.htm

CBT resources

https://cedar.exeter.ac.uk/iapt/iaptinterventions/

https://www.somersettalkingtherapies.nhs.uk/resources-links/self-help-guides/

Managing Isolation

General tips: https://www.theguardian.com/world/2020/mar/17/pause-reflect-and-stay-home-how-to-look-after-yourself-and-others-in-self-isolation

For older people:

https://www.campaigntoendloneliness.org/blog/what-will-coronavirus-mean-for-older-people/

https://www.thesilverline.org.uk/

Domestic Violence

https://www.womensaid.org.uk/womens-aid-comments-on-the-impact-of-coronavirus-on-women-and-children-escaping-domestic-abuse/

Financial Concerns

Government support: https://www.gov.uk/government/news/coronavirus-support-for-employees-benefit-claimants-and-businesses

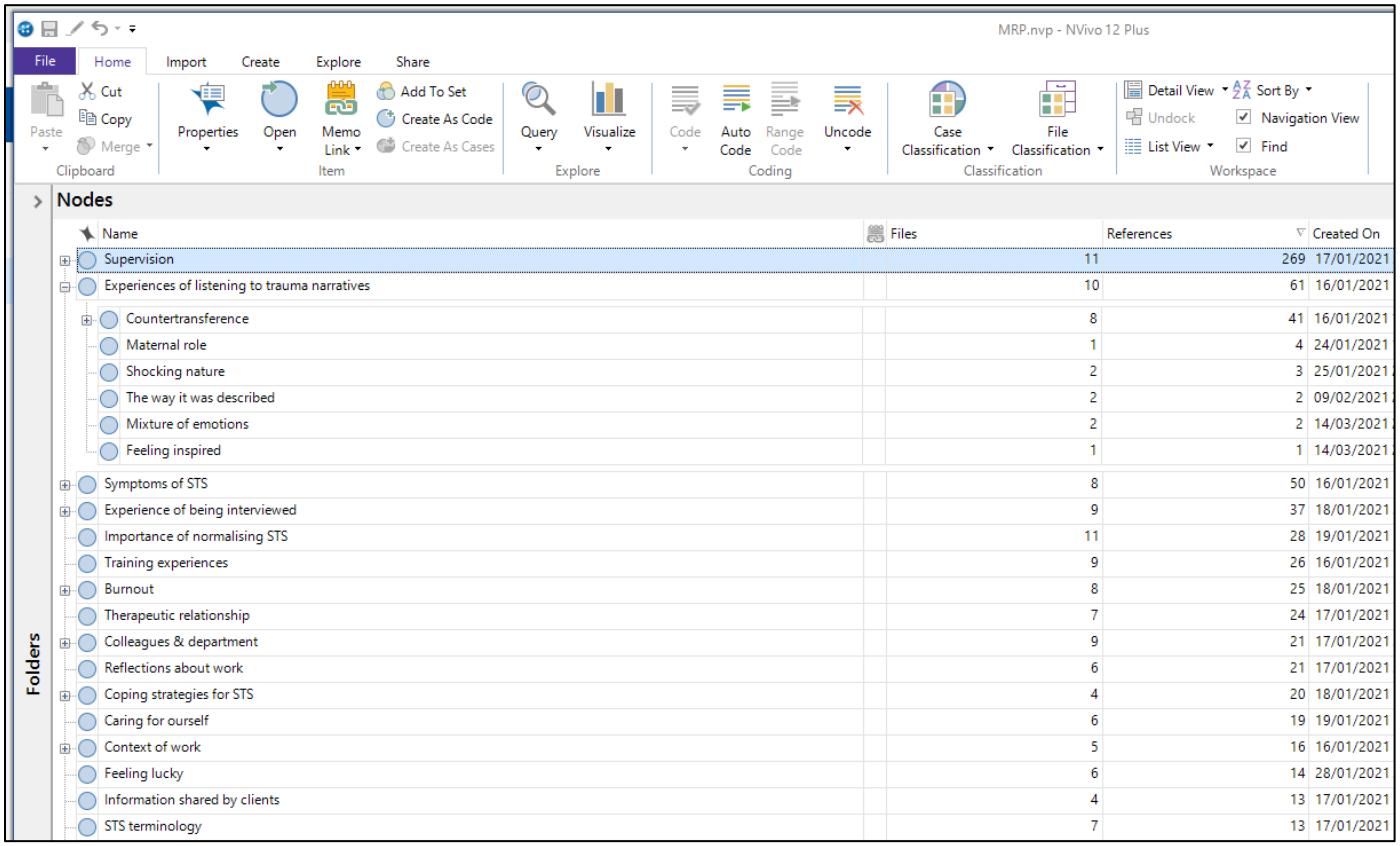
Citizens Advice: https://www.citizensadvice.org.uk/

Advice for Carers

https://www.carersuk.org/help-and-advice/health/looking-after-your-health/coronavirus-covid-19

Thank you again for your time and help on this project. If you have any concerns about the ethical conduct of the research please contact Dr Nick Moberly, Chair of the Psychology Research Ethics Committee on (0) 1392 724656 or N.J.Moberly@exeter.ac.uk

Appendix G: Example of Coding on NVIVO



Name	Files	References	Created On
Supervision	11	269	17/01/2021
Experiences of listening to trauma narratives	10	61	16/01/2021
Countertransference	8	41	16/01/2021
Maternal role	1	4	24/01/2021
Shocking nature	2	3	25/01/2021
The way it was described	2	2	09/02/2021
Mixture of emotions	2	2	14/03/2021
Feeling inspired	1	1	14/03/2021
Symptoms of STS	8	50	16/01/2021
Experience of being interviewed	9	37	18/01/2021
Importance of normalising STS	11	28	19/01/2021
Training experiences	9	26	16/01/2021
Burnout	8	25	18/01/2021
Therapeutic relationship	7	24	17/01/2021
Colleagues & department	9	21	17/01/2021
Reflections about work	6	21	17/01/2021
Coping strategies for STS	4	20	18/01/2021
Caring for ourself	6	19	19/01/2021
Context of work	5	16	16/01/2021
Feeling lucky	6	14	28/01/2021
Information shared by clients	4	13	17/01/2021
STS terminology	7	13	17/01/2021