VOLUME I: RESEARCH COMPONENT

THE EXPERIENCE OF WORKING WITH TRAUMA:

A PHENOMENOLOGICAL PERSPECTIVE OF MENTAL HEALTH

NURSES WORKING IN SECURE CARE

by

Natalie Emily McNeillie

A THESIS SUBMITTED TO THE UNIVERSITY OF BIRMINGHAM
FOR THE DEGREE OF DOCTOR OF CLINICAL PSYCHOLOGY

Department of Clinical Psychology
School of Psychology
The University of Birmingham
May 2019

Thesis overview

This thesis consisting of two volumes is submitted to the University of Birmingham towards the degree of Doctorate in Clinical Psychology.

Volume I comprises of three research chapters. The first presents a meta-ethnographic review of the literature exploring how therapists experience working with trauma survivors. The second chapter is an empirical research study exploring how mental health nurses working in secure care make sense of their experience of working with trauma. The third chapter is a public dissemination document which provides an accessible overview of the review and empirical chapters.

Volume II comprises of five clinical practice reports. The first presents the case of Albert[1], a 58-year-old man who had engaged in fire-setting. This was formulated from Cognitive-Behavioural and Psychodynamic perspectives. The second presents an evaluation of nurse's experience of a training package delivered in secure care. The third presents a single-case experimental design evaluating the effectiveness of needs-led interventions informed by the Newcastle model. Interventions were implemented for Rose, a 68-year-old lady who was presenting with behaviour that challenges in the context of Alzheimer's Disease. The fourth presents a case study for Jack, a 32-year-old man who was presenting with self-harm. Interventions focused on Cognitive-Behavioural and Acceptance-based techniques. The fifth presents an abstract of an oral presentation about utilising a behavioural approach to support George, a 7-year-old boy who was presenting with selective mutism.

[1] All client names have been changed to maintain confidentiality.

Acknowledgements

Firstly I would like to thank the wonderful nurses who agreed to take part in my research. I really value the time you spent talking to me about your experiences as I know how busy you all are. I was marvelled by your strength and resilience which shone through when talking about your work.

Secondly I would like to thank my research supervisor Professor John Rose for pushing me through my final year and motivating me to get to the end. Your guidance and support have been invaluable and I certainly would not have achieved this without you. Thank you to Dr Francesca Mantia-Conaty who worked tirelessly to recruit my participants in such a short space of time before I went on maternity leave.

Thirdly I would like to thank my appraisal tutor Dr Hermine Graham for her support throughout my training and Dr Elizabeth Kent for making my return to work as stress free as possible.

I would also like to say thank you to my parents, family and friends who have encouraged and supported me to get where I am today. Thank you for being so understanding as I have worked my way through my final year of training.

I want to say an extra special thank you to my husband. Your support has kept me going throughout my whole journey to becoming a Clinical Psychologist, but particularly over the last few months. I do not know how I would have done this without you. Thank you for being patient and believing in me even when I had doubts. And finally, to my darling Dylan. You have changed my world in ways I could never have imagined. Your cheeky little ways have brightened up the days when I have felt like I will never get there. I love you both, always.

Table of contents

a) Volume I: Research component

i) Chapter I: Literature review: How do therapists experience their work with trauma survivors? A Meta-Ethnographic Review 1

Abstract 2

1.0 Introduction 4

1.1 Vicarious trauma 4

1.2 The negative impact of exposure to trauma narratives 5

1.3 The positive impact of exposure to trauma narratives 8

1.4 Policy context 9

1.5 Rationale for exploring the impact of others trauma on therapists 9

1.6 Aim of the current review 10

2.0 Methodology 11

2.1 Type of review 11

2.2 Systematic literature search 12

2.3 Quality appraisal tool 15

2.4 Data extraction and synthesis 21

3.0 Results 40

3.1 Theme one: Altered outlook on life and perception of self and other 42

3.2 Theme two: Emotional experiences 46

3.3 Theme three: Cognitive experiences 50

3.4 Theme four: Behavioural responses 53

4.0 Discussion 56

4.1 The complex and profound experience of working with trauma 56

4.2 Clinical implications 60

4.3 Limitations of this review 62

4.4 Future directions 63

4.5 Conclusion 64

5.0 References 65

ii) Chapter II: Empirical paper: The experience of working with trauma: A phenomenological perspective of mental health nurses working in secure care 75

Abstract 76

1.0 Introduction 78

1.1 Defining trauma 78

1.2 Prevalence and impact of trauma 78

1.3 Containing distress 80

1.4 Impact of working with trauma 80

1.5 Study rationale 82

1.6 Study aim 83

2.0 Methodology 85

2.1 Design 85

2.2 Ethical considerations 85

2.3 Participant recruitment 86

2.4 Sample 87

2.5 Data collection 90

2.6 Data analysis 91

2.7 Reflexivity 92

3.0 Analysis 94

3.1 Theme One: Altered perceptions 95

3.2 Theme Two: Impact on the self 101

3.3 Theme Three: Managing exposure 109

4.0 Discussion 116

4.1 Altered perceptions and impact on the self 118

4.2 Managing exposure 121

4.3 Critique 122

4.4 Clinical implications 124

4.5 Future directions 126

4.6 Conclusion 127

5.0 References 128

iii) Chapter III: Public dissemination document 135

1.0 Overview 136

2.0 Literature review: How do therapists experience their work with trauma survivors: A Meta-Ethnographic Review 137

2.1 Background 137

2.2 Method 138

2.3 Findings 138

2.4 Conclusions 139

3.0 Empirical paper: The experience of working with trauma: A phenomenological perspective of mental health nurses working in secure care 140

3.1 Background 140

3.2 Method 141

3.3 Findings 141

3.4 Conclusions 143

4.0 References 144

b) Appendices for Volume I 147

i) Empirical paper

Appendix 1: Confirmation of ethical approval from the University of Birmingham 148

Appendix 2: Confirmation of ethical approval from the Health Research Authority 149

Appendix 3: Confirmation of ethical approval from the Research & Innovation department of the participating trust 150

Appendix 4: Recruitment poster 151

Appendix 5: Participant information sheet 152

Appendix 6: Consent form 155

Appendix 7: Demographic questionnaire 157

Appendix 8: Sample of IPA stages 1-3 for Jodie 158

Appendix 9: Sample of IPA stage 4 for Jodie for the theme “Impact on the self” 162

Appendix 10: Sample of IPA stages 6 for the subtheme “Emotional expression” 167

Appendix 11: Outline of themes with contributing participants 173

c) Volume II: Clinical practice component

i) Clinical Practice Report 1: Assessment and formulation of Albert's fire-setting behavior 1

Abstract 2

Introduction 4

Presenting difficulties 4

Assessment method 4

Assessment of the presenting difficulties 6

History of fire-setting 6

Index offence (Arson) 6

Formal measures 8

Interpretation 9

Therapeutic relationship 10

Personal history 11

Family 11

Education/employment 12

Relationships 12

Mental health difficulties 12

Vulnerability and protective factors 13

Formulation of fire-setting from a Cognitive perspective 14

Longitudinal formulation 14

Formulation of fire-setting from a Psychodynamic perspective 19

Triangle of conflict 19

Triangle of person 20

Reflections 24

References 26

ii) Clinical Practice Report 2: Service Evaluation of nurse training in forensic secure care 29

Abstract 30

Introduction 32

Aims 35

Methodology 36

Participants 36

Procedure 36

Data collection tools 37

Ethical considerations 38

Analysis 38

Results 39

Attendance 39

Response rate 40

Pre/post measures 41

Follow-up measures 44

Discussion 53

Barriers to individuals accessing and implementing the training 54

Facilitators to individuals accessing and implementing the training 56

Strengths and limitations of this Service Evaluation 57

Recommendations 58

References 59

iii) Clinical Practice Report 3: Single Case Experimental Design: Investigating the effectiveness of needs-led interventions for behaviour that challenges, using the Newcastle Model 63

Abstract 64

Case summary 66

Presenting difficulties 66

Background information 67

Assessment 67

Formulation 71

Intervention 76

Method 78

Design 78

Results 80

Visual interpretation of the data 80

Statistical analysis 84

Discussion 88

Treatment outcome 88

Limitations of the design and the analysis 89

References 91

iv) Clinical Practice Report 4: Supporting Jack with self-harm, using Cognitive Behavioural and Acceptance-based interventions 97

Abstract 98

Case summary 100

Presenting difficulties 100

Background information 100

Assessment 101

Clinical interview 101

Assessment of the presenting difficulties 101

Previous psychological input 105

Risk assessment 105

Formal measures 106

Assessment considerations 106

Goal-setting 107

Formulation 108

Cognitive model of self-harm 108

Longitudinal formulation 109

Maintenance cycles 111

Interventions 114

Focusing on progress 114

Normalising 115

Cognitive restructuring 115

ACT principles 116

Safe place 117

Alternative ways of coping 117

Evaluation 119

Outcome measures 119

Review of goals 120

Jack's presentation 120

Reflections 122

Effectiveness of the interventions 122

Personal/professional development 122

References 124

v) Clinical Practice Report 5: An abstract of an oral presentation of a behavioural approach to selective mutism 130

Abstract 131

References 133

d) Appendices for Volume II 135

i) Clinical Practice Report 1

Appendix 1: Cognitive formulation of fire-setting 136

Appendix 2: Psychodynamic formulation of fire-setting 137

ii) Clinical Practice Report 2

Appendix 3: Pre and post assessment 138

Appendix 4: Nurse training follow-up 139

Appendix 5: Nurse training interview template 143

Appendix 6: Minutes of the Research and Innovation meeting 144

Appendix 7: NRES: Differentiating Audit, Service Evaluation and Research 146

iii) Clinical Practice Report 4

Appendix 8: Longitudinal formulation of Jack's difficulties 147

Appendix 9: Maintenance cycle of reassurance-seeking 148

Appendix 10: Maintenance cycle of self-harm 149

Appendix 11: Jack's coping plan 150

List of illustrations

a) Volume I: Research component

i) Chapter I: Literature review

Figure 1: Noblit and Hare's (1988) stages of meta-ethnography 11

Figure 2: Flowchart of article selection 14

Figure 3: NICE Quality Appraisal Checklist for Qualitative Studies 16

Figure 4: Cognitive model of vicarious trauma and growth 59

ii) Chapter II: Empirical paper

Figure 5: Interview topic guide 90

Figure 6: Smith et al's (2012) stages of IPA 91

Figure 7: Thematic map 122

b) Volume II: Clinical practice component

i) Clinical Practice Report 2

Figure 1: Job title of participants 39

Figure 2: Level of knowledge reported pre and post training 42

Figure 3: Level of confidence reported pre and post training 43

Figure 4: Perceived impact on clinical practice pre and post training 44

Figure 5: Level of knowledge and confidence reported at follow-up 45

Figure 6: Level of impact and application reported at follow-up 46

ii) Clinical Practice Report 3

Figure 7: Formulation of Rose's difficulties using the Newcastle model 74

Figure 8: Frequency of shouting at others 80

Figure 9: Frequency of swearing at others 81

Figure 10: Frequency of kicking/banging on doors 82

List of tables

a) Volume I: Research component

i) Chapter I: Literature review

Table 1: Search strategies 12

Table 2: Inclusion/exclusion criteria 15

Table 3: Application of the NICE Quality Appraisal Checklist to this review 17

Table 4: Summary of articles included in the current review 24

Table 5: Summary of superordinate and subordinate themes with papers that contributed 41

ii) Chapter II: Empirical paper

Table 6: Inclusion/exclusion criteria 86

Table 7: Participant information 88

Table 8: Outline of superordinate and subordinate themes 95

b) Volume II: Clinical practice component

i) Clinical Practice Report 2

Table 1: Number of measures completed pre and post training 40

Table 2: Number of participants responding to each question on the follow-up questionnaire 41

Table 3: Mean awareness of and confidence in being able to identify support 47

ii) Clinical Practice Report 3

Table 4: Results of the Challenging Behaviour Scale pre and post-intervention 83

CHAPTER I

LITERATURE REVIEW

HOW DO THERAPISTS EXPERIENCE THEIR WORK WITH TRAUMA SURVIVORS? A META-ETHNOGRAPHIC REVIEW

Abstract

Background

Hearing about trauma can leave a mark on an individual, leading to a significant change in worldview that shatters their existing beliefs and is pervasive across view of self, other and the world. Individuals present with a range of symptoms that mimic Post-Traumatic Stress Disorder although the symptoms are less severe. The experience of such symptoms is likely to impact on how individuals relate to clients. Despite this, some individuals can experience growth through an enriched understanding of self and other. This altered perspective enables individuals to respond in ways that promote growth and positivity in their own lives. The aim of this review was to synthesise existing qualitative literature exploring how therapists experience working with trauma survivors.

Methodology

A systematic literature search found 16 studies which were selected for review following the application of inclusion/exclusion criteria and quality appraisal. Noblit and Hare's (1988) approach to meta-ethnography was followed.

Results

The themes identified outline a cognitive model of vicarious trauma whereby therapists presented with cognitive, emotional, physiological and behavioural 'symptoms' due to marked changes in schemata following repeated exposure to

trauma. The literature suggests that therapists experience growth and development alongside vicarious trauma through witnessing clients' resilience and growth.

Conclusion

This meta-ethnographic review suggests that the impact of working with trauma is profound and complex for therapists bearing witness to their client's pain and concurrently, their growth. Despite some limitations, the findings have enabled recommendations for individuals and employing organisations as well as areas of further research.

1.0 Introduction

1.1 Vicarious trauma

Vicarious trauma refers to the impact that working with trauma survivors can have on the individuals working with them (McCann & Pearlman, 1990). Vicarious traumatisation is described through Constructivist Self-Development Theory as a cumulative and pervasive process in which the helper's inner experiences are negatively and permanently transformed through listening to traumatic material frequently and repeatedly over time (Pearlman & Saakvitne, 1995). This can include changes in the way individuals view themselves, others and the world (Bride, Radey & Figley, 2007). Beliefs around trust, safety, intimacy, esteem and control are challenged or disrupted by trauma work (Pearlman & Saakvitne, 1995). This may result in increased cynicism, hopelessness and risk awareness in daily life. It shatters people's view of the world as being safe, predictable and caring through witnessing the cruelty of mankind (Bartoskova, 2017; Janoff-Bulman, 1992; Sui & Padmanabhanunni, 2016). Herman (1992) proposed that "trauma is contagious" (p. 140).

Individuals may experience emotional and behavioural responses because of repeated exposure to traumatic narratives (Newell & MacNeil, 2010). This can include exhaustion/lethargy, anxiety, sadness, anger, guilt, shame, fear as well as a difficulty managing these intense emotional experiences (McCann & Pearlman, 1990). As a result, helpers may avoid situations that they perceive as potentially dangerous (Resick & Schnicke, 1992). Additionally, McCann and Pearlman (1990) identified the potential for helpers to internalise their client's traumatic stories which

can consequently alter their memory systems. Paivio (1986) purported that therapists may experience intrusive images, flashbacks or dreams as the part of their memory that stores imagery is altered. Numbing, dissociation and hyper-arousal may also be present (Herman, 1992). Although Post-Traumatic Stress Disorder (PTSD) symptoms can be experienced to a lesser degree, it is the cognitive shift that defines vicarious trauma (Elwood, Mott, Lohr & Galovski, 2011).

The paralleling of vicarious trauma and PTSD symptoms, along with the idea that “trauma is contagious” (Herman, 1992, p. 140), indicates that it is likely that there are adverse clinical implications for the therapeutic relationship. A disruption to the therapeutic alliance, over-stepping boundaries, conflict within professional teams and a pull to rescue or control clients may occur as a defence against overwhelming emotions (Herman, 1992). An alternative response may be to avoid, minimise or deny the client’s experiences (Baranowsky, 2002).

There are various terminologies that are used inter-changeably with vicarious trauma to reflect similar experiences such as “secondary trauma”, “burnout”, “compassion fatigue” and “stress”. These concepts are related but have subtle differences in their definitions. These concepts need to be explored before being able to fully understand the notion of vicarious trauma and as such will be briefly reviewed below.

1.2 The negative impact of exposure to trauma narratives

Figley (1995) outlined secondary trauma as an emotional or behavioural response to caring for someone who has experienced trauma. This can occur after a

single exposure (Conrad & Kellar-Guenther, 2006). Secondary trauma does not include changes to cognitive schemata that are inherent in the experience of vicarious trauma and can include family members who are looking after their loved one (Figley, 1995). Individuals may experience avoidance, intrusive images, numbing, exhaustion and hyper-arousal, paralleling what is experienced by individuals with PTSD (Baird & Kracen, 2006; Bride, Robinson, Yegidis & Figley, 2004; Hensel, Ruiz, Finney & Dewa, 2015).

Compassion fatigue reflects changes in emotions and behaviour through listening to trauma narratives (Joinson, 1992). Figley (1995) proposed that individuals may experience intrusive thoughts, hyper-arousal and avoidance, essentially re-experiencing the traumatic event. Compassion fatigue is a state where functioning is impaired, and exhaustion is prominent (Arnold, Calhoun, Tedeschi & Cann, 2005). Individuals may feel less compassionate, empathy, pleasure and hope (Figley, 1995). Changes in cognitive schemata are not the focus here like in vicarious trauma (Baird & Kracen, 2006), it is the proposition that the helper experiences similar symptoms to individuals with PTSD, but these are not at a clinically significant level (Pearlman & Saakvitne, 1995). This differs from secondary trauma as it only affects individuals working professionally in a caring role (Figley, 2015).

Stress is manifested in the level of psychological distress that stressors have on an individual and can be experienced by a broader range of individuals in relation to a wider range of stressors. For example, the Transactional Model of Stress proposes that the environment produces various stressors and that it is the individual's perception of these that determines stress levels (Lazarus & Folkman, 1984). Henry and Evans (2008) purported that distress occurs when there is

dissonance between workplace demands and the individual's perceived ability to meet them.

Burnout is often used to describe an individual's response to situations which are interpersonally demanding and emotionally draining and is most often aligned with individuals who care for others (Jenkins & Baird, 2002). Maslach (1982) suggested that individuals may feel physically and emotionally exhausted which can lead to depersonalisation with, or disconnection from, their clients, which can, in turn, reduce their sense of personal accomplishment. A cognitive shift in worldview or loss of compassion is not the focus here: it is the idea that individuals feel overwhelmed, powerless and have low job satisfaction (Maslach, 2003). This can occur in any professional role and is not related directly to hearing about trauma (Cieslak et al., 2014).

The cost of caring for individuals who care for others, with or without a trauma history, is that it is emotionally taxing. This ultimately has an impact on the care individuals provide to service users (Figley, 1982, as cited in Figley, 2015). The Francis Report (2013) highlighted a lack of compassion and desensitisation amongst staff. These factors contributed to the additional deaths that occurred due to the inadequate care that was provided.

Recent research has focused on the positive impact of working with trauma survivors and potential satisfaction or growth that emerges during therapeutic work. Concepts such as "compassion satisfaction" and "vicarious post-traumatic growth" have been developed and will be discussed briefly below.

1.3 The positive impact of exposure to trauma narratives

Some individuals experience positive psychological changes through working with trauma survivors (Arnold et al., 2005). Tedeschi and Calhoun (2004) referred to this as vicarious post-traumatic growth. It is proposed that growth can happen because of vicarious trauma, through infusing new material with existing beliefs (Linley, Joseph & Loumidis, 2005). It is this enrichment in understanding of self and others which enable individuals to gain skills in relationships, have more appreciation for life and the resilience of mankind, and experience satisfaction from witnessing the growth of others (Herman, 1992; Pearlman & Saakvitne, 1995; Schauben & Frazier, 1995; Shakespeare-Finch, Smith, Gow, Embelton, & Baird, 2003; Splevins, Cohen, Joseph, Murray & Bowley, 2010). Key characteristics include: increased compassion, empathy, sensitivity and tolerance, a drive to live life more meaningfully, a changed sense of priorities, a recognition of new possibilities and a greater sense of personal strength (Arnold et al., 2005; Tedeschi & Calhoun, 2004). Splevins et al. (2010) highlighted an increased sense of admiration, inspiration and hope.

Compassion satisfaction refers to a sense of pleasure that an individual may get from feeling that they have helped their clients in their recovery (Figley, 2002). Craig and Sprang (2010) described it as a sense of fulfilment and satisfaction emerging because of effective clinical work. It is proposed that the helper's belief in the efficacy of therapy, and their sense of self-worth is strengthened in this phenomenon (Radey & Figley, 2007).

1.4 Policy context

Employee well-being is an important issue particularly following concerns that staff were not being appropriately supported in work (Francis, 2013). Sloan et al. (2014) highlighted that less than two thirds of NHS Trusts had a policy which focused on staff well-being or had implemented recommendations proposed by the National Institute of Clinical Excellence (NICE) guidelines (2009) regarding emotional well-being at work. In January 2017 the Prime Minister proposed that an independent review be carried out examining how employers can better support their workforce. The Stevenson/Farmer Review (2017) outlined six core and four enhanced standards. These predominantly focus on opening-up a dialogue about mental health and raising awareness about the support available.

1.5 Rationale for exploring the impact of others trauma on therapists

Exploring whether therapists experience vicarious trauma is important as a therapist's ability to contain their client's emotions as well as their own is an important aspect of effective therapy (Pistorius, Feinauer, Harper, Stahmann & Miller, 2008). Having insight into how therapists experience trauma work has important implications for the level of support that services can consider providing, including supervision and training needs. Prioritising therapist well-being ensures that their experiences are validated and processed. Enabling a therapist to make sense of trauma narratives and what this means for their view of the world will maximise the possibility of them remaining in the role and feeing fulfilled and enriched from their work.

There are existing reviews examining the impact of working with trauma survivors on various professions exploring papers using quantitative and qualitative methodology (Baird & Kracen, 2006; Beck, 2011; Cohen & Collens, 2013; Sabin-Farrell & Turpin, 2003). This article aimed to review existing qualitative research exploring how therapists experience working with trauma survivors, through meta-ethnographic methodology. This approach aims to identify, compare and synthesise themes from existing research to provide a coherent narrative of the impact of working with trauma survivors (Finfgeld, 2003). This approach enables re-conceptualisation of themes and has the potential to identify new areas of research (Campbell et al., 2011; Williamson, Parkes, Wight, Petticrew & Hart, 2009).

1.6 Aim of the current review

The aim of this meta-ethnographic review was to explore and describe how individuals providing therapy to trauma survivors experience their work. Original themes were extracted and re-analysed to integrate existing literature and gain a deeper understanding of therapists' experience.

2.0 Methodology

2.1 Type of review

The articles were reviewed using meta-ethnographic methodology. Noblit and Hare's (1988) step by step guide on how to apply this methodology was followed throughout this review and is presented in Figure 1.

Although meta-ethnography utilises the interpretations of the data, not the raw interview data for the synthesis (Doyle, 2003), this review excluded papers that did not report participant quotes as it was felt that this would enable the author to gain a greater understanding of the original interpretations.

1) Getting started – This involves formulating a research question answerable through qualitative literature
2) Deciding what is relevant to the initial interest – This involves searching for studies, defining inclusion/exclusion criteria and quality appraisal
3) Reading the studies – This involves getting familiar with the content of the articles and extracting details on the study population, key themes etc (Britten et al., 2002)
4) Determining how the studies are related – This involves determining how studies relate using tables or lists
5) Translating the studies into one another – This involves comparing themes across the studies to look for similarities
6) Synthesising translations – This involves combining related themes to create new interpretations
7) Expressing the synthesis – This involves presenting the hypotheses generated by the synthesis

Figure 1: Noblit and Hare's (1988) stages of meta-ethnography

2.2 Systematic literature search

2.2.1 Search strategy

The search for literature was carried out on the 2nd of October 2018 using three electronic databases: MEDLINE (1946 – October 2018), PsycINFO (1806 – October 2018) and Embase (1947 – October 2018) to identify articles pertaining to therapists' experience of working with trauma. Please see Table 1 for the search strategies used when searching these databases. "Stress" and "burnout" were not included as keywords as these were felt to be experienced more widely than working therapeutically with trauma, as identified in the Introduction, and are therefore not theoretically relevant to the aim of the review.

Table 1: Search strategies

Step	Search terms
A	Keyword search for "vicarious posttraumatic growth" **or** "vicarious post-traumatic growth"
B	Keyword search for "vicarious trauma" **or** "vicarious traumatisation" **or** "vicarious traumatization"
C	Keyword search for "secondary trauma" **or** "secondary traumatisation" **or** "secondary traumatization" **or** "secondary traumatic stress"
D	Keyword search for "working with trauma" **or** "trauma work"
E	Keyword search for "compassion satisfaction" **or** "compassion fatigue"
F	Combine A – E using **or**.
G	Keyword search for "psychologists" **or** "psychotherapists"
H	Keyword search for "counsellors" **or** "counselors" **or** "therapists"
I	Keyword search for "mental health workers" **or** "mental health professionals" **or** "clinicians"
J	Combine G – I using **or**.
K	Keyword search for "qualitative" **or** "interviews"
M	Combine F, J and K using **and.**

To outline the process of selecting articles for the review a flowchart recommended by Moher et al. (2009) has been included in Figure 2. This figure details the flow of article selection from the initial search through to papers being included in the review following the application of exclusion criteria.

The initial search unveiled a total of 261 articles: 192 articles were found on PsycINFO, 40 articles were found on Embase and 29 articles were found on MEDLINE. After removal of duplicates 213 titles were screened for suitability. Of these, 138 articles were identified as either conference/dissertation abstracts or books and three were not written in English. The titles and abstracts of the remaining 72 articles were subject to inclusion/exclusion criteria which identified 19 articles as suitable for inclusion. Inclusion/exclusion criteria are detailed in Table 2. Ten potential additional papers were identified from the reference section of these 19 papers and were subject to the same inclusion/exclusion criteria.

Papers were screened prior to quality appraisal to ensure that at least 75% of the sample were therapists' working with trauma survivors and if they did not meet the criteria they were excluded. This criterion was included because some of the studies did not solely focus on the experience of therapists and included individuals who were working therapeutically with trauma survivors, rather than delivering psychological therapy as part of the sample (i.e. Psychiatrists or Occupational Therapists), or therapists who did not have a trauma caseload (de Figueiredo, Yetwin, Sherer, Radzik & Iverson, 2014; Marriage & Marriage, 2005; McCormack & Adams, 2016; Puvimanasinghe, Denson, Augoustinos & Somasundaram, 2015; van Minnen & Keijsers, 2000). Papers that did not provide a breakdown (Edelkott, Engstrom & Hernandez-Wolfe, 2016; Satkunanayagam, Tunariu & Tribe, 2010) or

description of job roles were also excluded (Barrington & Shakespeare-Finch, 2013; Hyatt-Burkhart, 2014). As such a further nine articles were excluded. A total of 20 papers were deemed suitable for inclusion and were selected for quality appraisal.

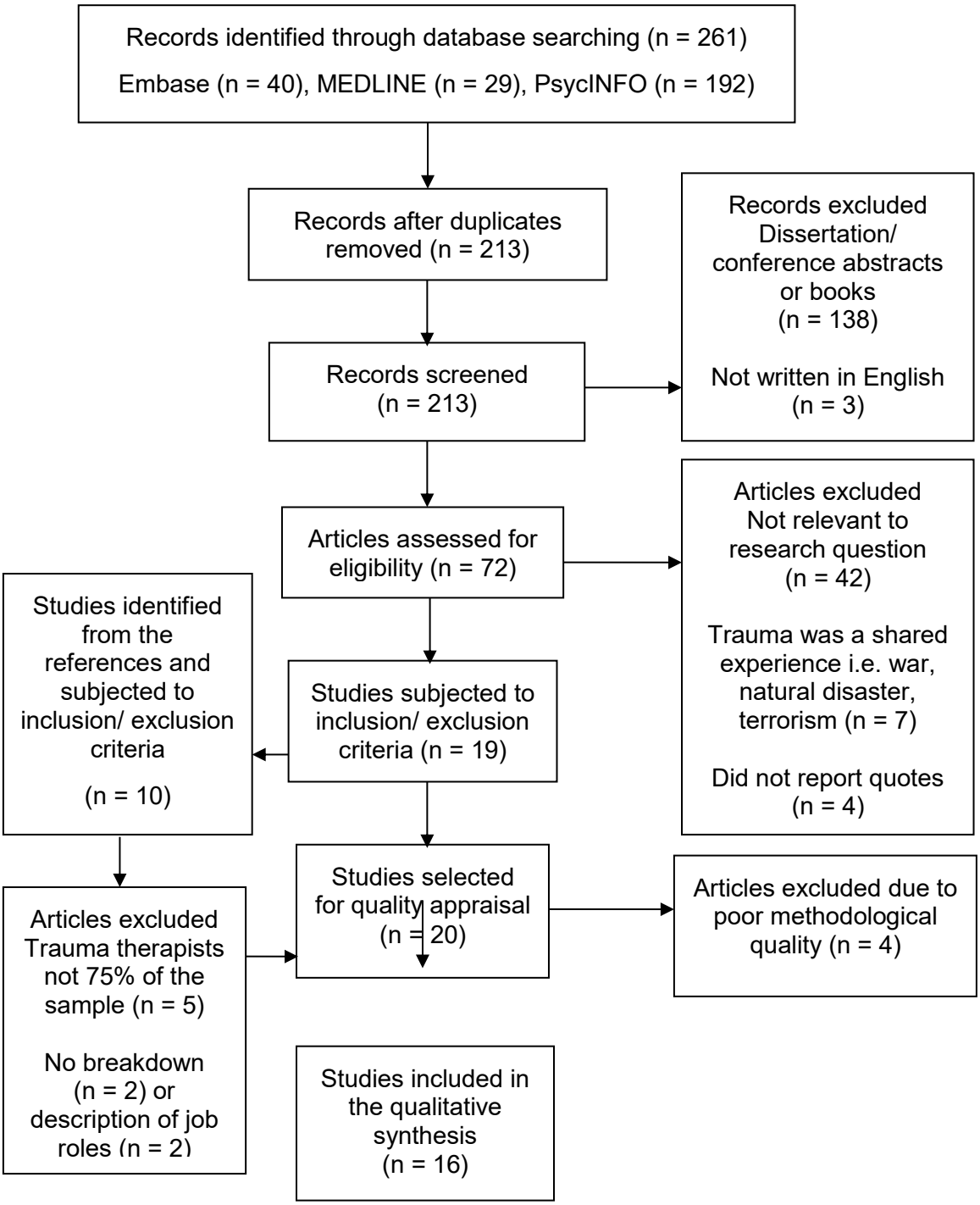


Figure 2: Flowchart of article selection using Moher et al's Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA)

Table 2: Inclusion/exclusion criteria

Inclusion	Exclusion
Fully or partly qualitative methodology	Not written in English
Explored how individuals providing therapy experience working with trauma survivors	Dissertation or conference abstracts, or books
Peer-reviewed articles	Did not report participant quotes in the analysis section
At least 75% of the sample were engaging in therapy with trauma survivors	Based on a shared experience of trauma i.e. war, natural disaster, terrorism
	74% or less of the sample were engaging in therapy with trauma survivors
	No breakdown or description of job roles

2.3 Quality appraisal tool

The quality framework developed by NICE (2012) was selected to assess the quality of the methodology in the papers reviewed. Please see Figure 3 for an overview of the quality appraisal criteria using this framework and Table 3 for an outline of how this appraisal tool was applied to the studies in this review. If articles were deemed to fulfil a criterion they were awarded one point. To aid clarity a traffic light system has been utilised. For instance, if a criterion was deemed to be met then it has been coded green, if it has not been met it has been coded red and amber if there was not enough information to rate this. To differentiate between the methodological strength of the papers, points were added to indicate whether the study was considered poor (0-5 points, coded red), medium (6-9 points, coded amber) or good (10-14 points, coded green) quality.

Section 1: Theoretical approach

Is a qualitative approach appropriate?

Is the study clear in what it seeks to do?

Section 2: Study design

How defensible/rigorous is the research design/methodology?

Section 3: Data collection

How well was the data collection carried out?

Section 4: Validity

Is the role of the researcher clearly described?

Is the context clearly described?

Were the methods reliable?

Section 5: Analysis

Is the data analysis sufficiently rigorous?

Are the data 'rich'?

Is the analysis reliable?

Are the findings convincing?

Are the findings relevant to the aims of the study?

Are the conclusions adequate?

Section 6: Ethics

How clear and coherent is the reporting of ethical considerations?

Section 7: Overall assessment

How well was the study conducted?

Figure 3: NICE Quality Appraisal Checklist for Qualitative Studies

Table 3: Application of the NICE Quality Appraisal Checklist to this review

Authors and year of study	***Is a qualitative approach appropriate?***	***Is the study clear in what it seeks to do?***	***How defensible/rigorous is the research design/methodology?***	***How well was the data collection carried out?***	***Is the role of the researcher clearly described?***	***Is the context clearly described?***	***Were the methods reliable?***	***Is the data analysis sufficiently rigorous?***	***Are the data 'rich'?***	***Is the analysis reliable?***	***Are the finding convincing?***	***Are the finding relevant to the aims of the study?***	***Are the conclusions adequate?***	***How clear and coherent is the reporting of ethical considerations?***	***How well was the study conducted? (including total rating)***
Arnold, Calhoun, Tedeschi & Cann (2005)	√	√	√	√	X	X	?	√	?	?	√	√	X	?	+ (7/14)
Baker (2012)	√	√	?	√	√	√	?	√	?	?	√	√	X	√	+ (9/14)
Bartoskova (2017)	√	√	?	√	?	√	?	√	√	?	√	√	√	X	+ (9/14)
Bell (2003)	√	√	?	√	?	√	√	X	√	?	√	√	X	?	+ (8/14)
Benatar (2000)	√	√	?	?	X	X	?	X	√	?	√	√	X	X	- (5/14)

Authors and year of study	***Is a qualitative approach appropriate?***	***Is the study clear in what it seeks to do?***	***How defensible/rigorous is the research design/methodology?***	***How well was the data collection carried out?***	***Is the role of the researcher clearly described?***	***Is the context clearly described?***	***Were the methods reliable?***	***Is the data analysis sufficiently rigorous?***	***Are the data 'rich'?***	***Is the analysis reliable?***	***Are the finding convincing?***	***Are the finding relevant to the aims of the study?***	***Are the conclusions adequate?***	***How clear and coherent is the reporting of ethical considerations?***	***How well was the study conducted? (including total rating)***
Engstrom, Hernandez & Gangsei (2008)	√	√	?	√	X	X	?	√	√	√	√	√	√	X	+ (9/14)
Hernandez, Gangsei & Engstrom (2007)	√	√	?	X	√	X	?	?	?	?	√	√	√	?	+ (6/14)
Hernandez-Wolfe, Killian, Engstrom & Gangsei (2015)	√	√	?	√	X	√	?	X	?	√	?	√	X	?	+ (6/14)
Hunter (2012)	√	√	√	√	√	X	√	√	√	√	√	√	√	X	++ (12/14)
Iliffe & Steed (2000)	√	√	?	?	X	X	?	√	?	?	X	√	X	**?**	- (4/14)

Authors and year of study	***Is a qualitative approach appropriate?***	***Is the study clear in what it seeks to do?***	***How defensible/rigorous is the research design/methodology?***	***How well was the data collection carried out?***	***Is the role of the researcher clearly described?***	***Is the context clearly described?***	***Were the methods reliable?***	***Is the data analysis sufficiently rigorous?***	***Are the data 'rich'?***	***Is the analysis reliable?***	***Are the finding convincing?***	***Are the finding relevant to the aims of the study?***	***Are the conclusions adequate?***	***How clear and coherent is the reporting of ethical considerations?***	***How well was the study conducted? (including total rating)***
Killian (2008)	√	√	?	√	?	X	?	√	?	?	√	√	X	X	+ (6/14)
Lonergan, O'Halloran & Crane (2004)	√	√	?	√	X	√	√	√	?	?	√	√	X	X	+ (8/14)
Lu, Zhou & Pillay (2017)	√	√	?	?	√	√	?	√	√	?	√	√	√	√	++ (10/14)
Pack (2014)	√	√	√	?	X	X	√	?	√	?	√	√	X	√	+ (8/14)
Pistorius, Feinauer, Harper, Stahmann & Miller (2008)	√	√	?	X	X	X	?	√	√	?	√	√	X	?	+ (6/14)

Authors and year of study	***Is a qualitative approach appropriate?***	***Is the study clear in what it seeks to do?***	***How defensible/rigorous is the research design/methodology?***	***How well was the data collection carried out?***	***Is the role of the researcher clearly described?***	***Is the context clearly described?***	***Were the methods reliable?***	***Is the data analysis sufficiently rigorous?***	***Are the data 'rich'?***	***Is the analysis reliable?***	***Are the finding convincing?***	***Are the finding relevant to the aims of the study?***	***Are the conclusions adequate?***	***How clear and coherent is the reporting of ethical considerations?***	***How well was the study conducted? (including total rating)***
Possick, Waisbrod & Buchbinder (2015)	√	√	?	√	X	X	?	√	?	?	√	√	?	√	+ (7/14)
Silveira & Boyer (2015)	√	√	?	X	X	X	?	√	√	√	√	√	?	√	+ (8/14)
Steed & Downing (1998)	√	√	?	X	?	X	?	?	?	?	√	√	√	?	- (5/14)
Straker & Moosa (1994)	√	?	?	√	√	X	?	X	?	√	X	√	X	X	- (5/14)
Sui & Padmanabhanunni (2016)	√	√	?	√	X	√	?	√	√	√	√	√	X	√	++ (10/14)

2.3.1 Exclusion of articles following quality appraisal

Following quality appraisal of each paper, four papers were excluded from the review as these were considered poor quality (Benatar, 2000; Iliffe & Steed 2000; Steed & Downing, 1998; Straker & Moosa, 1994). Factors considered to be poor quality included not outlining what methodology was used or justifying why it was selected and minimal discussion of ethical considerations, limitations and implications of the research. In papers considered to be poor quality there were elements missing such as how the role of the researcher may have impacted on the results, an outline of the interview topic guide, details regarding the setting, how many people were involved in the analysis or how the research was presented to the participants. These factors present a threat to the validity of this review as it is difficult to tease out any bias or follow the process of conducting the study. Similarly, articles which included minimal quotes would have made it very difficult to fully understand the authors' thought process when interpreting themes. As this review was re-analysing original themes it was felt that these articles would weaken the impact of the synthesised results as they are subject to the original author's interpretation. Thus, of the 20 papers appraised, only 16 were included in the review (please see Figure 2). Three papers were considered good quality and 13 were considered medium quality. Methodological considerations are highlighted in Table 4.

2.4 Data extraction and synthesis

The author read each study to become familiar with their content and noted their key characteristics. Table 4 presents a summary of articles that have been

included in this review outlining key points. The author then extracted the main findings (themes) of each paper and noted initial ideas around what the data demonstrated. The author did this by reviewing each paper in chronological order and reflecting on whether the paper represented similar ideas to the previous paper or a different concept. The author then reviewed the original interpretations and extracted quotes to define and provide support for the themes. In this review reciprocal translation was used as the themes in multiple studies were similar and were thus organised into common themes (Thomas, Harden & Newman, 2012).

2.4.1 Sample characteristics

There was a total of 212 participants (176 females and 36 males) across the papers. Studies were carried out in America (Texas, Utah, Colombia, San Diego, Denver, North Carolina, Ohio, and Minneapolis), Scotland, Australia (Sydney, New South Wales), Canada, Israel and South Africa.

A range of participants were included in the papers reviewed. This included psychotherapists (Bartoskova, 2017; Pack, 2014), psychologists (Arnold et al., 2005; Bartoskova, 2017; Bell, 2003; Engstrom, Hernandez & Gangsei, 2008; Hernandez, Gangsei & Engstrom, 2007; Hernandez-Wolfe, Killian, Engstrom & Gangsei, 2015; Killian, 2008; Lonergan, O'Halloran, & Crane, 2004; Pack, 2014; Sui & Padmanabhanunni, 2016), trainee psychologists/counsellors (Baker, 2012; Lu, Zhou & Pillay, 2017), CBT therapists (Bartoskova, 2017), social workers (Bell, 2003; Engstrom et al., 2008; Hernandez-Wolfe et al., 2015; Killian, 2008; Lonergan et al., 2004; Pack, 2014; Pistorius et al., 2008; Possick, Waisbrod & Buchbinder, 2015), counsellors (Arnold et al., 2005; Bartoskova, 2017; Hunter, 2012; Killian, 2008;

Lonergan et al., 2004; Pack, 2014; Pistorius et al., 2008; Silveira & Boyer, 2015) or marriage/family therapists (Engstrom et al., 2008; Hernandez-Wolfe et al., 2015; Killian, 2008; Pistorius et al., 2008).

Some studies focused on therapists working with a range of different traumas (Arnold et al., 2005; Bartoskova, 2017; Hunter, 2012; Lu et al., 2017; Sui & Padmanabhanunni, 2016). Other papers focused specifically on therapists working with children who have experienced trauma (Lonergan et al., 2004; Silveira & Boyer, 2015), and more specifically sexual abuse (Pistorius et al., 2008; Possick et al., 2015). Other papers recruited therapists who worked with victims of sexual abuse (Killian, 2008; Pack, 2014), domestic violence (Bell, 2003) and torture (Engstrom et al., 2008; Hernandez-Wolfe et al., 2015). Additionally, Hernandez et al. (2007) explored therapists' experience of working with victims of political violence and kidnapping. Baker (2012) does not identify what types of trauma her participants were working with.

Table 4: Summary of articles included in the current review

Author	Sample	Research Methodology	Key Findings	Methodological Considerations
1. Arnold, Calhoun, Tedeschi & Cann (2005)[2]	21 psychotherapists (psychologists or counsellors) in a "major south eastern city" in North Carolina, USA working with a range of different traumas 11 females, 10 males Mean percentage of clinical work with clients who have experienced trauma was 45% Mean of 16.9 years clinical experience Recruited via snowball sampling	Naturalistic interview Content Analysis	11 themes: "Impact of trauma work on self-perception", "impact of trauma work on general outlook on the world and other people", "trauma work and spirituality", "therapists' professional philosophy regarding trauma work", "therapists transient negative response to trauma work", "therapists attention to self-care", "therapists identification of challenging client groups", "clients posttraumatic growth", "therapists personal experiences with trauma", "cumulative vs individual impact of clients on therapists growth/development" and "caveats about the difficulty of determining the impact of trauma work"	The researcher acknowledges that they were involved in the interview and analysis process but does not give details on how this may have impacted on the results – this is important as it is implied that the researcher worked as a psychotherapist where the research was carried out and was completing this research as part of her MSc Coding was checked by an independent rater who was not familiar with the study and utilises member checking however it is unclear how discrepant results were addressed Paper does not discuss the ethical issues or limitations of the study Contextual details about the setting are absent Quotes are included in the narrative but without context Quality appraisal rating: 7/14 (+)

[2] The study numbers in Table 4 are used throughout the results section

Author	Sample	Research Methodology	Key Findings	Methodological Considerations
2. Baker (2012)	11 master's level therapists from a Doctorate in Psychology course at a university in Minneapolis who were working with trauma survivors 10 females, 1 male Mean percentage of trauma survivors on caseload was 28% Mean of 8.8 years' experience as a psychotherapist Recruited via purposive sampling	2 x Semi-structured interviews Interpretative Phenomenological Analysis	9 themes - "Living nightmare – adverse emotional and physical effects", "working toward prevention – the need for a graduate level course", "the double-edged sword of being a trauma therapist", "coping on three levels- intellectual/professional, spiritual and physical", "a deeper sense of spirituality", "self-doubt – what is wrong with me?", "decreased trust in other people, pulling away from gentle, previously trusted others", "difficulty separating clients' experiences from one's own life", "fear of the unknown – what is going on with me?"	Paper does not discuss the limitations of the study No justification as to why analysis method was selected Data analysis is rigorous Utilises member checking to enhance authenticity Author acknowledges their potential influence on the research as they have also had experience of vicarious trauma Appropriate discussion of ethical issues Quotes are included in the narrative but without context Only one person engaged in the analysis Quality appraisal rating: 9/14 (+)

Author	Sample	Research Methodology	Key Findings	Methodological Considerations
3. Bartoskova (2017)	Ten self-identified trauma therapists (clinical psychologists, psychiatrist, counsellors, psychotherapists or CBT therapists) engaged in trauma work in Scotland, working in three organisations specialising in sexual health, veterans and women in the Criminal Justice System (either the NHS or private organisations) 7 females, 3 males At least 40% of caseload were trauma cases Mean of 7.23 years working with victims of trauma Between 2 and 16 years clinical experience Recruited via self-selected sampling	Semi-structured interview Interpretative Phenomenological Analysis	4 themes: “Responding to a client”, “noticing growth in self”, “making a difference” and “finding their own ways to process the trauma work”	Rich quotes with contextual information are included No justification as to why sampling method was selected Data analysis is rigorous Limited discussion of ethical issues Does not outline researcher’s role in the study No discussion regarding how many people were involved in the analysis Quality appraisal rating: 9/14(+)

Author	Sample	Research Methodology	Key Findings	Methodological Considerations
4. Bell (2003)	30 Domestic Violence counsellors (social workers or psychologists) in a “south-western city” in the USA (shelter, private therapy practice, law enforcement agency and a hot line) 29 females, 1 male Recruited via snowball sampling, although also states that which participants to interview developed as the data unfolded ? Recruited via theoretical sampling	2 x Semi-structured interviews Grounded Theory	Findings section is split into two sections “experience of distress” and “counsellor strengths”	Does not discuss the role of the researcher however as the research was completed as part of her PhD it is likely that her role may have impacted on the results Carries out 2 interviews with the counsellors to triangulate the data Utilises member checking to enhance authenticity but unclear how discrepant results were addressed Description of analysis is not clear as explanation is brief Vicarious trauma is only a part of the study No discussion of ethical issues or limitations of the study No justification as to why analysis method was selected Unclear how many people engaged in the analysis Quality appraisal rating: 8/14 (+)

Author	Sample	Research Methodology	Key Findings	Methodological Considerations
5. Engstrom, Hernandez & Gangsei (2008)	11 mental health professionals (social workers, marriage and family therapists or psychologists) from a torture treatment centre in San Diego, USA 10 females, 1 male Recruited via purposive sampling	Semi-structured interview Grounded Theory	3 themes: “Being positively affected by the resilience of clients”, “alteration of perspectives on the therapist’s own life” and “valuing the therapy work”	Quotes with contextual information are included Data was coded by 3 people and discrepancies were discussed among researchers The researcher acknowledges that they were involved in the interview and analysis process but does not give details on how this may have impacted on the results Contextual details about the setting are absent Quality appraisal rating: 9/14 (+)

Author	Sample	Research Methodology	Key Findings	Methodological Considerations
6. Hernandez, Gangsei & Engstrom (2007)	12 therapists (psychologists and a psychiatrist) working with victims of political violence or kidnapping in governmental and non-governmental organisations in Colombia 9 females, 3 males Between 1 and 18 years working with this population Between 3 and 27 years clinical experience Recruited via purposive sampling	Semi-structured Interview Grounded Theory	3 themes: “Clients effect on therapists”, “vicarious trauma”, “vicarious resilience”	Limited details regarding the interview or analysis process Considers the role of the researchers and the impact that this might have had on the data Data was coded by more than one researcher and was reviewed by an external auditor however it is unclear how discrepancies were addressed Quality appraisal rating: 6/14 (+)

Author	Sample	Research Methodology	Key Findings	Methodological Considerations
7. Hernandez-Wolfe, Killian, Engstrom & Gangsei (2015)	13 mental health providers (psychologists, social workers or marriage and family therapists) working in 3 torture treatment centres in the USA 12 females, 1 male Between 4 and 30 years professional experience ? Recruited via purposive sampling	Semi-structured Interview Grounded Theory	3 themes: “Vicarious trauma”, “vicarious resilience” and “intersectional identities and trauma work”	Sampling method is unclear Data analysis is not rigorous as the explanation of how this was carried out is brief Does not discuss ethical issues Researchers engaged in reflexive practice but do not report on this in the write-up i.e. how their role may have impacted Implies that data was coded by more than one researcher and reports that discrepant results were discussed in meetings No justification as to why analysis method was selected Quality appraisal rating: 6/14 (+)

Author	Sample	Research Methodology	Key Findings	Methodological Considerations
8. Hunter (2012)	8 therapists working with a range of different traumas from 5 counselling agencies in Sydney, Australia 7 females, 1 male 75% of participants had 50% of cases which they considered difficult Experience of being a therapist ranged from less than 2 years to more than 10 Recruited via purposive sampling	Semi-structured interview Field notes were produced after the interview to consider the researcher's presence on the data collected Grounded Theory	4 themes: "Empathic resonance of the therapist", "the role investment by the client", "sense of mutual affirmation between them" and "the satisfaction and risks of working with trauma"	The researcher acknowledges that they were involved in the interview and analysis process and that bias might be present (the researcher was completing this research as part of their MSc) however measures were put in place to limit this i.e. reflexive diary Rich data with quotes 2 data collection methods were utilised which enhances the validity Vicarious trauma is only a part of the study Does not fully address ethical issues Contextual details about the setting are absent Quality appraisal rating: 12/14 (++)

Author	Sample	Research Methodology	Key Findings	Methodological Considerations
9. Killian (2008)	20 clinicians (social workers, psychologists, counsellors or marriage and family therapists) working in agencies treating survivors of childhood sexual abuse in "a large metropolitan area" of Texas 16 females, 4 males Mean of 8 years working with sexual abuse cases ? Recruited via purposive sampling	Semi-structured interview Grounded Theory	4 themes: "Recognising symptoms of work stress", "risk factors in developing burnout", "definitions of self-care" and "specific self-care strategies"	Sampling method is unclear Data analysis is rigorous Results section is brief (as it also includes a quantitative study) so includes limited quotes and does not explore diversity of perspective Paper does not discuss the limitations of the study Data collection was carried out appropriately Limited discussion of ethical issues Does not outline researcher's role in the study Contextual details about the setting are absent No justification as to why analysis method was selected Unclear how many people were involved in the analysis or whether member checking was used Quality appraisal rating: 6/14 (+)

Author	Sample	Research Methodology	Key Findings	Methodological Considerations
10. Lonergan, O'Halloran & Crane (2004)	8 therapists (social workers, psychologists or counsellors) working with children who have experienced trauma (hospitals, private practice and community mental health centres) in Denver 7 females, 1 male At least 50% of the caseloads focused on clinical work with clients who have experienced trauma Mean of 13 years working with trauma Recruited via purposive and snowball sampling	Semi-structured interview Field notes were completed regarding the researcher's thought and decision-making processes	Utilised a developmental model to depict the journey of a trauma therapist: "Beginning of the journey", "trial and tribulation" and "challenge and growth" Within this developmental model were 3 themes: "View of therapy", "self-care issues" and "view of self"	Does not describe what method was used to analyse the data The researcher acknowledges that they were involved in the interview and analysis process and kept a reflexive diary but does not give details on this in the write-up i.e. how their role may have impacted Includes quotes with pseudonyms but does not explore diversity of perspective 2 data collection methods were utilised which enhances the validity Limited discussion of ethical issues and does not reflect on the limitations of the study Coded by two researchers and a third person provided feedback however unsure how discrepant results were addressed Quality appraisal rating: 8/14(+)

Author	Sample	Research Methodology	Key Findings	Methodological Considerations
11. Lu, Zhou & Pillay (2017)	8 students from a Doctorate in Counsellor Education and Supervision course in North Central America (Ohio) who had experience working with trauma cases 4 females, 4 males Recruited via purposive sampling	Semi-structured interview Open Coding	3 themes: “Immediate reactions”, “information processing” and “post-exposure development”	The researcher acknowledges that they were involved in the interview and analysis process and used self-reflection and peer-debriefing to enhance the credibility of the results/ consider biases The paper does not report how the research was described to participants Appropriate consideration of ethical issues Rich data with quotes and context No member checking No justification as to why analysis method was selected Limited details regarding the interview process Analysis was conducted by one person but then reviewed with a second person, differences were discussed but unsure how discrepant results were addressed Quality appraisal rating: 10/14 (++)

Author	Sample	Research Methodology	Key Findings	Methodological Considerations
12. Pack (2014)	22 counsellors (social workers, counsellors or psychotherapists) working with victims of sexual abuse in New South Wales, Australia 19 females, 3 males Recruited via purposive sampling	Interviews Focus groups Thematic Analysis	5 themes: “The search for the self”, “reformulation of personal and professional identities” “the male counsellor participants”, “the importance of collegial support” and “the search beyond self”	Uses 2 methods of data collection to triangulate The researcher acknowledges that they were involved in the interview process and uses the first person to emphasise her presence in the paper however she does not reflect on how this may have impacted on the results Unsure whether the data analysis is rigorous as this section is brief Does not report on how many people were involved in the analysis and how discrepancies were resolved Contextual details about the setting are absent Does not discuss limitations of the study Quality appraisal rating: 8/14(+)

Author	Sample	Research Methodology	Key Findings	Methodological Considerations
13. Pistorius, Feinauer, Harper, Stahmann & Miller (2008)	14 female therapists (marriage and family therapists, social workers or counsellors) working with sexually abused children from two facilitates providing therapeutic services in Texas and Utah Mean of 6 years clinical experience working with sexually abused children ? Recruited via purposive sampling	Unstructured interview Grounded Theory	2 themes: “Impact on the therapist from working with sexually abused children” and “coping with the stresses associated with working with sexually abused children”	Limited details regarding the interview process Paper does not discuss the ethical issues or limitations of the study 4 researchers were involved in the analysis process however it is unclear how discrepant results were addressed Rich data with quotes and context Sampling method is unclear Contextual details about the setting are absent No justification as to why analysis method was selected The researcher acknowledges that they were involved in the interview and analysis process but does not give details on how this may have impacted on the results Quality appraisal rating: 6/14 (+)

Author	Sample	Research Methodology	Key Findings	Methodological Considerations
14. Possick, Waisbrod & Buchbinder (2015)	14 social workers providing therapy to children who have been sexually abused in government or non-profit therapy centres in Israel 13 females, 1 male Mean of 5 years clinical experience providing therapy to sexually abused children ? Recruited via purposive sampling	Semi-structured interviews A research diary was completed regarding the researcher's thoughts throughout interviewing and analysis Interpretative Phenomenological Analysis	2 themes: "The first pole – You yourself can become a victim of the therapy" and "the second pole – constructing empowering meaning"	Sampling method is unclear Addresses ethical issues Includes quotes with pseudonyms but does not explore diversity of perspective Uses 2 methods of data collection to triangulate Interviews were analysed by more than one researcher but unclear how discrepancies were addressed Contextual details about the setting are absent The researcher acknowledges that they were involved in the interview and analysis process and kept a reflexive diary but does not give details on this in the write-up i.e. how their role may have impacted Limited discussion regarding the limitations of the study Quality appraisal rating: 7/14 (+)

Author	Sample	Research Methodology	Key Findings	Methodological Considerations
15. Silveira & Boyer (2015)	4 female counsellors working in an organisation that provides treatment to child victims of interpersonal trauma in the Pacific Northwest region of Canada Between 8 and 22 years clinical experience working with child victims of interpersonal trauma Recruited via purposive sampling	Interview Engaged in journal writing to consider the researchers own biases Thematic Analysis Instrumental multiple case study design	3 themes: “Hope and optimism”, “inspired by the client’s strengths” and “putting challenges and strengths into perspective”	Limited details regarding the interview process Rich data with quotes and context Uses member checking and more than one researcher coded, discrepancies were discussed The researcher acknowledges that they were involved in the interview and analysis process and kept a reflexive diary but does not give details on this in the write-up i.e. how their role may have impacted Limited discussion of the limitations of the study Uses 2 methods of data collection Contextual details about the setting are absent Quality appraisal rating: 8/14 (+)

Author	Sample	Research Methodology	Key Findings	Methodological Considerations
16. Sui & Padmanabhanunni (2016)	6 psychologists working with victims of a range of different traumas in South Africa (private practice or community and public health settings) 4 females, 2 males Recruited via purposive sampling	Semi-structured interview Field notes were completed after each interview regarding the researcher's experience of the interview and reflections on any emerging concepts Thematic Analysis	2 themes: "Vicarious trauma" and "positive transformations"	Data analysis is rigorous Rich data with quotes and pseudonyms Coding was checked by an independent assessor Utilises member checking No discussion regarding the limitations of the study Uses 2 methods of data collection No justification as to why analysis method was selected The researcher acknowledges that they were involved in the interview process and kept a reflexive diary but does not give details on this in the write-up i.e. how their role may have impacted Quality appraisal rating: 10/14 (++)

3.0 Results

The analysis produced four superordinate themes “altered outlook on life and perception of self and other”, “emotional experiences”, “cognitive experiences” and “behavioural responses”. These themes were derived though combining the similarities and identifying the differences across the different papers to provide a synthesised understanding of therapists’ experiences of working with trauma survivors. Although these themes will be discussed separately, many of the ideas overlap so will be discussed together where these intersect. Some of the superordinate themes are broken down into subordinate themes. Please see Table 5 for an outline of how the themes have been organised along with papers that contributed to each theme. Short quotes are included in the narrative of this review, but further examples of illustrative quotes have been included at the end of each subordinate theme. Each study has been allocated a number in Table 4 which will be used throughout the results section.

Table 5: Summary of superordinate and subordinate themes with papers that contributed

Superordinate theme	**Papers contributing to this theme (out of 16)**	**Subordinate themes**	**Papers contributing to this sub-theme**
Altered outlook on life and perception of self and other	14 papers contributed Killian (2008) and Hernandez-Wolfe et al. (2015) did not contribute	View of the self	Arnold et al. (2005), Baker (2012), Bartoskova (2017), Bell (2003), Engstrom et al. (2008), Hunter (2012), Lonergan et al. (2004), Lu et al. (2017), Pistorius et al. (2008), Silveira & Boyer, (2015), Sui & Padmanabhanunni (2016)
		View of others and the world	Arnold et al. (2005), Baker (2012), Bartoskova (2017), Bell (2003), Engstrom et al. (2008), Hernandez et al. (2007), Hunter (2012), Lonergan et al. (2004), Pack (2014), Pistorius et al. (2008), Possick et al. (2015), Silveira & Boyer (2015), Sui & Padmanabhanunni (2016)
Emotional experiences	14 papers contributed Bartoskova (2017) and Engstrom et al. (2008) did not contribute	Emotional turmoil and growth	Arnold et al. (2005), Baker (2012), Bell (2003), Hernandez et al. (2007), Hernandez-Wolfe et al. (2015), Hunter (2012), Killian (2008), Lonergan et al. (2004), Lu et al. (2017), Pack (2014), Pistorius et al. (2008), Possick et al. (2015), Silveira & Boyer (2015), Sui & Padmanabhanunni (2016)
		Bodily expressions	Arnold et al. (2005), Baker (2012), Bell (2003), Hernandez-Wolfe et al. (2015), Killian (2008), Lu et al. (2017), Pack (2014), Pistorius et al. (2008), Possick et al. (2015), Sui & Padmanabhanunni (2016)
Cognitive experiences	All 16 of the papers contributed	Intrusions	Arnold et al. (2005), Baker (2012), Bartoskova (2017), Bell (2003), Hernandez-Wolfe et al. (2015), Hunter (2012), Killian (2008), Pistorius et al. (2008), Possick et al. (2015), Sui & Padmanabhanunni (2016)
		Altering perspectives	Arnold et al. (2005), Baker (2012), Bartoskova (2017), Bell (2003), Engstrom et al. (2008), Hernandez et al. (2007), Hernandez-Wolfe et al. (2015), Hunter (2012), Lonergan et al. (2004), Lu et al. (2017), Pack (2014), Pistorius et al. (2008), Possick et al. (2015), Silveira & Boyer (2015), Sui & Padmanabhanunni (2016)
Behavioural responses	11 papers contributed Bell (2003), Hernandez-Wolfe et al. (2015), Killian (2008), Lu et al. (2017), Possick et al. (2015) did not contribute	No sub-themes	Arnold et al. (2005), Baker (2012), Bartoskova (2017), Engstrom et al. (2008), Hernandez et al. (2007), Hunter (2012), Lonergan et al. (2004), Pack (2014), Pistorius et al. (2008), Silveira & Boyer (2015), Sui & Padmanabhanunni (2016)

3.1 Theme one: Altered outlook on life and perception of self and other

This theme represents the therapists' changed view of self, others and the world based on their exposure to trauma narratives. Therapists identified negative beliefs that had developed through the sheer horror of listening to traumatic material. There was however a sense of growth and development that emerged through engaging with this population.

3.1.1 View of the self

This sub-theme relates to a marked change in therapists' view of self because of working with trauma survivors. There is a real sense of inadequacy, low self-esteem and doubting of one's professional abilities (1-3, 8, 10). One therapist described how they felt like "[they] didn't know what [they were] doing (Baker, 2012, p. 7). Another described "feeling completely incompetent" (Bartoskova, 2017, p. 38). This appeared to be fuelled by feeling overwhelmed, tired, helpless, hopeless and incompetent due to the nature of trauma work (2-3). The idea that it takes longer to achieve change when working with trauma survivors (2-3) brings with it the implicit notion that therapists are repeatedly exposed to traumatic material. Considering this, it is likely that this contributes to the tainted beliefs therapists have about themselves as an ineffective clinician as they are overloaded with sensitive information, yet progress is slow. Additionally, it is when things are not going well within therapy that therapists internalise this and blame themselves (3), asking themselves "what [is] wrong with me?" (Baker, 2012, p. 7) or have beliefs that they are not fit to be a therapist because they experience intense emotions (10).

Although working with trauma survivors is challenging, and disrupted therapists' view of themselves, an experience of growth and development was evident (1, 13, 15-16). Therapists were observed to focus more on their own abilities, strengths, resilience and potential for growth (15-16) because of witnessing their client's resilience, with a sense of "if their clients can do it, so can they" (1, 15-16). Some therapists viewed having an increased awareness of their vulnerability as positive as it enabled them to live their own life to the fullest and appreciate the people in their lives more, as life can change at any given moment (1, 4, 13, 16). Bartoskova (2017) proposed that this positive shift in self-perception is a consequence of making sense of trauma in relation to their work. There was also a sense of viewing the self as stronger because of listening to stories of how people have overcome adversity (5, 11). One therapist suggested that the stronger they become, the more able they feel to cope with life's situations (5). Witnessing post-traumatic growth and progress in clients increased therapist's confidence and belief in their effectiveness as a clinician (3, 11, 13, 15).

Illustrative quotes contributing to the subordinate theme "view of the self"

"I would then take that to be on as that's my fault or … something I am doing wrong" (Bartoskova, 2017, p. 38)

"Years ago, I would think that I was a bad person because I couldn't handle it. I should be out of this profession" (Lonergan et al., 2004, p. 361)

"If kids can do it, and teens can do it, and have things in their lives that are just horrible, then maybe I can continue to do it" (Silveira & Boyer, 2015, p. 521)

"I improved myself in a meaningful way. I developed myself. It demanded of me to make an effort to the edge of my abilities and to develop myself with them. It demanded of me to also encounter the bad in me. I am today a much richer and fuller person" (Possick et al., 2015, p. 829)

3.1.2 View of others and the world

This sub-theme relates to a shift in the way therapists view the world because of exposure to traumatic stories. Therapists spoke about the impact of having an increased awareness of the capability of mankind for cruelty (the “dark side of human nature”, Arnold et al., 2005, p. 253) and the existence of profound suffering. There was a tendency to focus on the violent acts that people perpetrate and at times to overgeneralise the existence of abuse (1, 10, 13, 16). Therapists expressed shock and disgust as their previously held (“naïve”, Pistorius et al., 2008, p. 188) beliefs were shattered by the realisation that the world is dangerous, unsafe and unfair (3-4, 8, 13-14, 16). These beliefs challenged previously held ideas around safety, trust and control (2, 8). There was a heightened sense of danger (8) and an idea that such beliefs were “forever changed and there’s nothing that can alter that” (Bell, 2003, p. 516). One therapist described how it “shaded my view of life” (Arnold et al., 2005, p. 254).

To make sense of their experiences, therapists viewed others as either victims or perpetrators, and the world as either safe or unsafe (14). This potentially enabled the therapists to distance themselves from the horror of the “darker side of life” whilst also remaining vigilant to its presence. Therapists presented as cynical, mistrusting, paranoid and suspicious (2-4, 13-14, 16). This resulted in increased attempts to ensure that loved ones were protected (8, 13, 16) and impacted on their capacity to be intimate with their spouses (2, 8-9, 13). Engaging with trauma survivors also challenged therapists’ spirituality (1-2, 8, 12).

For some therapists working with trauma survivors had a positive impact on their view of the world. As opposed to focusing on trauma survivors as victims, there was a real sense of strength and resilience in being able to survive and continue to live their lives through witnessing their clients change and grow (1, 4-6, 8, 15). Some therapists were able to transfer the notion of strength and resilience to their view of others (1, 6, 15). This renewed belief that trauma survivors are resilient had a marked impact on therapists' everyday thought processes. Witnessing survivors overcome adversity and heal enabled therapists to put their own difficulties into perspective and prompted them to address such difficulties (4-7, 15). There was a real sense of hope and optimism because of witnessing trauma survivors cope and thrive (1, 3, 5-7, 10, 12, 14-16).

Having an increased awareness of the darker side of life allowed some therapists to develop a broader view of life which changed their view of perpetrators, enabling them to be more empathic to factors that predispose them to acts of violence (1, 15). Some therapists were more open to broadening their spirituality because of the existential nature of trauma (1-2, 6). There were renewed beliefs in the therapeutic process (6, 10, 15) and motivation to support survivors in their recovery (5-6, 13-15).

Illustrative quotes contributing to the subordinate theme "view of others and the world"

"I have follow up with some of my clients and I'm reminded that the whole world is not in crisis … that women do learn how to laugh and be silly again … I truly feel it's watching a rebirth of a human being" (Bell, 2003, p. 516)

"I remember when I was working at rape crisis centre, at one stage I was thinking all men are rapists and I was just really terrified of men in general ... I suppose my worldview now is that men are potential perpetrators, doesn't mean that they all are, but there's a potential" (Sui & Padmanabhanunni, 2016, p. 130)

Illustrative quotes contributing to the subordinate theme "view of others and the world"

"I can actually remember coming out of a session and speaking to a co-worker and saying 'there is no God' having just had an interview with a little child who had been subjected to extreme sadism and abuse of every kind and had been rejected by her own parents as well" (Hunter, 2012, p. 185)

"The surprising degree of strength, ability to persist in the face of terrible past traumas and current obstacles. And to go forward with energy, hope, even enthusiasm for life in spite of the terrible hardships and traumas that people have suffered" (Engstrom et al., 2008, p. 16)

3.2 Theme two: Emotional experiences

This theme represents the emotions experienced by therapists working with trauma survivors and how this is manifested in their bodies. These emotional experiences were wide-ranging, intense and often damaging. However, some positive emotions were experienced through being involved in the recovery of trauma survivors.

3.2.1 Emotional "turmoil" and growth

A range of fluctuating, distressing emotions were experienced by therapists exposed to trauma narratives (14). Listening to the horrendous ordeals that trauma survivors have been through left therapists feeling sad (1-2, 8, 10, 13-14, 16) and angry (1, 6, 16). This is unsurprising given the disruption to previously held beliefs that the world is safe and fair (3-4, 8, 13-14, 16). There was a sense of fear (1-2, 6-7,13) and anxiety (1-2, 9, 14) regarding the safety of self and others. This is likely to

be a consequence of newly formed beliefs that the self is vulnerable, and abuse is prominent (1, 10, 13, 16).

The sense of naivety previously mentioned provides a context in which feelings of shock (1, 11, 13) and disgust (14) are heightened as an increased awareness of trauma shakes their previously held belief system (3-4, 8, 13-14, 16). Some therapists reported feelings of guilt (14), possibly due to the realisation that they are one of the lucky ones. Frustration (1, 9, 11, 16) and irritability/agitation (7, 9, 14, 16) were experienced, which is possibly linked to feelings of hopelessness and helplessness about not being able to change what the client has been through (2, 11, 16).

There is a real sense of these emotions being overwhelming (6, 9, 13), draining (8) and difficult to control (9, 16). Possick et al. (2015) refer to the notion of emotional heaviness and resulting turmoil that therapists experience when engaging with trauma survivors. They proposed that identifying one's own vulnerabilities in a client can mean that a therapist's work becomes all-consuming – intruding on and infiltrating their personal life. Therapist's described "carrying [a client's] suffering around with [her]" (Arnold et al., 2005, p. 248), experiencing intense anxiety when at home (2) and "carry[ing] feelings home from work" (Killian, 2008, p. 35).

To protect themselves from further distress, some therapists described feeling detached/disconnected/dissociating (1, 7, 9-10, 13, 16), desensitised (4, 8) and "shut down" (Killian, 2008, p. 35) following repeated exposure to trauma narratives. Some therapists spoke about difficulties with emotional intimacy because of hearing about

trauma (13). There is a sense of "[not having] any more to give" (Killian, 2008, p. 35) and being burnt-out.

Some therapists experienced positive emotions from engaging with trauma survivors. There was a sense of pleasure derived from witnessing and being involved in a client's recovery (1-2). One therapist highlighted how an awareness of strength and resilience enabled her to regulate her own emotional experiences and prevent relationships from being adversely affected (15). Therapists reported increased levels of compassion (1, 4), empathy (1) and sensitivity (1, 13). Some therapists described increased gratitude for their own lives (1, 4, 13, 15) which enabled them to consciously make choices to live life to the full (1, 13).

Illustrative quotes contributing to the subordinate theme "emotional turmoil and growth"

"You feel that your psyche is on a roller coaster, on the loops, on the ups and on the downs. There is no emotion that doesn't arise in me, from the entire spectrum of the pleasant emotions and to the spectrum of the difficult emotions of pain, of guilt, of sadness, of frustration, of hopelessness" (Possick et al., 2015, p. 821 - 822)

"I've fantasized of . . . looking out the window. I'm like, I'd rather be doing anything than this. Where I go to is like being a waitress in Paris serving coffee to people and not having to make decisions . . . I dissociate" (Pistorius et al., 2008, p. 187)

"I guess I could put it succinctly by saying I go home and count my blessings—it's affected me that way. By the time I get home, I realize I've got a lot to be thankful for" (Arnold et al., 2005, p. 252)

"It just makes me put things into perspective. Actually I do have a pretty good life. I face challenges, but … how can I change something into something else?" (Silveira & Boyer, 2015, p. 521)

3.2.2 Bodily expressions

Some therapists presented an image of total exhaustion. Language such as "weariness", "fatigue", "tiredness", "exhaustion" and "lack of energy" were used when describing the impact that working with trauma survivors has on the body (1-2, 7, 9, 13, 16). There is a real sense of the work taking its toll with symptoms such as pain, nausea, dizziness/light-headedness, headaches/migraines, muscle tension/soreness and breathing difficulties (including asthma) being described, many of which had no medical cause (1-2, 4, 9, 11, 12, 14, 16). The impact on the body was further exacerbated when progress was slow (12). This image of an exhausted state is not surprising given the sleep disruption reported by some therapists (2, 4, 7, 9, 16). Emotions were sometimes expressed outwardly through tearfulness (2, 11, 13), perhaps as a way of discarding excess emotions.

There is also a sense of being on guard or "on edge" (Baker, 2012, p. 5) with increased hyper-vigilance and hyper-arousal being reported (2, 7, 16). This is unsurprising given the shift in worldview discussed earlier in the paper. This implies that therapists remained vigilant to potential threat as they constructed new schema around the behaviour of others, the danger in the world and their vulnerability within it.

Illustrative quotes contributing to the subordinate theme "bodily expressions"

"There are times where they share details with you, or they tell you stories or draw pictures, or make disclosures. And it just makes you sick, it's just hard to listen to. Mostly, my heart aches. So everyday you're going home crying, or you're freaking out or having nightmares because you're taking people's trauma home with you" (Pistorius et al., 2008, p. 186)

Illustrative quotes contributing to the subordinate theme "bodily expressions"

"And then there are those times when I'm just tired, you know? Just really, really tired. I feel sort of the—it's not the weight of the world, but it feels like that a little bit sometimes at the end of the day" (Arnold et al., 2004, p. 249)

"To encounter the cases is not simple at all. It is like waves, very, very difficult cases. I remember myself actually not able to breathe, a physical experience that I have no air" (Possick et al., 2015, p. 822)

"That was emotionally hard for me just because, like this was a real person who had experienced these things. I cried with her in [the] session because, like, that was just very hard for me to hear, that like she had lived through that experience" (Lu et al., 2017, p. 326)

3.3 Theme three: Cognitive experiences

This theme represents the cognitive experiences of therapists working with trauma survivors. Therapists' cognitive experiences were influenced by their newly formed beliefs about the self as vulnerable, others as dangerous and the world as unsafe. Cognitive experiences in this section reflected the therapists' "in the moment" thought processes or intrusions on their personal life. Witnessing the growth and resilience of trauma survivors had a positive impact on therapists' thoughts about their own difficulties, life, trauma survivors and their professional work.

3.3.1 Intrusions

Some therapists reported thinking about their clients outside of work hours, especially sessions that had been challenging (2). Many of the therapists reported that they experienced intrusive thoughts, images and nightmares about their client's trauma (1-4, 7, 9, 13-14, 16). One study reported flashbacks in one of their therapists (7). Possick et al. (2015) described how this imagery flooded, intruded and infiltrated

the therapist's personal life. There is a sense of re-playing the trauma in one's own head as if it is in real time and not being able to get it out of one's head (2, 9). This had an impact on therapists' ability to be intimate with their partner (9, 13). Conversely intimacy can trigger memories of trauma reported by clients (9). Possick et al. (2015) discussed how therapists struggled to maintain the boundary between their personal and professional lives which made them feel like they lacked control.

Experiencing such imagery is likely to reinforce therapists' beliefs about the world being unsafe and hostile. It is therefore unsurprising that suspiciousness or paranoia was present for some individuals (2-4, 13-14, 16). This presented as hyper-vigilance and hyper-arousal (2, 7, 16) with some individuals questioning their own personal relationships (8, 13) due to mistrust of others (2,14, 16). Bell (2003) described some of her participants as feeling more negative towards others.

Some therapists described confusion (7) and forgetfulness (9) as consequences of working with trauma. Pistorius et al. (2008) identified a sense of dread experienced by some therapists where they hoped that clients would not attend their appointments or experienced relief when they cancelled. One therapist reported that they do not want to hear about trauma so they do not ask for details (Pistorius et al., 2008). These experiences suggest both a conscious and an unconscious desire to avoid exposure to traumatic material.

Illustrative quotes contributing to the subordinate theme "intrusions"

"I replay everything in my head as if it's happening […] it was those visuals that I had, not being able to get those out of my head. And then seeping into my outside life" (Baker, 2012, p. 8)

"I sometimes dream about rape in different ways. Myself in it, my daughter in it…It's just very distressing dreams" (Sui & Padmanabhanunni, 2016, p. 130)

Illustrative quotes contributing to the subordinate theme "intrusions"

"There are still times when I see a videotape of a client talking about abuse that's just horrific that I can't get out of my head. Then I can't be intimate with my husband at all, I just can't, and I tell him, "You know, I saw something at work …" (Killian, 2008, p. 35)

"When I started working here, it came up [it was] terrible, terrible, powerful, the part of hearing it and thinking what would happen if? If it would happen to one of my children. Maybe it's happening and I don't know. It puts [one] terribly in a place of apprehension. You hear how common it is, how widespread it is. You hear mothers that are like me and like you, standing helpless facing this place that their child is abused [damaged] very badly" (Possick et al., 2015, p. 824)

3.3.2 Altering perspectives

There was a reduced level of optimism (1) and hopelessness (6-7, 10-11, 14) in therapists engaging with trauma survivors. Therapists reported feelings of helplessness and powerlessness (1-2, 12, 14, 16). This is potentially due to an awareness of the limitations of therapy in changing what has happened to their clients (6, 11, 13) as well as clients making slow progress (2).

However, there was a sense of hope and optimism which developed from witnessing trauma survivors cope and thrive (1, 3, 5-7, 10, 12, 14-16). Some therapists found witnessing clients' recovery rewarding (2), particularly their involvement in facilitating that change (3, 8, 10, 15). Witnessing post-traumatic growth and progress in clients increased therapists' confidence and belief in their effectiveness as a clinician (3, 11, 13, 15). There were renewed beliefs in the therapeutic process (6, 10, 15) and motivation to support survivors in their recovery (5-6, 13-15).

Witnessing survivors overcome adversity and heal enabled therapists to put their own difficulties into perspective and prompted them to address such difficulties

(4-7, 15). Therapists were grateful for their own lives (1, 3-4, 13, 15-16). Some therapists described being less judgemental (4). Admiration and respect for survivors of trauma was evident (3, 5, 7, 15).

Illustrative quotes contributing to the subordinate theme "altering perspectives"

"The hardest thing is knowing that whatever trauma happened to them, they can't go back somehow and fix it … it's a very helpless feeling" (Baker, 2012, p. 6)

"After working with people who have suffered these kinds of problems, your definition of a problem changes. One takes issues with more ease. One defines what is serious differently" (Hernandez et al., 2007, p. 234)

"People often say: ''How can you do this kind of work?'' ''How can you sit here and hear these terrible things day after day.'' And my stock response is usually: ''Well I couldn't if there was no hope.'' I am hearing stories of regeneration, of people succeeding over hideous odds often. And if there wasn't that, I couldn't do it" (Pack, 2014, p. 23)

"I think it's the only thing that keeps us going in this profession, really[,] is [sic] seeing what people have—where the resilience is, where the strengths are, and having enormous respect and admiration for what keeps people going" (Engstrom et al., 2008, p. 18)

3.4 Theme four: Behavioural responses

This theme represents the behaviours displayed by therapists engaging with trauma survivors. Therapists were reported to pull away from others or express a desire to protect their loved ones. Positive consequences of engaging with trauma survivors included appreciation of others and their own life as well as behaving in ways to promote this.

Most therapists expressed a tendency to pull away from others or a desire to protect their loved ones. Pulling away from others through avoidance (1-2, 13) and isolation (2, 13) was evident. This included not wanting to talk about work (13) and

avoiding intimacy (2, 8, 13) due to feeling drained after a day's work. The desire to pull away from and isolate the self from others appeared to be rooted in therapists' decreased ability to trust others (2, 8). One therapist highlighted losing faith in her religion and consequently leaving her church (12). The newly formed belief that the world is unsafe impacted on the behaviour of therapists (8). Hyper-vigilance was evident (2) with therapists presenting as over-protective of their own children (8, 10, 13) and taking measures to ensure the safety of loved ones (13, 16).

Some therapists viewed having an increased awareness of their vulnerability as positive in that it enabled them to live their own life to the fullest and appreciate the people in their lives more, as life can change at any given moment (1, 4, 13, 15-16). Some therapists spoke about treating others with kindness and respect because of engaging with trauma survivors (1, 13, 15), others spoke about being more emotionally expressive (1) or thoughtful and attentive (3). Some therapists reported better communication with their children (13). Therapists were grateful for their own lives (1, 3-4, 13, 15-16) and were more motivated to address their own difficulties (5-6, 15).

Illustrative quotes contributing to the superordinate theme "behavioural responses"

"We try not to be so over protective that they can't go anywhere, but if my kids want to go and have a sleepover at a friend's place, then I have a sense of hesitation" (Hunter, 2012, p. 185)

"So, you know, you come home, and you see your husband, and he's excited to see you, wants to spend time with you […] I have had to learn to say, 'Look […] I've spent half my day doing EMDR with clients around their sexual abuse. I'm in no position to be intimate with anyone.' I need to sit on the couch and watch some sitcom or something" (Baker, 2012, p. 8)

Illustrative quotes contributing to the superordinate theme "behavioural responses"

"You glamorize it and it's not glamorous. It's dirty and it's tedious, and you get burned out and it's tiring. It is definitely a heavy job and, I don't know if I can do this my whole life. You don't really talk about these things or even think about it, you'd just, you'd find yourself crying" (Pistorius et al., 2008, p. 186)

"Life as I know it could change dramatically overnight, so I have an obligation to live my life more fully because it's not guaranteed that life will continue the way it has" (Arnold et al., 2005, p. 252)

4.0 Discussion

The aim of this review was to gain a deeper understanding of how therapists experience working with trauma survivors. This paper examined existing qualitative literature with a reasonable degree of integrity and synthesised the original themes, extracting quotes to support new interpretations. The themes identified in this review suggest a cognitive model of vicarious trauma and growth whereby therapists presented with cognitive, emotional, physiological and behavioural 'symptoms' due to marked changes in schemata following repeated exposure to trauma.

4.1 The complex and profound experience of working with trauma

This review presents a profound picture of the impact of working with trauma, with symptoms which align themselves to the concept of vicarious trauma. Marked changes in beliefs about the self, others and the world can be evident (Bride et al., 2007; Pearlman & Saakvitne, 1995). Therapists could view themselves as incompetent and vulnerable, others as dangerous, untrusting and 'predatory' and the world as unsafe and unfair. This may challenge previously held belief systems and is consistent with research by Janoff-Bulman (1992). Armed with this new knowledge therapists can act in ways to enhance the safety of self and others. The exhaustion of hearing about trauma can be outstanding, taking therapists on an overwhelming emotional, physical and never-ending journey as no matter what they do they cannot remove the trauma history. This can become internalised as personal failure, thus strengthening the belief that they are incompetent and further exacerbating their exhaustion.

Trauma material can infiltrate the therapist's personal life and may reinforce their view of the hostile world. Therapists can be left feeling drained and like they cannot escape. To stay safe, therapists can detach from the emotional content, perhaps as a way of avoiding engaging with difficult material (Baranowsky, 2002). For some therapists they could develop schemas that separate the perpetrators from the victims. This appears to enable the therapist to separate themselves from the unsafe world (i.e. they are neither perpetrators or victims) yet ensures that they remain vigilant to its presence (i.e. just in case they become positioned as one). Additionally, it is possible that the thought of somebody being both a victim and a perpetrator, challenges therapists' view of the world which is why they may attempt to distance themselves from this notion. Some of these symptoms present like burnout, compassion fatigue and secondary trauma but it is the shift in worldview that makes their presentation more in keeping with vicarious trauma (Elwood et al., 2011). Although Killian (2008), Lonergan et al. (2004) and Lu et al. (2017) acknowledged that the experience of vicarious trauma may impact on the therapeutic relationship, the papers in this review did not appear to consider how the experience of vicarious trauma 'symptoms' might impact on the quality of the therapy provided to clients.

So how do therapists move beyond this and begin to experience growth and development? Cohen and Collens (2013) proposed that the experience of vicarious trauma and post-traumatic growth occur through empathic engagement with trauma narratives. They purported that helpers experience shock from their client's adverse experiences or their remarkable strength and resilience. Their paper suggests that therapists go through a process of meaning making as these experiences challenge their existing global beliefs and as such a cognitive shift is experienced. These

authors reflected on how positive *and* negative changes to the helper's belief system can occur and drew on the work of Joseph and Linley (2008) in making sense of this i.e. that the self is multi-faceted and can thus integrate both positive and negative aspects. Adding to this understanding, Linley et al. (2005) proposed that as new beliefs are infused with old beliefs the therapist comes to a point where they can experience growth and development because their understanding of the world is enriched. Bartoskova (2017) proposed that this occurs through a process of sense-making.

In this review some individuals experienced a positive shift in their cognitive schemata which appeared to have important implications for their cognitive, emotional and behavioural responses in both their personal and professional's lives. There appeared to be a sense of strength and a recognition of their own abilities through witnessing the resilience of trauma survivors. Pearlman and Saakvitne (1995) proposed that growth occurs when helpers are inspired by their client's ability to survive adverse experiences. Social learning theory appears relevant here whereby therapists bear witness to growth and incorporate this into their own experiences (Bandura, 1977).

Therapists may find trauma work rewarding, particularly when they view themselves as having been a part of their client's growth. Bartoskova (2017) proposed that as confidence increases, the level of self-doubt plateaus as therapists begin to see the impact of trauma work. Bearing witness to recovery may also affirm therapists' commitment to their work as well as their belief in therapy. Seeing the self as more vulnerable may prompt therapists to live their life more fully and appreciate their loved ones more. This is in line with research by Tedeschi and Calhoun (1996).

Through this process therapists may be able to alter their view of others as either victims or perpetrators of adverse events, to develop a more nuanced, compassionate, optimistic perspective which is more in keeping with their profession i.e. formulation-driven. Being aware of others suffering may enable therapists to contextualise their own difficulties and witnessing client resilience could prompt them to take action. For some individuals there may be an increase in emotional connectiveness with others and gratitude for their own fortune.

Although there is evidence of compassion satisfaction (i.e. finding being involved in a client's recovery satisfying; Figley, 2002), the experience of therapists in this review appears to move beyond this as it includes a much deeper change in the therapist's belief system. The symptomology described in the papers examined in this review is more consistent with the idea of vicarious post-traumatic growth. Building on the ideas of Cohen and Collens (2013) and the findings of this review, a cognitive model of vicarious trauma and growth is outlined in Figure 4.

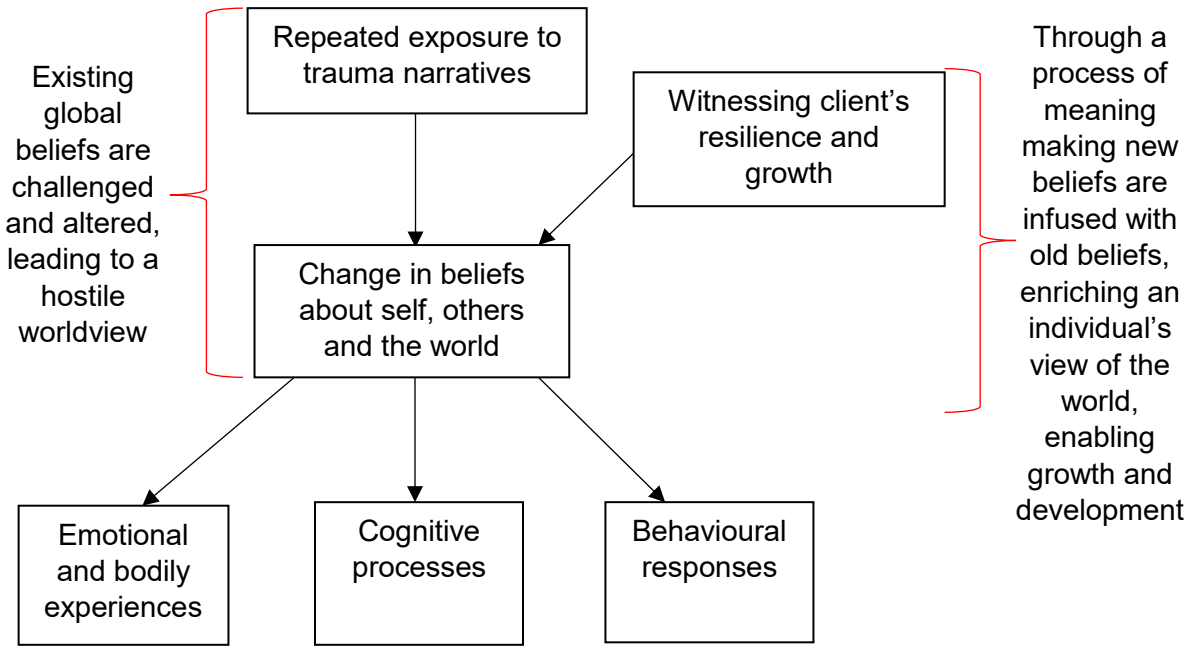


Figure 4: Cognitive model of vicarious trauma and growth

4.2 Clinical implications

The findings of this review bring to attention the profound impact of working with trauma. An awareness of the adverse effects of trauma work is important given that containment of the self and other is an important aspect of effective therapy (Edwards, 2009; Lonergan et al., 2004; Pistorius et al., 2008). Existing research outlines the potential impact of vicarious trauma on the therapeutic relationship (Herman, 1992; Lonergan et al., 2004; Pistorius et al., 2008) and therefore the findings strengthen the argument that employee well-being should be prioritised, in line with government recommendations (Stevenson & Farmer, 2017).

Synthesising existing qualitative literature examining the impact of trauma work has enabled a deeper insight into the possible negative effects of working with trauma. This knowledge has important implications for the level of support that services can consider providing to helpers in minimising the adverse of effects of trauma work. It would be beneficial to open-up the dialogue about vicarious trauma and its effects when individuals embark on their journey as helpers of trauma survivors. Reinforcing this periodically would be particularly important in normalising the experience of vicarious trauma. This may be through clinical supervision, training, away days and reflective practice sessions. Asking about how helpers are finding the work is important given the reported internal changes that occur; these may not be easy to see externally. Being able to process and make sense of how repeated exposure to trauma is having an impact on therapists' sense of self and way of being can be extremely validating and potentially protective against how they navigate their way through such changes. It can also enable organisations to identify difficulties and put in measures to support the individual.

Techniques which utilise a Cognitive Behavioural, Compassion Focused or Acceptance and Commitment Therapy focus could be beneficial in supporting individuals who work with trauma survivors. This would target self-criticism, acceptance of the nature of trauma work, maladaptive ways of coping, intrusive thoughts, physiological symptoms and challenging beliefs about self, depending on what is being experienced. This focus would mirror the themes that have emerged from this meta-ethnographic review. Key difficulties could be identified at a team level and interventions could be provided through individual and group forums.

Normalising the nature of trauma work (i.e. it takes longer to achieve change) could be beneficial in challenging beliefs that one is incompetent. Taking a systemic approach, where organisations are open to a culture that has an awareness of and normalises the experience of vicarious trauma, would be beneficial in mitigating the effects of working with trauma, particularly as having a strong support system has been identified as paramount for coping with trauma work in other studies (Killian, 2008; Pistorius et al., 2008).

An important finding of this review was that some therapists experienced their own growth through being involved in their client's recovery. This can moderate against thoughts of self-doubt (Bartoskova, 2017). Again, a system-led approach around strength and resilience can further facilitate growth and development in helpers. As a society we tend to focus more on the negative aspects of life rather than the positive. This is reflected in the larger focus on the negative aspects of trauma work in the findings section of this review. Introducing a narrative around what is going well could become more integrated in the ethos of organisations providing support to trauma survivors and incorporated into clinical supervision and

reflective practice. This could moderate the adverse effects of long-term interventions or when therapy ends abruptly.

4.3 Limitations of this review

This review included papers of a reasonable quality which were assessed using NICE's (2012) guidance on quality appraisal. There are two arguments in this regard. Some of the papers that were included in this review were on the cusp of good quality and may have reduced the reliability of the findings. However, one could also argue that excluding papers deemed poor quality may have meant that important findings were missed that may have altered the results and provided alternative perspectives. Thus the 16 articles that were included provide an understanding of *some* therapists' experience of their work with trauma survivors; it is unlikely to be representative of *every* therapist who works with trauma.

Additionally, although a systematic search strategy was adopted it is important to acknowledge that there may be relevant articles which were not identified due to some of the criteria that outlined what was suitable for inclusion. For instance, articles which were not peer reviewed, did not include participant quotes or had less than 75% of therapist included in the sample were excluded. These articles may have provided an alternative perspective to the experience of working with trauma.

The type of review selected for this paper relies on the interpretation of the original findings as well as new interpretations by myself. This means that there is a level of subjectivity inherent in the methodology utilised. The analysis was reviewed on several occasions with my supervisor to increase the reliability of the review however the qualitative paradigm means that potential bias is always present. It is

possible that my view of the world as a Trainee Clinical Psychologist may have impacted on the way I interpreted the data. For instance, I have been heavily exposed to a Cognitive Behavioural way of thinking throughout my training and this is my preferred model. This is likely to have guided my way of thinking when synthesising the data and may have prevented me from looking at this more freely.

This review outlines a range of differing reactions to working with trauma. It was difficult to ascertain whether these responses came from different participants, the same participants at different times or the same participants at the same time.

4.4 Future directions

Future directions for research could link in with some of the clinical implications discussed in this review. It would be useful to explore how embedding an organisational culture around the effects of vicarious trauma, normalising the experience and a focus on what is going well, impacts on helpers' experience of vicarious trauma and post-traumatic growth. If organisations were to pilot this, it would be useful to evaluate its effectiveness.

Some researchers have begun to think about how vicarious trauma and post-traumatic growth co-exist and the process behind this (Cohen & Collens, 2013; Linley et al., 2005). The results of this review provide some evidence for a cognitive model of vicarious trauma and growth. Further research would be welcomed to understand this process and factors which influence it in more depth. Further investigation utilising quantitative measures could be indicated to test the validity of the proposed model.

Future research exploring the impact of vicarious trauma on the quality of the therapy provided to clients would be useful given the reflections made by Killian (2008), Lonergan et al. (2004) and Lu et al. (2017). Finally, further exploration of the differing reactions reported by therapists working with trauma may be beneficial to further enhance our understanding of vicarious trauma and post-traumatic growth.

4.5 Conclusion

Although this review has some limitations, the findings are based on several studies which were appraised to be of reasonable quality. This review proposes that therapists experience growth and development alongside vicarious trauma through witnessing clients' resilience and growth. Through synthesising existing research, the current findings outline a cognitive model of vicarious trauma and growth which enriches our understanding of therapists' experience of working with trauma survivors. The findings of this review have enabled recommendations to be made for organisations to support individuals working with trauma survivors as well as potential areas of further research.

5.0 References

Arnold, D., Calhoun, L, G., Tedeschi, R., & Cann, A. (2005). Vicarious posttraumatic growth in psychotherapy. *Journal of Humanistic Psychology, 45*, 239 - 263.

Baird, K., & Kracen, A, C. (2006). Vicarious traumatization and secondary traumatic stress: A research synthesis. *Counselling Psychology Quarterly, 19,* 181 – 188.

Baker, A, A. (2012). Training the resilient psychotherapist: What graduate students need to know about vicarious traumatization. *Journal of Social, Behavioral and Health Sciences, 6*, 1 – 12.

Bandura, A. (1977). *Social learning theory.* Englewood Cliffs, New Jersey: Prentice Hall.

Baranowsky, A, B. (2002). The silencing response in clinical practice: On the road to dialogue. In C. R. Figley (Ed.). *Treating compassion fatigue* (pp. 155 – 170). New York: Brunner-Routledge.

Barrington, A, J., & Shakespeare-Finch, J. (2013). Working with refugee survivors of torture and trauma: An opportunity for vicarious post-traumatic growth. *Counselling Psychology Quarterly, 26*, 89 – 105.

Bartoskova, L. (2017). How do trauma therapists experience the effects of their trauma work, and are there common factors leading to post-traumatic growth? *Counselling Psychology Review, 32*, 30 – 45.

Beck, C, T. (2011). Secondary traumatic stress in nurses: A systematic review. *Archives of Psychiatric Nursing, 25*, 1 - 10.

Bell, H. (2003). Strengths and secondary trauma in family violence work. *Social Work, 48,* 513 – 522.

Benatar, M. (2000). A qualitative study of the effect of a history of childhood sexual abuse on therapists who treat survivors of sexual abuse. *Journal of Trauma & Dissociation, 1,* 9 – 28.

Bride, B, E., Radey, M., & Figley, C, R. (2007). Measuring compassion fatigue. *Clinical Social Work Journal, 35*, 155 − 163.

Bride, B, E., Robinson, M, R., Yegidis, B., & Figley, C, R. (2004). Development and validation of the Secondary Traumatic Stress Scale. *Research on Social Work Practice, 14*, 27 − 35.

Britten, N., Campbell, R., Pope, C., Donovan, J., Morgan, M., & Pill, R. (2002). Using meta ethnography to synthesise qualitative research: A worked example. *Journal of Health Services Research & Policy, 7,* 209 – 215.

Campbell, R., Pound, P., Morgan, M., Daker-White, G., Britten, N., Pill, R., … Donovan, J. (2011). Evaluating meta-ethnography: Systematic analysis and synthesis of qualitative research. *Health Technology Assessment, 15*, 1 – 164.

Cieslak, R., Shoji, K., Douglas, A., Melville, E., Luszczynska, A., & Benight, C, C. (2014). A meta-analysis of the relationship between job burnout and secondary traumatic stress among workers with indirect exposure to trauma. *Psychological Services, 11*, 75 – 86.

Cohen, K., & Collens, P. (2013). The impact of trauma work – A meta-synthesis on vicarious trauma and vicarious trauma growth. *Psychological Trauma: Theory, Research, Practice, and Policy, 5*, 570 - 580.

Conrad, D., & Kellar-Guenther, Y. (2006). Compassion fatigue, burnout, and compassion satisfaction among Colorado child protection workers. *Child Abuse & Neglect, 30*, 1071 − 1080.

Craig, C, D., & Sprang, G. (2010). Compassion satisfaction, compassion fatigue, and burnout in a national sample of trauma treatment therapists. *Anxiety, Stress and Coping, 23*, 319 – 339.

de Figueiredo, S., Yetwin, A., Sherer, S., Radzik, M., & Iverson, E. (2014). A cross-disciplinary comparison of perceptions of compassion fatigue and satisfaction among service providers of highly traumatized children and adolescents. *Traumatology, 20,* 286 – 295.

Doyle, L, H. (2003). Synthesis through meta-ethnography: Paradoxes, enhancements and possibilities. *Qualitative Research, 3*, 321 - 344.

Edelkott, N., Engstrom, D, W., & Hernandez-Wolfe, P. (2016). Vicarious resilience: Complexities and Variations. *American Journal of Orthopsychiatry, 86,* 713 – 724.

Edwards, D, J, A. (2009). Treating post-traumatic stress disorder in South Africa: An integrative model grounded in case-based research. *Journal of Psychology in Africa, 19*, 189 – 198.

Elwood, L, S., Mott, J., Lohr, J, M., & Galovski, T, E. (2011). Secondary trauma symptoms in clinicians: A critical review of the construct, specificity, and implications for trauma-focused treatment. *Clinical Psychology Review, 31,* 25 – 36.

Engstrom, D., Hernandez, P., & Gangsei, D. (2008). Vicarious resilience: A qualitative investigation into its description. *Traumatology, 14*, 13 – 21.

Figley, C, R. (1995). Compassion fatigue: Toward a new understanding of the costs of caring. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self care issues for clinicians, researchers, and educators* (pp. 3 − 28). Baltimore, Maryland: The Sidran Press.

Figley, C, R. (2002). Compassion fatigue: Psychotherapists' chronic lack of self-care. *Journal of Clinical Psychology, 58*, 1433 – 1441.

Figley, C, R. (Ed.). (2015). *Treating compassion fatigue* (3rd edition). New York: Bruner-Routledge.

Finfgeld, D, L. (2003). Metasynthesis: The state of the art—so far. *Qualitative Health Research, 13*, 893 – 904.

Francis, R. (2013). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry.* London: The Stationery Office.

Henry, O., & Evans, A, J. (2008). Occupational stress in organisations. *Journal of Management Research, 8*, 123 - 135.

Hensel, J, M., Ruiz, C., Finney, C., & Dewa C, S. (2015). Meta-analysis of risk factors for secondary traumatic stress in therapeutic work with trauma victims. *Journal of Traumatic Stress, 28*, 83 - 91.

Herman, J, L. (1992). *Trauma and recovery: The aftermath of violence*. New York: Basic Books.

Hernandez, P., Gangsei, D., & Engstrom, D. (2007). Vicarious resilience: A new concept in work with those who survive trauma. *Family Process, 46,* 229 – 241.

Hernandez-Wolfe, P., Killian, K., Engstrom, D., & Gangsei, D. (2015). Vicarious resilience, vicarious trauma, and awareness of equity in trauma work. *Journal of Humanistic Psychology, 55,* 153 – 172.

Hunter, S, V. (2012). Walking sacred spaces in the therapeutic bond: Therapists' experiences of compassion satisfaction coupled with the potential for vicarious traumatization. *Family Processes, 51,* 179 – 192.

Hyatt-Burkhart, D. (2014). The experience of vicarious posttraumatic growth in mental health workers. *Journal of Loss and Trauma: International Perspectives on Stress & Coping, 19*, 452 - 461.

Iliffe, G., & Steed, L, G. (2000). Exploring the counselor's experience of working with perpetrators and survivors of domestic violence. *Journal of Interpersonal Violence, 15*, 393 – 412.

Janoff-Bulman, R. (1992). *Shattered assumptions*. New York: The Free Press.

Jenkins, A, R., & Baird, S. (2002). Secondary traumatic stress and vicarious trauma: A validational study. *Journal of Traumatic Stress, 15*, 423 - 432.

Joinson, C. (1992). Coping with compassion fatigue. *Nursing, 22*, 118 – 119.

Joseph, S., & Linley, A, P. (2008). *Trauma, recovery and growth: Positive psychology perspectives on posttraumatic Stress.* New Jersey: Wiley & Sons.

Killian, K, D. (2008). Helping till it hurts? A multimethod study of compassion fatigue, burnout, and self-care in clinicians working with trauma survivors. *Traumatology, 14,* 32 – 44.

Lazarus, R, S., & Folkman, S. (1984). *Stress, appraisal, and coping.* New York: Springer.

Linley, P, A., Joseph, S., & Loumidis, K. (2005). Trauma work, sense of coherence, and positive and negative changes in therapists. *Psychotherapy & Psychosomatics, 74*, 185 – 188.

Lonergan, B, A., O'Halloran, M, S., & Crane, S, C, M. (2004). The development of the trauma therapist: A qualitative study of the child therapist's perspectives and experiences. *Brief Treatment and Crisis Intervention, 4,* 353 – 366.

Lu, H., Zhou, Y., & Pillay, Y. (2017). Counselor education students' exposure to trauma cases. *International Journal for the Advancement of Counselling, 39*, 322 – 332.

Marriage, S., & Marriage, K. (2005). Too many sad stories: Clinician stress and coping. *The Canadian Child and Adolescent Psychiatry Review, 14,* 114 – 117.

Maslach, C. (1982). Understanding burnout: Definitional issues in analyzing a complex phenomenon. In W. S. Paine (ed.), *Job stress and burnout: Research, theory and intervention perspectives* (pp. 29 – 40). Beverly Hills: Sage Publications.

Maslach, C. (2003). Job burnout: New directions in research and intervention. *Current Directions in Psychological Science, 12*, 189 – 192.

McCann, I, L., & Pearlman, L, A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress, 3*, 131 - 149.

McCormack, L., & Adams, E, L. (2016). Therapists, complex trauma, and the medical model: Making meaning of vicarious distress from complex trauma in the inpatient setting. *Traumatology, 22,* 192 – 202.

Moher, D., Liberati, A., Tetzlaff, J., Altman, D, G., … the Prisma Group. (2009). Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement. *PLoS medicine, 6,* e1000097.

National Institute for Health and Clinical Excellence. (2009). *Promoting mental wellbeing at work.* London: NICE.

National Institute for Health and Clinical Excellence. (2012). *Methods for the development of NICE public health guidance* (3rd edition). London: NICE.

Newell, J., & MacNeil, G, A. (2010). Professional burnout, vicarious trauma, secondary traumatic stress and compassion fatigue: A review of theoretical terms, risk factors and preventative methods for clinicians and researchers. *Best Practices in Mental Health, 6*, 57 – 68.

Noblit, G, W., & Hare, R, D. (1988). *Meta-ethnography: Synthesizing qualitative studies*. Newbury Park, California: Sage.

Pack, M. (2014). Vicarious Resilience: A multilayered model of stress and trauma. *Journal of Women and Social Work, 29*, 18 – 29.

Paivio, A. (1986). *Mental representations: A dual coding approach*. New York: Oxford University Press.

Pearlman, L, A., & Saakvitne, K, W. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors*. New York: W.W. Norton & Company.

Pistorius, K, D., Feinauer, L, L., Harper, J, M., Stahmann, R, F., & Miller, R, B. (2008). Working with sexually abused children. *The American Journal of Family Therapy, 36,* 181 – 195.

Possick, C., Waisbrod, N., & Buchbinder, E. (2015). The dialectic of chaos and control in the experience of therapists who work with sexually abused children. *Journal of Child Sexual Abuse, 24,* 816 – 836.

Puvimanasinghe, T., Denson, L, A., Augoustinos, M., & Somasundaram, D. (2015). Vicarious resilience and vicarious traumatisation: Experiences of working with refugees and asylum seekers in South Australia. *Transcultural Psychiatry, 52*, 743 – 765.

Radey, M., & Figley, C. (2007). The social psychology of compassion. *Clinical Social Work Journal, 35,* 207 – 214.

Resick, P, A., & Schnicke, M, K. (1992). Cognitive processing therapy for sexual assault victims. *Journal of Consulting and Clinical Psychology, 60*, 748 − 756.

Sabin-Farrell, R., & Turpin, G. (2003). Vicarious traumatization: Implications for the mental health of health workers? *Clinical Psychology Review, 23*, 449 - 480.

Satkunanayagam, K., Tunariu, A., & Tribe, R. (2010). A qualitative exploration of mental health professionals' experience of working with survivors of trauma in Sri Lanka. *International Journal of Culture and Mental Health, 3*, 43 - 51.

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

Shakespeare-Finch, J, E., Smith, S, G., Gow, K, M., Embelton, G., & Baird, L. (2003). The prevalence of posttraumatic growth in emergency ambulance personnel. *Traumatology, 9*, 58 – 70.

Silveira, F, S., & Boyer, W. (2015). Vicarious resilience in counselors of child and youth victims of interpersonal trauma. *Qualitative Health Research, 25,* 513 – 526.

Sloan, D., Jones, S., Evans, E., Chant, L., Williams, S., & Peel, P. (2014). *Implementing NICE public health guidance for the workplace: A national organisational audit of NHS Trusts in England, Round 2.* London: The Royal College of Physicians.

Splevins, K, A., Cohen, K., Joseph, S., Murray, C., & Bowley, J. (2010). Vicarious posttraumatic growth among interpreters. *Qualitative Health Research, 20*, 1705 – 1716.

Steed, L, G., & Downing, R. (1998). A phenomenological study of vicarious traumatisation amongst psychologists and professional counsellors working in the field of sexual abuse/assault. *The Australasian Journal of Disaster and Trauma Studies, 2*.

Stevenson, D., & Farmer, P. (2017). *Thriving at work: The Stevenson/Farmer review of mental health and employees* [online]. Department for Work & Pensions and Department of Health. Retrieved from: https://www.gov.uk/government/publications/thriving-at-work-a-review-of-mental-health-and-employers

Straker, G., & Moosa, F. (1994). Interacting with Trauma Survivors in Contexts of Continuing Trauma. *Journal of Traumatic Stress, 7,* 457 – 765.

Sui, X., & Padmanabhanunni, A. (2016). Vicarious trauma: The psychological impact of working with survivors of trauma for South African psychologists. *Journal of Psychology in Africa, 26,* 127 – 133.

Tedeschi, R, G., & Calhoun, L, G. (1996). The posttraumatic growth inventory: Measuring the positive legacy of trauma. *Journal of Traumatic Stress, 9*, 455 – 471.

Tedeschi, R, G., & Calhoun, L, G. (2004). Post-traumatic growth: Conceptual foundations and empirical evidence. *Psychological Inquiry, 15*, 1 – 18.

Thomas, J., Harden, A., & Newman, M. (2012). Synthesis: Combining results systematically and appropriately. In D. Gough, S. Oliver & J. Thomas (Eds.) *An introduction to systematic reviews* (pp. 179 – 226). London: Sage.

van Minnen, A., & Keijsers, G, P, J. (2000). A controlled study into the (cognitive) effects of exposure treatment on trauma therapists. *Journal of Behaviour Therapy, 31,* 189 – 200.

Williamson, L, M., Parkes, A., Wight, D., Peticrew, M., & Hart, G, J. (2009). Limits to modern contraceptive use among women in developing countries: A systematic review of qualitative research. *Reproductive Health, 6,* 1 – 12.

CHAPTER II

EMPIRICAL PAPER

THE EXPERIENCE OF WORKING WITH TRAUMA:

A PHENOMENOLOGICAL PERSPECTIVE OF MENTAL HEALTH

NURSES WORKING IN SECURE CARE

Abstract

Background

Trauma is prevalent in mental health and forensic populations. Within a secure setting, nurses may be exposed to narratives around trauma and violence as they have the most opportunities for therapeutic engagement. Existing literature identified the profound impact of working with trauma and the potential growth/satisfaction that some individuals experience. The impact of working with trauma has been identified in many professions but mental health nurses working in forensic services are noticeably absent from existing literature. The current study aimed to explore how mental health nurses working in secure care experience working with trauma and violence.

Methodology

Eleven mental health nurses were interviewed about their experience of working with trauma. Interpretative Phenomenological Analysis was utilised to analyse first-person experiential accounts.

Results

Three superordinate themes were identified: “altered perceptions”, “impact on the self” and “managing exposure”.

Conclusion

This study suggests forensic mental health nurses experience multiple levels of trauma through working with individuals with histories of trauma and violence. Nurses appear to experience changes in their belief system which impact on their emotional well-being and cognitive functioning. Nurses manage their work through sense-making and self-protection. Emotional expression is avoided as it is not deemed professionally acceptable/useful. Growth was identified in nurses' view of themselves and approach to others. The negative effects of working with this population can be minimised and the positive gains enhanced through organisations adopting a normalising/validating culture that focuses on growth, re-frames recovery and provides clinical supervision that focuses on the emotional impact of working with this population.

1.0 Introduction

1.1 Defining trauma

Trauma is defined as directly experiencing or witnessing an event that involves death, serious injury, threat to life or physical integrity of the individual or someone whom they are close to. Threats of serious injury or sexual assault are classified as traumatic along with actual incidents of harm to self and other (American Psychiatric Association, 2013). Trauma can thus include physical and sexual violence, emotional abuse, neglect and loss (Green, 2000; Stein, Wilicot & Soloman, 2016). Herman (1992, p.33) proposes that “psychological trauma is an affliction of the powerless. At the moment of the trauma, the victim is rendered helpless by overwhelming force…Traumatic events can overwhelm the ordinary systems of care that give people a sense of control, connection and meaning”. Herman (1992) captures the intrusive nature of trauma where individuals have no choice during the trauma or when dealing with the aftermath. The very nature of trauma positions the individual as a victim and infiltrates their way of being. Sadly, trauma is commonplace.

1.2 Prevalence and impact of trauma

Trauma is widely experienced throughout the world. The prevalence of trauma in the general population is estimated at 70% (Benjet et al., 2016; Kessler et al., 2017). These surveys did not include the United Kingdom (UK) in the sample. A survey in England reported that 31% of respondents had experienced at least one traumatic event in their life and 4% of respondents were exhibiting symptoms

indicative of Post-Traumatic Stress Disorder (PTSD). Only 13% of these respondents had been diagnosed with PTSD (Fear, Bridges, Hatch, Hawkins & Wessley, 2016). However, these surveys are unlikely to capture the multiple traumas experienced by some individuals (i.e. childhood sexual abuse) because these were rated as one occurrence rather than multiple incidents over a period of time. As such, the figures reported by these surveys may be more elevated than indicated.

Having a mental health difficulty or forensic history appears to increase the likelihood of PTSD symptomology. A UK study highlighted the lifetime prevalence of PTSD in a mental health setting as 29% and 52% in a forensic setting (Sarkar, Mezey, Cohen, Singh & Olumoroti, 2005). Multiple trauma was reported by 39% of the mental health sample and 61% of the forensic sample. An awareness of multiple trauma is important in these contexts as the experience of relentless abuse over a period of many years is likely to be received differently than hearing about an isolated incident of trauma. Trauma is prevalent and leaves a mark on an individual's life.

Symptoms of PTSD include re-experiencing the traumatic event through intrusive imagery, flashbacks, nightmares, hyper-vigilance, avoidance and negative affect (National Health Service, 2018). The world as people know it is altered through experiencing trauma and a shift in perception that the world is unsafe and unfair is common (Herman, 1992; McCann & Pearlman, 1990a). Within the forensic population some individuals experience trauma because of their engagement in violence (Friel, White & Hull, 2008; Papanastassiou, Waldron, Boyle & Chesterman, 2004). The impact of trauma is profound and complex.

1.3 Containing distress

For some individuals their experience of PTSD symptomology is so severe they require physical containment to keep themselves and others safe. A survey conducted in England highlighted that 1.7% of respondents experiencing PTSD symptomology had been admitted to an inpatient facility (Fear et al., 2016). Individuals who present with criminogenic needs in addition to trauma may require admission to a secure facility. In these cases, physical containment needs are met through enhanced security standards (Department of Health, 2010). Emotional containment needs are met through the individuals caring for and engaging with them therapeutically (Evans, 2006). Consistent with the work of Bion (1962) and Winnicott (1960), individuals caring for trauma survivors need to be able to hold and process the intense emotional experiences of their service users. As such, individuals working in secure care may be exposed to traumatic stories as service users try to make sense of what has happened to them with the people they begin to build trust and rapport with. Additionally some acutely unwell service users may present with aggression and violence is prevalent within secure settings (Dickens, Picchioni & Long, 2013). Thus, staff may be exposed to violence both directly (either first hand or witnessing assaults on others) and indirectly (through therapeutic discussions).

1.4 Impact of working with trauma

Hearing about trauma has the potential to shift cognitive schemata in individuals working with trauma survivors (Pearlman & Saakvitne, 1995). McCann and Pearlman (1990a) drew upon Constructivist Self-Development Theory (CSDT) to

conceptualise vicarious trauma. McCann and Pearlman (1990b) suggested that individuals “construct their own personal realities as they interact with the environment” (p.6). Individuals can experience a shift in their view of themselves, others and the world, through disruption to beliefs about control, trust, intimacy, safety and esteem through hearing about trauma (Bride, Radey & Figley, 2007; Pearlman & Saakvitne, 1995). Existing literature highlights symptoms which mirror those experienced by individuals with PTSD including avoidance of perceived danger, intrusive imagery, dissociation and a range of emotions including anxiety, fear and guilt (Herman, 1992; McCann & Pearlman, 1990a). There are other terms used to describe the impact of working with trauma which have been explored in the first chapter of this thesis.

Herman (1992) proposed that the experience of overwhelming emotions may impact on the therapeutic relationship through breaching boundaries, splitting within teams and adopting the role of a rescuer. Individuals may also minimise, avoid or deny the existence of trauma (Baranowsky, 2002). These may act as defences against painful emotions which are elicited through engaging with traumatic material (Herman, 1992).

Existing literature also suggests there are positive consequences of working with trauma where some individuals experience satisfaction or growth (Arnold, Calhoun, Tedeschi & Cann, 2005). Tedeschi and Calhoun (1996, 2004) referred to this as vicarious post-traumatic growth and suggested that individuals may live their life more meaningfully and appreciate their loved ones more after hearing about trauma. Growth occurs through being inspired by the survival of individuals who have experienced trauma (Pearlman & Saakvitne, 1995). Some individuals can recognise

their own strengths and abilities through witnessing the same in their clients (Silveira & Boyer, 2015; Sui & Padmanabhanunni, 2016). Cohen and Collens (2013) proposed that an individual can experience vicarious trauma *and* post-traumatic growth as the self is multi-faceted and can accommodate contrasting experiences as individuals begin to make sense of their work. Hearing about trauma and witnessing client growth and recovery challenges existing global beliefs, enabling them to become deeper and enriched.

1.5 Study rationale

Existing research into the effects of working with trauma has been explored in different professions such as frontline emergency services (Brown, Mulhern & Joseph, 2002), health workers (Beck, LoGiudce & Gable, 2015), interpreters (Splevins et al., 2010), researchers (Goldenberg, 2002) and therapists (Bartoskova, 2017). Vicarious trauma is a broader issue that appears to affect many professional groups exposed to trauma narratives. This study is interested in the experience of mental health nurses because their role is to engage with service users and support them in their recovery. Research suggests trauma is prevalent in the mental health and forensic population (Sarkar et al., 2005). It is therefore indicated that mental health nurses may be exposed to trauma narratives if service users are talking about their experiences as they have significant contact and opportunities for therapeutic engagement (Mason, Lovell & Coyle, 2008). Mental health nurses often do not have access to the training that other therapeutic professions do (Wheeler, 2018). Therefore, having an awareness of the impact of working with trauma is important for understanding how mental health nurses can be further supported, if necessary. This

is consistent with government recommendations regarding employee well-being (Stevenson & Farmer, 2017) following the concerns highlighted by Francis (2013).

There is currently limited research examining the impact of working with trauma on mental health nurses working in secure settings in the UK. A scoping of the literature highlighted that one study did include mental health nurses in the sample amongst other professions but did not focus solely on their experiences (Harris, Happell & Manias, 2015). Working in secure care brings additional challenges due to the criminogenic needs of service users that exist alongside trauma, so knowing how this additional issue impacts on staff well-being is important.

1.6 Study aim

The original aim of this study was to explore how mental health nurses working in secure care experience working with trauma. It was hoped that this study would provide an in-depth understanding of the adverse effects of working with trauma and the potential areas of growth within the secure care context. It was also hoped that the findings would enable a greater understanding of the support needs of mental health nurses working in secure care.

Although this study was interested in the impact of concurrent exposure to violence inherent in the secure care setting, the prominence of violence in nurses' narratives was not anticipated. As such, the aim of this study shifted somewhat to incorporate nurses' inclusion of violence when making sense of their experience of working with trauma, and thus includes direct and indirect exposure to trauma and/ or violence. It was felt that the original aim could not be met as it is likely that an

individuals' experience of direct and indirect exposure differs, as well as their experience of working with trauma versus violence. The nature of the study design restricted the separation of these concepts and their impact; thus the aim was modified to account for this. Therefore, the aim of this study was to explore how mental health nurses working in secure care experience working with individuals who have experienced trauma and present with violence.

2.0 Methodology

2.1 Design

This was a qualitative study exploring the meaning of working with trauma for mental health nurses working in secure care utilising Interpretative Phenomenological Analysis (IPA) and semi-structured interviews. A purposive sampling technique was selected to ensure the sample was homogenous (i.e. had similar experience of the phenomena being explored) as this is a key characteristic of IPA (Smith, Flowers & Larkin, 2012).

IPA is phenomenological in nature as it is committed to understanding how individuals experience and make sense of their own lived experience. Additionally, IPA is idiographic in emphasis because each participant's account of their experiences is examined in detail before looking across cases. IPA also includes the theory of hermeneutics. A double hermeneutic occurs where the researcher attempts to make sense of the participant making sense of their experience of a particular phenomenon. Thus IPA enables an understanding of how a particular experience has been understood from the perspective of a particular group of people, in a particular context (Smith et al., 2012). Given the interest in exploring how forensic mental health nurses make sense of working with trauma it was felt that an approach that enables an in-depth exploration of lived experience would meet the study aims.

2.2 Ethical considerations

Ethical approval was sought and granted by the University of Birmingham's Ethics Committee, the Health Research Authority and the Research and Innovation department of the participating NHS Trust (Appendix 1-3). Ethical issues were

considered as part of the application and included anonymity and confidentiality; informed consent; the right to study withdrawal; and the potential for distress to be experienced by the participants and/or the researcher. As such, participants were monitored during the interview for visible signs of distress. One participant appeared to be experiencing distress during the interview. This individual was debriefed at the end of the interview and signposted to their manager and additional support services within the trust.

2.3 Participant recruitment

Inclusion and exclusion criteria were formulated to enable a homogenous sample of participants to be identified. Please see Table 6 for details.

Table 6: Inclusion/exclusion criteria

Inclusion criteria	**Exclusion criteria**
Qualified mental health nurses (newly qualified through to ward managers)	Unqualified mental health nursing staff i.e. healthcare assistants (as they potentially have less exposure to traumatic material)
Working on a medium secure unit (Intensive Care Unit or acute wards)	Any other discipline i.e. OT, psychologists, psychiatrists (due to differences in their roles)
Male or female staff members	Working on the specialist (i.e. personality focused or long stay) or rehabilitation wards (as trauma may be spoken about less as service users progress towards discharge)
Working with service users who have experienced trauma	

Participants were recruited from a secure care mental health service in England. The participants who took part in this study were qualified mental health

nurses (referred to as nurses from here onwards) working on medium secure units with service users presenting with mental health and criminogenic needs, and histories of trauma. The researcher emailed psychologists and ward managers working on the Intensive Care Unit (ICU) and acute wards to promote the research and recruit participants who met the inclusion criteria. A poster detailing the study rationale was also placed at recruitment sites (Appendix 4).

The details of interested parties were forwarded to the researcher. Sixteen potential participants were contacted through email and three were approached face-to-face. The researcher arranged to meet with 11 individuals who expressed an interest in participating in the study. The researcher provided them with the participant information sheet which outlined the study aims/objectives to ensure participants could make an informed decision about taking part (Appendix 5). They were also invited to review the interview topic guide. Prior to the interview, participants were provided with a consent form to sign to confirm they consented to take part (Appendix 6). Participants were encouraged to focus on what it is like working with trauma for them as an individual, as opposed to at a team/organisational level.

2.4 Sample

Prior to the interview participants were provided with a questionnaire to collect demographic information and details regarding their experience working within secure care (Appendix 7). Table 7 provides details about the participants.

Table 7: Participant information

Assigned pseudonym	Details regarding demographics and experience working in secure services
James	James is 52 years old. He is a Band 7 staff nurse operating in a managerial role on the ICU. James qualified 17.5 years ago and has been working in the service for 16.5 years. Prior to working in secure care James had part time jobs working for an agency.
Jodie	Jodie is 23 years old. She is a Band 5 staff nurse working on one of the acute wards. Jodie qualified two years ago and has been working in the service since qualification. Prior to working in secure care Jodie worked in acute mental health, an eating disorder service and a CAMHS setting.
Peter	Peter is 36 years old. He is a Band 5 staff nurse working on the ICU. Peter qualified five years ago and has been working in the service for four years. Prior to working in secure care Peter worked in the private sector with individuals with learning disabilities and dementia. He also has experience working as a support worker in a variety of care settings.
Lucy	Lucy is 34 years old. She is a Band 5 staff nurse working on the ICU. Lucy qualified five years ago and has been working in the service since qualification. Prior to working in secure care Lucy worked with individuals with dementia and learning disabilities. She worked in a nursery and has caring responsibilities for a relative.
Chantelle	Chantelle is 30 years old. She is a Band 5 staff nurse working on one of the acute wards. Chantelle qualified 1.5 years ago and has been working in the service since qualification. Prior to working in secure care Chantelle worked as a healthcare assistant.
Michelle	Michelle is 33 years old. She is a Band 6 staff nurse operating in the role of deputy ward manager on the ICU. Michelle qualified six years ago and has been working in the service since qualification. Prior to working in secure care Michelle was a prison officer.
Paul	Paul is 43 years old. He is a Band 7 staff nurse operating in the role of ward manager on the ICU. Paul qualified 14 years ago and has been working in the service since qualification. Prior to working in secure care Paul had various jobs not related to the mental health field such as working in sales.
Sophie	Sophie is 26 years old. She is a Band 5 staff nurse who qualified a year ago and has been working on the ICU since qualification. Prior to working in secure care Sophie obtained a BSc in Psychology. During her degree Sophie secured a placement year as an Assistant Psychologist within CAMHS.
Katie	Katie is 35 years old. She is a Band 7 staff nurse operating in the role of ward manager on the ICU. Katie qualified four years ago and has been working on the ICU for three months. Prior to working in the service Katie worked in the prison service and female secure care. She also worked in a Youth Offending Team.

Assigned pseudonym	Details regarding demographics and experience working in secure services
Luke	Luke is 41 years old. He is a Band 6 staff nurse operating in the role of deputy ward manager on the ICU. Luke qualified 14 years ago and has been working in the service since qualification. Prior to working in secure care Luke worked as a healthcare assistant in a community setting with older adults.
Rob	Rob is 38 years old. He is a Band 7 staff nurse operating in a managerial role. Previously he worked on the ICU. Rob qualified 15 years ago and has been working in the service two years. Prior to working in secure care Rob worked in psychiatric liaison, acute and community settings, and drug and alcohol services.

A total of 11 participants took part in the study, six females and five males, with an age range of 23-52 years old. Six participants were working on the ICU and five participants were working on acute wards. Four participants held a managerial role and seven were working in a clinical capacity. Participants' length of time since qualification ranged between 1-17.5 years with a mean of 8 years.

Participants were exposed to trauma and violence through gathering information about a service user's history as part of the admission process. This was often gathered from the service user themselves as well as other professionals who had been involved in their care. Information regarding a new admission was then shared with other members of the nursing team in meetings. Details regarding trauma and violence were also accessible through the electronic notes system in psychology notes, risk assessments and pre-admission reports. Violence was prominent within this setting due to the nature of the service thus was often experienced, witnessed or present in discussions with service users and other members of the team about risk.

The ICU and the acute wards accepted admissions from outside of the hospital and internal transfers between wards. Service users were admitted to the

ICU if their mental health needs were acute and there was a high level of risk requiring a period of stabilisation. Service users then transitioned to an acute ward once their mental health had stabilised and their level of risk had reduced.

2.5 Data collection

The data were collected through semi-structured interviews with each participant. Each interview was audio-recorded with a dictaphone. A topic guide was used to structure the interview (Figure 5). The interviews took place during work hours in a room with only the participant and researcher present. The interviews ranged between 25 and 74 minutes.

1) How did you first come to work in mental health?
   - What drew you to working with this client group?
   - What did you expect your work to be like?
   - Did your experience meet your expectations?

2) Can you tell me a bit about your work?
   - Can you tell me about some of the stories of people you have worked with?

3) What has your experience been of working with individuals who have a trauma history?
   - What have you found challenging? (Prompt for examples)
     - How did this impact on you? (i.e. thoughts, feelings and behaviour)
     - When did you notice?
     - Why do you think it has impacted on you more than other stories?
     - How did you respond to the client/ others around you?
     - What have others noticed?

   - What are you left with at the end of a shift? What do you do with it?
     - What coping mechanisms do you use to help you deal with this?
     - What support do you access? Who did you tell?
     - What are the barriers to accessing support/ using coping skills?
     - What has been helpful/ unhelpful in supporting you to manage the work?
     - What else would help that is not already being offered/ used?

   - What have you found rewarding?
     - What made this such a rewarding experience?

Figure 5: Interview topic guide

2.6 Data analysis

Interviews were transcribed verbatim. Pseudonyms were allocated to protect anonymity and potentially identifying information was removed. IPA was implemented following Smith et al.'s (2012) steps which are outlined in Figure 6. Please see Appendix 8-10 for an example of how IPA has been applied for one participant to aid transparency as recommended by Yardley (2000).

1) Reading and re-reading – This involved becoming familiar with and attempting to absorb oneself in the data, whilst noting initial thoughts on each individual transcript.

2) Initial coding - This involved examining each individual transcript and making notes focusing on descriptive, linguistic and conceptual content at an exploratory level.

3) Developing emergent themes - This involved reviewing the codes from Step 2 and grouping these together based on common concepts to formulate interpretative themes for each individual transcript.

4) Searching for connections across emergent themes - This involved identifying common patterns across the emergent themes in each transcript and grouping them together in a table. This resulted in clusters of related themes.

5) Repeating steps one to four for each transcript.

6) Looking for patterns across cases - Identifying common patterns across the cases and grouping them together in a table. This enabled the development of superordinate and subordinate themes through abstraction and numeration.

Figure 6: Smith et al.'s (2012) stages of IPA

After steps 1-4 had been followed, the researcher created a short narrative summarising the emerging themes that were identified in each transcript. This enabled thinking around how themes might link with one another for each participant. Time was then spent organising each participant's themes into a table and reflecting on how they fit with one another, noticing any recurring themes. This enabled the

researcher to create superordinate and subordinate themes that encompassed the wider dataset. The researcher's own reflections following each interview and throughout the analysis were also considered.

Utilising IPA brings with it the inherent difficulties in the researcher attempting to interpret the participants' sense-making. To ensure the themes were clearly grounded in the data and limit bias, the researcher sought input from her supervisor in identifying and naming emergent themes within and across transcripts. The researcher also consulted with research tutors/peers through attendance at an IPA support group. The researcher continually referred to the transcripts, initial codes and emergent themes during step four. Following the final stage, the researcher extracted participant quotes from the transcripts to provide evidence for the themes.

2.7 Reflexivity

Reflexivity has been an important aspect of my study due to the double hermeneutic where I have attempted to make sense of participants' sense-making (Yardley, 2000). Being reflexive has supported me to hold my own worldview in conscious awareness. For instance, I have completed this study as part of my Clinical Psychology Doctorate and it is possible my worldview may have influenced my interpretations of the data. I have gained clinical experience working in secure care prior to and during my training and so I am aware I have preconceived notions of what it is like to work in secure care. This may have brought with it expectations of emergent themes, compounded by completing a literature review of vicarious trauma prior to analysing my results. Although I conducted this study as a researcher, I did complete a placement in the hospital being studied at the beginning of my training.

Although the participants did not appear to recognise me, their knowledge of my prior experience of the setting may have influenced the results. Additionally I have a preference for Cognitive Behavioural models to which I have been exposed throughout my training. This therefore may have guided my interpretations and prevented me from taking a different perspective.

To stay close to participants' sense-making and ensure I refrained from imposing my own assumptions during the interview and analysis process, I kept a reflexive diary and received supervision. For instance, there were times in the interviews when I felt frustrated by participants going off-topic and focusing on how they experience violence (primary or secondary exposure) or physical safety interventions, rather than hearing about trauma. I found myself feeling disappointed by this and repeatedly guided participants back to thinking about their experience of hearing about others' trauma. What I had not considered was how these experiences might be considered traumatising (directly or vicariously) by the participants themselves. Reflecting on this with my supervisor enabled me to look at my data with a different perspective and allowed me to be guided by my participants in the remaining interviews.

3.0 Analysis

The analysis produced three superordinate themes “altered perceptions”, “impact on the self” and “managing exposure” which have been broken down into subordinate themes. Please see Table 8 for an overview of how themes have been organised and Appendix 11 for contributing participants and additional quotes.

During the interviews, participants often reverted to discussing their experience of violence. Participants reflected on the potential for feeling unsafe on the ward due to violence. It is possible that violence is commonplace and expected within this environment, given that participants reflected on this frequently despite not being specifically asked about it. Additionally there is a sense of violent offending being normal within a secure setting because of the nature of the service, with narratives around violence occurring regularly. Therefore, when the superordinate themes are presented in the next section, I would invite you to consider the participants’ inclusion of violence when talking about their experience of working with trauma. This directs the reader to thinking about the impact of working with service users who present with trauma histories *and* violence, either currently or historically. When the researcher refers to trauma and violence throughout the analysis please note that this includes direct (i.e. being assaulted) and indirect exposure (i.e. hearing about violence or trauma).

Table 8: Outline of superordinate and subordinate themes

Superordinate themes	Subordinate themes
1) Altered perceptions	1) Looking out on the world
	2) Looking in at oneself
2) Impact on the self	3) Carrying the trauma
	4) Emotional expression
	5) Thriving
3) Managing exposure	6) Protecting the self
	7) Sense-making

3.1 Theme One: Altered perceptions

This theme represents participants' experience of altered perceptions following their exposure to trauma and violence within secure care. Changes in their worldview and self-concept were articulated together with the impact of such changes in the present.

3.1.1 Subtheme One: Looking out on the world

This subtheme focuses on how working with trauma and violence has impacted on the participants' worldview. Working in secure care appeared to have increased participants' awareness of what is going on in the world.

Michelle: "Um but you have definitely got more of awareness of, of exactly like, what's going on … regards crime and why people have come here"

Luke: "I think that, we can be quite sheltered. In a way I live, we live our lives and it's not really that sheltered here, at all [laughs] … Is it? It's completely not so. So you become a lot more aware that a lot, a lot of people, or it feel, sometimes it feels like a lot of people in society, go through a lot of trauma"

In these quotes an increased awareness is evident of the existence of trauma and violence. Luke indicates that society are generally protected from the horrors of the world and that working in secure care increases the potential for exposure to such narratives through engaging therapeutically with service users. Some participants reported that an increased awareness of trauma and violence had altered their worldview.

Luke: "I think, yeah I've got a pretty different awareness, to the world than like say even like some of my friends or whatever … who don't, really do this kinda job. Yeah so, I think like that's, that's a big difference. I probably look at the world like, in a different way … I guess it's changed my world view"

Paul: "You know there's something, really, horrible happened to this chap and occasionally he would hint at it, and he would say that the people'd raped him and stuff like that. But, at times, he, you weren't sure whether he was telling the truth and the family seemed, quite, functional"

Participants' perceptions differed from before they worked in secure care and the views of others. Ideas around normality were also challenged. For instance, Paul appears to be struggling to make sense of how a seemingly normal family could harm their child. Participants also reflected on how they interpret the existence of trauma and violence and use this to construct new meaning.

Paul: "You feel that, you know that they shouldn't be people like that in society that can, do things that are so, wicked"

Chantelle: "So, it gets my mind thinking … a lot, about how the world is … and how unfair, and unjust sometimes"

It appeared that others were viewed as bad and the world was viewed as unfair, and for some participants this appeared difficult to comprehend. Other participants reflected on the profound impact trauma has on its victims.

James: "Some people are broken … To be honest"

Paul: "Um, to some extent when you can see, the damage that it's done. So, you know when you can see, the impact that it's had on that other person and I guess that sticks in your mind a bit more"

The belief that people are damaged and broken brings with it the implicit notion they cannot be fixed. This brings into question whether service users can be treated and recovery can be achieved.

Katie: "I do, generally feel bad for them … That you can't, cause nothing will ever fix that … You can, give them, the best care, in the world but it's not gonna take it away is it?"

Sophie: "You just think this is life now. He's, probably not going to, he's never gonna be, recovered and completely in the community … completely normal. That's not gonna happen for him. It's not possible if you look at his whole family and, the treatment plans we had him on … He was on really high doses of medication … and, ECT and lots of other stuff going on. And there was minimal improvement so … I think it's, just hard cause you think, I really felt for him. Um, cause he, kind of just had, no chance really …You kind of just think, that poor guy, literally had no chance … at happiness. Leading even a relatively normal life"

Some participants reflected beliefs that indicated a lack of hope for service users' future. This included their recovery, being discharged from services and a chance to be "normal" and "happy". Individuals who have experienced trauma are deemed unfixable because such traumas cannot be removed from their history despite the best efforts of the individuals caring for them.

3.1.2 Subtheme Two: Looking in at oneself

This subtheme focuses on how an increased awareness of trauma and violence has impacted on the participants' sense of self and view of their own lives.

Viewing the world as dangerous can lead to wariness and hyper-vigilance around the safety of self and others.

James: "More observant, I guess … Like, you're more vigilant … Cause you come into contact. Especially in forensic, psychiatry you come into contact with people who've done really, horrible stuff. You know. And, yeah, I guess you're more vigilant, you're more wary of, human nature, you know"

Jodie: "I risk assess all the time. It doesn't matter where I'm going … what I'm doing"

These quotes reflect the uneasiness participants experience around others. Some participants described a tendency to hold back trust given their awareness of violence and trauma. There is a sense of not being able to switch off from potential risk and carrying out work-like assessments outside of the work environment. Being a parent provided a different perspective as participants considered the potential for abuse in their own lives.

Paul: "So you see that person as a child and then you think, well that could be … my child. And if my child was, their child. He'd be doing it to my child. And you get really angry … that, somebody could do that and you know um, physical abuse or sexual abuse whatever"

James: "Becoming a parent, again you're more, you know. It could, it could be a member of my family. It could be … my son. It could be someone close to me. You know, so I, guess it makes you more, willing to look after people, I find … You go that extra mile I think"

These extracts reflect different perspectives. Paul's experience of anger is strengthened by the idea of his own child being abused whereas it enables James to be more compassionate within his job role. For some participants, their view of other people's problems appeared to have become desensitised because of exposure to trauma and violence. Others' problems were positioned as insignificant in comparison to service users' histories.

Sophie: "With friends it can be hard to, when someone comes to you with a really, something that looks really mundane. They are really worried about something silly and you're just like, come on [laughs]. There are other people with much worse. Obviously, you do care but it, because the people you work with here have had really horrible things happen to them and … Have had really horrible pasts. And now they are in these situations, it kind of puts things into perspective that way … [Laughs]. I sound really uncaring"

Jodie: "I think I find … less time to engage in conversation with people who have trivial problems … So if someone's moaning about, urr their boyfriend or, dinner or, the children [inaudible] food, and I think then well you, whatever [inaudible], you haven't, murdered, your son today so. You know, I don't really wanna talk about this today … Let's talk about it tomorrow. Not the same day I finish work"

Additionally, participants' sense of self appeared to shift through working with trauma and violence, with evidence of self-blame.

Paul: "Because nurses are set up in such, in a way, particularly when you work on an ICU but also on acute wards, where, you feel that, you're gonna come here and you're gonna be unwell, I'm gonna treat you, you're gonna get better. And when somebody doesn't get better, you know after a long time people start to feel like, I do my job wrong? You, you know is this me? What am I not doing? Am I failing here in some way?"

James: "You go over thing and you, almost think you, have you missed something? … You know. Could we have done something differently? … You feel like, especially if you're, when you're in a senior level people tend to look up to you and … You feel have I let the team down? … You know for example, we had someone's committed suicide. And, I just thought, I should have said more. Should I have said something more? … It's, a sense of … failure isn't it? Yeah … Especially if something goes horrible wrong"

Participants appeared to locate the problem within themselves when service users did not appear to be recovering. Participants also appeared to have ideas around how they *should* be and hold judgements about themselves if they did not meet these expectations.

Sophie: "It can be horrible to hear these things but, you have to think of it as a professional and kind of, don't let it affect me. I have to, see what I can do to help them. This is their problem, it's not my problem. It shouldn't be upsetting me, because, I need to be in a good position to be able to help them"

Michelle: "Yeah because I think if someone has a shocked reaction, it makes me, question how I should be feeling … and, almost mirror how they are"

These extracts present contrasting views. Sophie expresses the belief that if she is affected by her work then she is not being professional, and if she is not being professional then how can she help her service users? Michelle describes feeling like she should react the same way as others by expressing her emotions. Her position differs from Sophie who sees this as detrimental. Some participants described feeling ill-equipped and unsure how to interact with service users with trauma histories. This potentially suggests that working with trauma leaves participants questioning or judging their own abilities.

Peter: "Because initially … I found it difficult, knowing what to say to a patient when they're telling me … They've had this traumatic experience cause sometimes I think, I don't know how to respond … or what to say. And sometimes I'm like a bit worried about saying the wrong thing … So sometimes I've just like, I've said nothing … I've kind of like listened and I've tried to listen … But sometimes, because the patient's looking for a response from me, I, haven't got a response"

Participants reported not knowing what to say to service users who have experienced trauma. There is a real sense of walking on egg shells where participants are constantly aware of making sure they do not trigger distress in service users. Some participants reported feeling untrained, suggesting it is not their remit but that of psychology and appeared to doubt their own knowledge and skills.

3.2 Theme Two: Impact on the self

This theme represents how exposure to trauma, violence and a shift in worldview has impacted on participants' emotional well-being and cognitive functioning. Participants also described ways in which they and their service users thrive.

3.2.1 Subtheme Three: Carrying the trauma

This subtheme focuses on the idea that trauma intrudes on participants internally and is carried with them outside of the work environment. Participants reflected on the potential for being affected by trauma.

Sophie: "I just try not to let the things get to me and I think that's why it's important that I go home and switch off because otherwise if you ruminate it will … You don't wanna burn out. I've only been in nursing for a year [laughs]"

Paul: "I don't feel like I, I probably don't, I don't think I take it home with me or anything like that … too much"

The potential for intrusion of trauma into the mind of participants is clear in these extracts. For some participants there appeared to be tension between whether it was normal to feel others' trauma or whether it was detrimental to their well-being. Participants spoke about trying to not take work home with them but there is a sense of this being impossible. Some participants described how particular cases have remained with them, etched in their mind.

Katie: "And he just stuck in my mind because it was just such a horrific case and, I don't know how you'd ever process … that in your head. Do you?"

Rob: "Sort of one that's been, at the back of my mind for a few years, and him … If we, well not, not if we fail but if, we can't successfully … help in some way"

Cases that remained with participants appeared to involve severe, unimaginable trauma or when participants felt they had failed service users. Other participants described being unable to shut off after a day's work.

Chantelle: "It is difficult to disconnect your job, from your feelings … cause we're only human isn't it? So, sometimes I find myself, ok I'm not at work but I'm actually thinking about what, what the patients go through … So, I can say that it's been difficult sometimes to sort of disconnect that [pause]. Disconnect the whole thing, from, my feelings … Yeah. I can say, that's been challenging … When I'm not at work … And then I tell myself no I should be thinking about this when I'm back in at work … And then I tell myself, I'm human so it, it's bound to come to my mind"

Participants reflected on how they notice themselves thinking about work or their service user's trauma history when at home. For Chantelle, there is tension between whether this is normal and she appears to struggle to find the balance between allowing herself to experience her work whilst protecting herself from letting it absorb her too much. Katie reflected on her experience of providing support to staff who are working with trauma.

Katie: "But what I do find difficult I suppose is supporting other people. So it's like the, domino effect of the trauma being passed on … And then by the time it, you know with every person something else is added on, because that staff member will feel a certain way … And then they need support from me and I don't feel, in all honesty, I try and contain it as much as I can [laughs] … But I don't feel equipped to deal with that so I feel like I soak it up. And then it's just … I'm taking something else home with me … Because I've gotta take it away from them cause I can see that they're in pain. I feel that a leader should be able to contain and … support with that. But then it's almost like I feel like I've got nowhere to go with it … There isn't anywhere for me to put it"

Katie describes how trauma is transmitted through people and gets more overwhelming as more people experience and try to make sense of it. Katie feels she *should* be able to contain herself and others due to her role and feels responsible for buffering her staff from distress. This means she absorbs the end-product which is multiple layers of meaning-making. However, Katie has nowhere to process this herself and so carries the burden alone.

3.2.2 Subtheme Four: Emotional expression

This subtheme focuses on the impact that exposure to trauma and violence had on participants' emotional well-being and their expression of this. Some participants explained the shock of hearing about trauma and violence when they first started working in secure care but over time this dissipated. Once participants became used to hearing about trauma and violence their emotional reactions shifted.

Katie: "My initial response is I feel really sad. Like this morning, the thing that I was sitting on this morning. You know, at some point in that person's life there's been a significant trauma … Unfortunately now it's all, jumbled up in the context of his, psychotic illness … But I know it's there because, it's clearly something's happened to him and it's not been very nice. And I just feel really really sad for the person … Um. And then I get quite angry cause I feel that someone's done that … to this person … And now he's left with, you know at a really young age, a really crap, crap prognosis probably … It's like he'd always be in a service cause of his risk and his illness … You know, so I feel quite sad but it does, tend to with me transpire into anger"

Participants appeared to direct feelings of sadness towards the people who are perceived as victims of abuse and anger towards the perpetrators. Working with trauma and violence was sometimes overwhelming.

Katie: "I think, all of the emotions that it rakes up I think that's probably what I find most difficult. I would like to think I've got a decent level of insight into myself … But I do know that it leaves me with lots of, different emotions"

Chantelle: "I sort of like withdraw … And then I don't want to talk about it at that particular moment because what I tend to do is cry … cry cry and then, then I can't talk. But then I'm able, to sort of like, talk about things, later on"

Participants reflected on the different ways they feel emotionally overwhelmed by their work. There is a sense of their emotional experience being too much, extracted from somewhere deep within, that participants are just left to deal with. Some participants found it helpful to release this externally through crying. Other participants spoke about the importance of remaining in control of emotions through suppression.

Michelle: "Probably not as in touch with my emotions, as I should be … Um, so, yeah I don't, rarely like, cry and stuff … And I don't talk about emotions … I find that I don't talk about emotions as much … I think, I've learnt to just, switch things off"

Jodie: "I think it just manifests itself in my, behaviour and ability to, well my ability, of how I deal with emotion cause I don't really deal with emotion anymore … So, like I was saying to somebody the other day, I can't remember the last time I cried. I think that's just what happens. Because I've got so used to the routine of, go home, take your clothes off, emotion gone … A lot of people also, vent their emotions to me … And I think right well, push yours away let's deal with so and so"

Suppressing emotions appeared to be an active process where participants engaged in conscious acts to rid themselves of emotion i.e. "push away" and "switch off". Participants thought that suppressing emotions enabled them to carry out their job role more effectively but participants were again left wondering whether this was detrimental to their well-being. Not expressing emotion appeared to be commonplace as this was considered unprofessional and not a quality of a good nurse.

Michelle: "I think it would've almost been looked down upon, if I'd have got, emotional … Cause everyone else is so, hardened so there's an expectation, that you're hard as well … So I think you quickly find that, when you qualify … And so, knowing that, you need to be like this because everyone else is like this"

Luke: "Mental health nurses shouldn't be like needing … CBT or need to be using it myself that kind of thing so … that you should be like, you know, the person helping out not … not needing help so"

Participants conceptualised suppression of emotions as either wearing a mask or developing a hard shell. Both depict protection of the self from external threat.

Peter: "Any emotion towards them I'm having to like, kind of like, mask that the best way I can … Because sometimes they, I don't know they might be feeling a bit paranoid or they might, if they see some emotion, they might judge me … So it's a matter of trying to like mask any emotion I've got … Cause they don't, in my view, they don't need to know about my feelings … Cause they've got their own feelings to deal with"

Paul: "I guess, after, after working on the ICU, forensic unit for a couple of years, I guess, I became hardened and how I noticed as, terrible as it sounds, is I went home one day, and I was speaking to my wife, and I … I said oh you know something funny happened today and I, relayed this, story. And she was just horrified. I can't remember what it was but, she just said, that's not funny. That's just like horrible [laughs]. And, then you kinda realise that, you've, you know that you develop this, kind of a little you know it's a bit cliché isn't it? But you do, you do develop a little bit of a shell, don't you? But, it's not possible to think about the things that people've been through and to deal with the, reaction, the impact of that, and be fully engaged emotionally in that … You know you have to some extent be a little bit outside of it and not give all of yourself to it because, you just couldn't, do that, function still. It's like how does a, you know, how does a police officer, you know scrape somebody off a road"

Both participants reflect that it is inevitable that they experience overwhelming emotions when working with trauma but this should be hidden away or deflected to protect themselves. Peter fears being judged by the people he is caring for but also appears to not want to burden them. Paul fears being unable to "function" if he were to fully open up and describes how becoming hardened and desensitised are an

essential factor that enable him to remain in his role as a nurse. His comparison to the police is interesting and perhaps portrays how distressing he finds his work. Participants identified feeling drained and emotionally exhausted. This impacted on their personal lives.

Katie: "Mentally just completely exhausted. Like I've got nothing left to give to … Anyone. I feel like I give everything here and then I get home, I'm conscious of it so I make sure it's masked for my daughter so she feels … Like we're doing things but, you know she goes to bed and, I've got no energy for my, I've got a relationship, I've got no energy for it … Sometimes I just can't even deal with, I don't know it's like, I avoid things that actually I need to do for my own life so re-tax my car, pay bills, you know all the adult things that I'm meant to do and … I don't know if that's probably part of my personality but I just cannot deal with it. I just put everything on hold, I just can't deal with it cause I just feel like I haven't got the, tolerance, patience or, energy, to acknowledge, the stuff that I need to do"

3.2.3 Subtheme Five: Thriving

This subtheme focuses on growth and development. Participants reflected on how their altered perceptions impacted on them in positive ways. The following quotes reflect gratitude for having a loving family and the importance of enjoying life.

Sophie: "I'm really grateful that I can go home, to a loving house. I've got a roof over my head … Um and I kinda just put things into perspective that way"

Michelle: "I suppose it's what you take from it. Cause I take from it, I'm gonna have the best life I can then … And do everything that I possibly can [laughs] … Cause you never know what's gonna happen"

Participants also appeared able to integrate knowledge of trauma and violence and construct an understanding as to how they intersect.

James: "And on his second admission, I, found out that he was, abused … sexually, by, I think when he was in care … And he's, ability to, trust … It's almost he spent his whole life hitting out, like that won't happen to me again"

Lucy: "Maybe that, close, proximity to people makes him feel anxious because of the abuse, and you know because of the trauma"

These participants reflect on how service users' current difficulties are linked to their experience of childhood abuse. There is a sense that such behaviour is enacted to protect themselves from being re-abused. Some participants reflected on being more empathic towards service users through having an awareness of this and it enabled them to be more open-minded to people in their personal lives.

Rob: "I like to think I'm more understanding … I'm less likely to judge … It's made me less judgemental of individuals. It's made me think about well why would you do that? What's your background? I don't know but maybe something's happened. So it's almost like you don't bite"

Having an awareness of trauma enabled participants to be more understanding of others and think about why they may be behaving in a particular way rather than jumping to conclusions. Some participants described a shift in how they viewed the crimes committed by service users over their time working in secure care.

Luke: "I guess early on I'd probably be like, there'd be some situations where I'd kinda like, be shocked and … hold kinda certain prejudices. Yeah certain crimes or whatever. But now I mean I dunno now I just kinda like try and like just focus on the person really and just try and like, [pause] umm, yeah just try and focus on the person"

Jodie: "And being able to listen to and understand people and not be affected by, the stories they tell you … So you can actually focus on the person, rather than be clouded by, the fact they've told you they've raped somebody … Cause it doesn't even affect you anymore … Which is a negative but at the same time it's quite positive … Cause you can extract that part of their history … and just focus on them"

Focusing on the person rather than the crime was deemed essential in enabling participants to look beyond the offence history, and by doing this it was easier to work with service users who have engaged in violence. Later in Jodie's interview she reflects on how this could be viewed as desensitisation but feels this is paramount so her judgement is not clouded and she can care for the individual standing in front of her.

For some participants there was a sense of resilience and perseverance even though their work is often difficult.

Sophie: "Sometimes you come out feeling quite good about, I managed that, I'm still alive [laughs]. I can drive home"

Michelle: "I haven't, gone anywhere else since I qualified [laughs]. I stuck to it"

In addition to witnessing growth in themselves, participants described witnessing progress in service users as fulfilling and inspiring.

Rob: "Seeing people take small changes … umm, progressing. I don't expect anyone to just be perfect [laughs] but it's nice to see when they're, when things, begin to click for them … And they'll start to have more positive relationships, they're not blowing up every time … They're moving forward … You know, [pause] seeing them less tortured"

Peter: "When you've had the patient admitted and they're at the lowest point … of their life. And, you know they might have stayed with you for like two years, on the ward … And then like they're kind of like, you can see how they've improved and they've … [Inaudible]. It might not be tremendous amounts, but they've improved enough to move on to an acute ward"

In these extracts even small changes are considered rewarding as participants reflect on how such changes can impact on other aspects of service users' lives which enable them to move forward. There is an acknowledgement of how acutely

unwell service users are upon admission and that it can take a while to see such changes. Participants described fulfilment when they felt they had directly contributed to a service user's recovery.

Peter: "If you've got like your own personal patient, and he's been admitted, and you, you've seen all the way through it's like it's a bit more rewarding cause, you feel that like you've contributed more to, the treatment … umm even if it is like a, a little bit. It's still quite rewarding"

Recovery appeared to be a shared experience for the service user, individual nurses and the wider team. Witnessing progress and growth in service users enabled participants to experience hope.

Katie: "I feel, that my hope has been re-instilled. I see people come in, in utter crisis and in a very short period of time … they're improving. And I get to see that on a daily bay, I feel very privileged to see that on a daily … basis"

Paul: "You have to think of that one person I think. I think you get it in your head and it's one person then, if I can help one person then everything else is ok"

3.3 Theme Three: Managing exposure

This theme represents participants' attempts to manage working in secure care through sense-making or employing mechanisms to protect the self from the potential negative effects of working with this population.

3.3.1 Subtheme Six: Protecting the self

In this subtheme participants described the strategies they implement to manage working with individuals who have experienced trauma and committed violent acts. Minimising the severity and impact of trauma and violence was evident.

Sophie: "We had a patient whose … whole family had, a wide array of mental health difficulties … They were, physically abused … Their parents would starve them and, I think there was sexual abuse and, the siblings were abusing each other. It was just all very messy and it just did not … Sound, like a nice environment to grow up in"

Michelle: "If I told someone in the street, that I sit and watch films and, play the computer on my own with, someone that's murdered someone and put them, under the floorboards, for three days they'd be like what … What are you doing [laughs]? … Like are you for real? … But I suppose you have to just either not think about that … Or make it out to be, not such a bad thing …Cause there's so many people that I interact with that are murderers. It's not, a big a deal as it was, when I was, not working in this field"

Minimisation appeared to be employed to protect participants from the emotions that might surface if they were to think about trauma and violence in detail without censor. It is possible that participants might experience intense emotions which may impact on their ability to care for service users. Minimising thus acts to create emotional distance between participants and service user histories. Humour appeared to be an important minimisation strategy used by participants.

Sophie: "You do have to, have a chat and I think you have to as well make light of the situation. Because, I know it's not something that's funny or anything but you have to, otherwise you won't come back to work"

Paul: "You develop this kinda gallows humour, don't you? But, um, that you, can see a bit of, humour, or you will laugh about something which is really quite horrendous, not because you think it's funny … But that's just kind of a way of, normalising a situation to some extent amongst yourselves. And, kind of, being able to deal with it"

Desensitisation and keeping busy were other strategies used by participants to help them manage their work.

Katie: "You just become, a little bit numb to it really I think … until you stop and think about it but of course we don't stop cause we just keep going … and don't give ourselves the time to pause really … and think about it"

Michelle: "I think as a way of protecting yourself, because, every single client, that I've dealt with, they come into the service, because they've had some kind of trauma … um, so I think as a way of protecting, yourself, you have to, desensitise yourself to it and, it's almost as if it's normal day to day stuff now … for everyone to have experienced trauma cause you don't get shocked anymore … There's very little, I don't think I've been shocked in about a year … [Laughs]. Cause you're so, used to hearing, such horrific stories … So, I think you just have to, completely desensitise yourself to protect yourself cause, I would continuously hear, bad things … for 13 hours a day … [Laughs] um I think if you didn't, like normalise it, you probably wouldn't be able to cope, outside of work"

Trauma and violence are commonplace in secure care and therefore tolerance for these increases. Desensitisation appeared to be essential for ensuring participants could function within their job roles by giving them emotional distance. Keeping busy appeared to enable participants to not think about the emotional impact of their work by not allowing any opportunity to do so. Katie's use of "we" perhaps refers to her belief that keeping busy is part of the nursing culture. Externalisation was a strategy that participants demonstrated during their interviews.

James: "I think it's even more becoming a parent ... So, if your child should, start using drugs at a early age or be, traumatised by their teacher or someone in trust … What effect that can have … on them … It makes you [pause], think more really than just a job … If you were traumatised it could have ended up differently"

The use of "you" in James extract enables him to distance himself from the idea of trauma happening in his own life and yet his discussion of this suggests he remains vigilant. Normalisation was another strategy used by participants to help manage their work. The function of this appeared to be that it enabled participants to acknowledge when they do feel affected by their work.

Luke: "I guess it is about kinda like, [pause] acceptance of the fact that like, I'm a human person therefore I will have like an initial reaction to whatever I might read in a file"

Other participants described ways they detach, distance or disconnect from their work to mitigate the negative effects of working with trauma and violence.

Peter: "First thing is I get, out my work clothes, just to like, just to switch off from work"

Sophie: "I try really hard to not take it on myself. I'm quite good at, separating … This is their problem, it's not my problem"

Participants appeared to find it useful to detach from work by carrying out acts that have become symbolic in separating work from home as well as cognitive strategies to separate the self from trauma.

3.3.2 Subtheme Seven: Sense-making

This subtheme focuses on how participants make sense of their work internally and through seeking support from others. Sharing the load appeared a prominent function of seeking support.

Chantelle: "And after that [talking to a colleague] you kind of, I kind of feel better. Because I know that I'm not by myself in this situation. And I'm not on my own … That kind of thing. So I think, yeah, the support, at work, really helps"

Michelle: "Depending on, the severity, of what I've heard, I do like to talk about it … So, I like to offload … I'm not one to keep it, to myself … um and I find that once I've said, the information it's not, so much a burden … So I find sharing it easy, and it helps. … um, once you've shared it, it doesn't feel like it's your responsibility cause there's so many people"

Seeking support from others enabled some participants to release intense emotions and normalise their distress. Some participants described internally processing whatever they notice is left with them at the end of a shift.

Rob: "I'd probably think about them a bit, as I leave. I've evolved this thing where it takes me about half an hour to get home … That's the thinking time … So I generally, won't put the radio on or play music … um sometimes I do, but if I notice it's there, I'll just try to, process it … before I get home"

The drive home from work appeared essential in giving participants time to reflect on their day, make sense of and then process it before arriving home. This enabled them to leave work at work. Other participants described how they seek support for validation.

Sophie: "Have a chat with my other half. And kind of maybe talk to him a little bit about how bad my day's been just so he can be like that sounds really bad … So that you get some kind of reassurance that, yeah that does sound horrible [laughs] … your job is hard"

It is possible that feeling validated enables participants to accept that their emotions are understandable when perhaps they are doubting this. Participants identified that support from others is essential for coping with their work but that it is difficult to obtain. This was due to issues around confidentiality, putting the needs of others first (when in a management role) and feeling like they do not have the time to prioritise this.

Lucy: "From that point it can be, a bit stressful because you can only share information with the people that you work with … because we're all bound by the same confidentiality and so forth … You can't just, you know, finish work and say ah wow. You can say you've had a stressful day but you can't go into detail. If someone says why what happened? You can't say well, we had this case. Cause you just can't do it"

Rob: "Stepping into clinical incidents, situations when people need me … Providing supervision for people who are asking for it. You know there ain't enough time in the day … So if I have to make a choice, I'm just going to sound like a martyr, I'll sort them out, I'll look after the people"

Some participants reported that they do not believe the current provision of support at work was meeting their needs.

Jodie: "For me, personally, is people's ability to understand what I'm saying, and actually offer me either a listening ear, or something constructive back … Cause I was saying to somebody I love clinical supervision, the whole idea of it, management supervision. Great. Um, but realistically, this is just a bit you know. But this is me being sceptical, it works really well for a conversation, to have that release ... But in terms of actually exploring things, in terms of people genuinely understanding what you mean, or having that genuine impartial view … it doesn't happen … Because, you know most of your clinical supervisors, they're either friends, they're either people you've worked with, people who know other people … You don't have that really free boundary of going all the way, out in the open with anything you've got to say … You still are restricted slightly … So having a awareness of that, sort of minimises what you would discuss"

Katie: "If I had a major issue … it would be expected that I went to a nurse higher than me or the matron or whatever else. But I just don't feel that they're, I'm not saying they're not equipped cause I don't know what their training is, but I would wanna go … to someone with the specialist training really to help me. Cause otherwise it's alright giving me a solution as a manager as to what to do but I'm not asking for that, I'm asking to be able to, speak about how I'm feeling … really openly. And then leave it there"

Participants appeared to be yearning for a space to not only offload but for someone to contain and make sense of what they are experiencing. Current provisions of support were solution-focused but what participants believed they needed was exploration around emotional experiences. There is also something around privacy and feeling restricted by what they can share. This appeared to be due to participants feeling uncomfortable disclosing emotions that perhaps they feel are not acceptable within their profession, to their peers. Containment appears important as participants suggest they might consider "going all the way, out in the open". Therefore, participants identified that they would like access to support which focuses on the emotional impact of their work.

Luke: "When I was going through that thing, that kinda, 10 year lapse or whatever. I don't know what to describe it as. It would've been good to have like a bit more, a bit of like someone who came down, and offered like psychological intervention for staff"

Jodie: "It'd be great if … every hospital could hire, a psychotherapist or something that people can book in to see … somebody that's completely impartial to the service. That would be great … because then it wouldn't even matter what band you are, who you're speaking to … that person's there for you … How to answer that question perfectly is there needs to be somebody, for staff … not just, activities for staff … So, someone who's completely for staff … would be great"

These extracts suggest that what participants believe they would benefit from is clinical supervision from a Clinical Psychologist who is external to the service and is specifically employed to support staff with the emotional impact of their work.

4.0 Discussion

The analysis suggests that working in secure care increased the potential for exposure to trauma and violence which appeared to alter the nurses' perceptions and impact on their cognitive and emotional experiences. These experiences were predominantly negative but the findings suggest that nurses did experience some growth and satisfaction. Nurses employed different strategies to manage their work.

It appears that narratives about violence are drawn upon by nurses when making sense of their work with individuals who have experienced trauma *and* present with aggression. It is possible that participants spoke about violence because thinking or talking about trauma is difficult. Throughout the interview's participants appeared hesitant and it seemed like it was difficult for them to articulate or recall details about trauma. Other participants actively voiced this. There was a sense of trauma being best left untouched as participants worried about triggering distress in their service users and potentially themselves.

An alternative perspective is that participants spoke about violence because the frequency or severity is such that it stands out when reflecting on their experience of their work. Additionally, Holmes and Federman (2003) highlighted that nurses are socialised to narratives around violence within forensic settings. As such it is possible that violence is spoken about more than trauma because it is more apparent. It is also plausible that nurses find experiencing (either first hand or witnessing assaults on others) or hearing about violence (either service users offending histories or their current presentation) traumatic so this is what comes to mind when talking about trauma.

Finally it is possible that there are methodological reasons why the participants may not have discussed trauma in the way that had been intended by the original study aim. For instance the interview schedule was designed to be open to not constrain participants sense-making and allow for both negative and positive responses to be explored. However, in doing so this may have invited narratives around violence and thus restricted a focus on trauma. Additionally it may have been useful to outline the concept of vicarious trauma in the Participant Information Sheet to ensure that participants were fully aware of the aim of the study. This may have invited a different perspective to what has been presented in the accounts in this study.

As such the findings suggest that there are multiple levels of trauma experienced by nurses working in secure care. This includes primary (i.e. when violence is directed towards them or they are witness to it) and secondary trauma (i.e. when they hear about service users' histories or current behaviour). Secondary trauma appears to be split into two levels and includes hearing about service users' engagement in violence *and* their experience of trauma. The experience of these multiple levels of trauma appear to have a pervasive impact on the nurses exposed to them. The experience of trauma is complex and it was difficult to separate the impact of each level of trauma as this was not the focus of the study. It was felt that an attempt to do this would over-complicate and dilute the meaning of the results. Outlined below is a discussion about how the experience of these multiple levels of trauma appear to impact on nurses working in secure care.

4.1 Altered perceptions and impact on the self

The analysis suggests that exposure to trauma and violence had an impact on nurses' perceptions (Theme One). This included changes in worldview (Subtheme One), beliefs about the self and how this relates to one's own life (Subtheme Two). Some participants appeared to view themselves as incompetent, others as bad and the world as unsafe/unfair. For some this appeared to challenge previously held beliefs. This is consistent with CSDT and existing literature (Janoff-Bulman, 1992; McCann & Pearlman, 1990b; Pearlman & Saakvitne, 1995). The analysis also suggests that participants appeared to locate the blame within themselves when service users were not progressing and doubted their knowledge/abilities to work with trauma.

These altered perceptions appeared to lead to hyper-vigilance around the safety of self and others and the positioning of other people's problems as insignificant (Subtheme Two). Positioning trauma survivors as damaged appeared to leave nurses feeling hopeless about their potential for recovery (Silveira & Boyer, 2015; Sui & Padmanabhanunni, 2016). However, Jacob, Gagnon and Holmes (2009) suggested it could be the social construction of "mentally ill offenders" that result in the shift in worldview and hyper-vigilance.

The impact of working with trauma and violence is clear (Theme Two). Nurses described "carrying the trauma" as it intrudes on their internal and external world (Subtheme Three), consistent with CDST theory and existing literature (Baker, 2012; Killian, 2008; McCann & Pearlman, 1990a). Hunter (2012) highlighted how individuals appear to become desensitised due to regular exposure. In this study

nurses experienced a shift in their emotional reaction to trauma and violence over their time working in secure care (Subtheme Four). Participants reflected on feeling sad for the victims and anger towards the perpetrators.

Some participants described feeling overwhelmed, drained and exhausted but emotions were mostly suppressed (Subtheme Four). This was perceived as essential for enabling nurses to carry out their job role effectively and protect themselves and their service users from intense emotions. Menzies-Lyth (1960) proposed that emotional suppression acts to protect nurses from getting too emotionally involved. This ran parallel to the notion of emotionality being unprofessional and counterintuitive to the nursing role (Jacob et al., 2009; Mason et al., 2008; Morrison, 1990). This appears to be present in forensic mental health nurses (Harris et al., 2015). However, although this appears to be a dominant narrative within nursing, it is not outlined in professional guidance regarding management of stress at work (Royal College of Nursing, 2015).

Concurrently, nurses appeared to integrate their knowledge of trauma and violence and construct an understanding as to how service users' current difficulties are linked to their experience of trauma (Subtheme Five). This suggests that nurses can draw on and apply psychological theory to understand their work. This enabled empathy towards service users which was generalised outwards to others in their personal life (Arnold et al., 2005). Over time nurses were able to look beyond service users' offence history and focus on the person. A similar phenomenon has been identified by Rose and Walker (2018) and Hunter and Schofield (2006). It is possible that nurses can look beyond the offence history because of their integrated understanding of trauma and violence.

Additionally nurses appeared to experience growth through hearing about service users' resilience and progression (Subtheme Five). Nurses described feeling thankful for their own lives which prompted them to act in ways to enhance this further. Witnessing growth in service users appeared fulfilling and evoked hope, particularly when nurses were involved in their recovery (Michalchuk & Martin, 2018; Tedeschi & Calhoun, 2004). Participants also recognised their own resilience and perseverance to remain in a difficult job.

Although there are elements that are consistent with CSDT theory and suggestive of vicarious trauma, the experiences described by participants in this study do not appear to mimic PTSD symptoms to the degree that is suggested in existing literature (Herman, 1992; McCann & Pearlman, 1990a). These studies identify a range of emotional, cognitive and behavioural responses associated with vicarious trauma in therapists such as anxiety, guilt, shame, fear, avoidance of perceived danger, dreams, dissociation and hyper-arousal which were not reported by participants in this study.

It is possible that nurses may have been reluctant to share some of their experiences due to the belief that it is not professional to be experiencing such reactions and the stigma around mental health professionals receiving help, as expressed by the participants in this study. It is also possible that the suppression of emotions reported by nurses in this study may be indicative of PTSD-type avoidance and provide an explanation for the minimal levels of distress reported. Another explanation is that the nature of the exposure is different for nurses and therapists due to differences in their role and their engagement with service user's trauma. For instance, it is possible that engaging in therapy with someone who has experienced

trauma may elicit more intense responses than hearing about trauma through information-gathering, team meetings, reports or discussions with service users about risk as the nature of therapy is intended to be in-depth and exploratory. The analysis provides support for vicarious post-traumatic growth in nurses.

4.2 Managing exposure

Participants described strategies to mitigate the negative effects of working with trauma and violence (Theme Three). They appear to act to protect the self from threat (Subtheme Six), by creating emotional distance from service users' histories and enabling the avoidance of intense emotions that might surface (Lauvrud, Nonstad & Palmstierna, 2009; Menzies-Lyth, 1960). Normalisation appears to enable nurses to accept the times when they do feel affected by their work as it is inherent in their existence as a human (Ling, Hunter & Maple, 2014). To prevent trauma intruding on personal lives, symbolic acts or cognitive strategies to separate work from home and the self were utilised (Hunter & Schofield, 2006). Seeking support from others enabled nurses to offload and feel validated (Subtheme Seven; Ling et al, 2014). The importance of time for internal processing was evident (Killian, 2008).

The analysis suggests that despite believing that support was essential in their job role, many participants found it difficult to obtain or did not feel like the current provision of support was meeting their needs as it was more solution-focused (Subtheme Seven). Participants described needing a containing and confidential space to make sense of the emotional impact of their work. Similar reflections were made by Evans (2006) and Sommer and Cox (2005). They suggested supervision

that enables staff to explore the emotional impact of working with trauma would be beneficial in mitigating the potential negative effects of such work. This is recommended by the Nursing and Midwifery Council (2015).

Please see Figure 7 for a diagram suggesting how the themes and factors identified in the literature may contribute to nurses' experience.

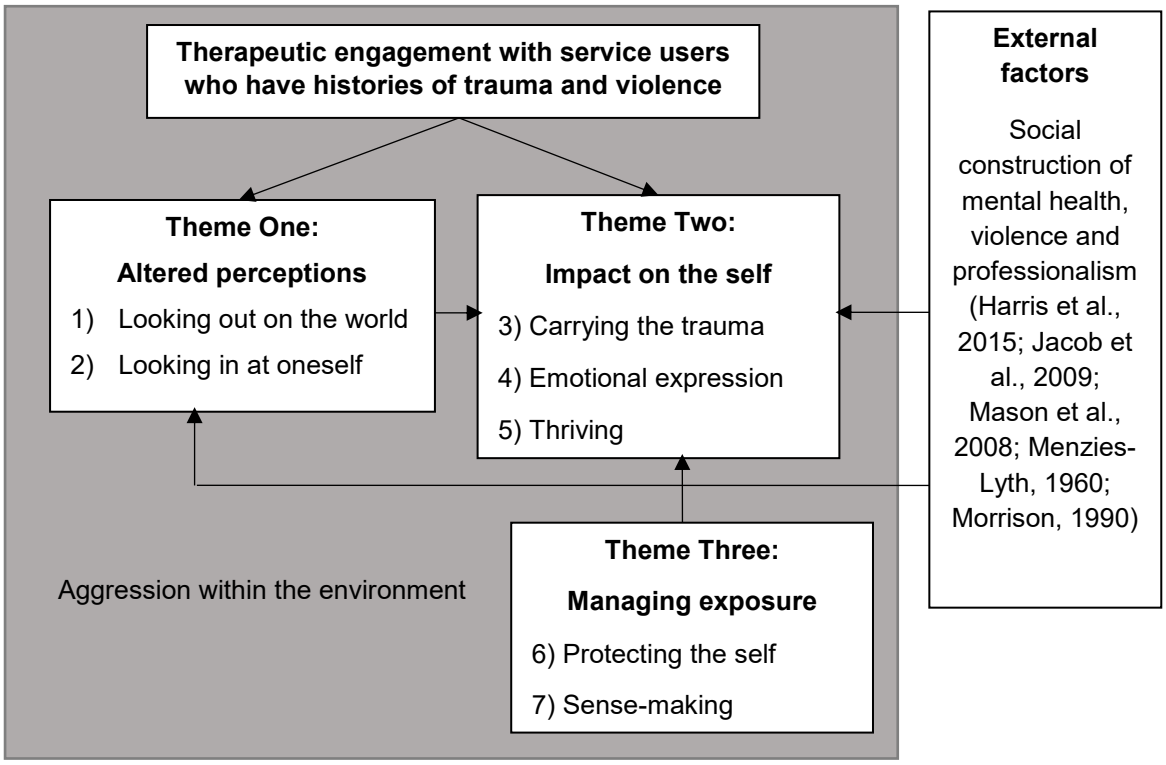


Figure 7: Thematic map

4.3 Critique

The findings provide an in-depth explanation of mental health nurses' experience of multiple levels of trauma in this secure setting through their exposure to trauma and violence. The findings also provide insight into the different ways in which nurses manage their work. These findings add to the evidence base as there

are currently limited studies exploring the impact of trauma and violence on forensic mental health nurses.

Due to the nature of IPA, the findings present my interpretation of nurses' experience of working with trauma and violence. Although efforts were made to increase the credibility of my interpretations (as outlined previously), it is important to recognise that I do bring with me my own personal experiences and assumptions which may have restricted or shaped my perspective somewhat. As such there may be alternative explanations.

Due to the phenomenological nature of qualitative studies and purposive sampling in this study, the generalisability of the findings is limited. Whilst attempts were made to explore participants' experience of working with trauma and violence, a full account of this may not have been gained. It is possible that a particular type of nurse opted to engage in this study which means that different perspectives may not be represented. For instance, it is possible that nurses who were particularly affected by their work have left the service. Therefore the findings may provide an understanding of *some* nurses' experience of their work with trauma and violence, and it is unlikely to be representative of *every* nurse who works with trauma and violence.

As previously discussed, participants drew on their experience of violence when talking about trauma. Thus, the nature of this study altered somewhat to incorporate this inclusion and the idea that nurses experience multiple levels of trauma has been presented. This shift in focus meant that it was difficult to separate the impact of trauma at each level (as this was not the initial aim) and it is therefore unclear which aspects of the findings relate to primary trauma and which relate to

secondary trauma. It is possible that the different levels of trauma may have elicited different responses.

4.4 Clinical implications

This study identified the impact of working with trauma and violence on the nurses caring for them. This has important implications for the support organisations can provide to minimise the potential negative effects of working with this population, consistent with the government's recommendations (Stevenson & Farmer, 2017). Approaching this systemically through focusing on an organisational culture that has an awareness of and normalises the potential negative effects of working with trauma and violence would be useful. It would be beneficial to introduce the concept of trauma (as experienced by service users and nurses) when individuals commence working in secure care and throughout their career. This could be achieved through clinical supervision, reflective practice or training and would challenge existing beliefs around unprofessional behaviour and hopefully make it easier to talk about trauma. Interventions to target self-blame and doubt could include normalising the nature of trauma work and validating its impact on the person.

Introducing a narrative around the emotional impact of the work would be beneficial in providing nurses a space to process their otherwise suppressed emotions. This would be best delivered by a different profession or an individual external to the service to acknowledge nurses' concerns around sharing difficult emotions with peers. This would also meet the need of feeling validated which some nurses identified as the function of seeking support. Etherington (2000) and

Pearlman and Saakvitne (1995) provide guidance on the implementation of trauma-specific supervision.

Interestingly nurses were more focused on the negative impact of their work than the positive and this is reflected in the analysis. Thus, an organisational ethos which encourages a dialogue around what is going well could potentially facilitate growth, resilience and satisfaction in nurses and counteract the negative impact (Michalchuk & Martin, 2018). This also presents an opportunity to re-frame the notion of trauma and recovery to enable nurses to look beyond the permanence of trauma and recovery as being normal by formulating a new narrative around what recovery looks like in secure care. Constructing a new narrative may increase hopefulness.

Nurses believed that experiencing overwhelming emotions was unsafe for themselves and their service users. Remaining in control of their emotional responses through suppression and detachment was deemed important for protecting themselves and their service users but also for enabling them to carry out their job role effectively as a “professional” and a “good nurse”. Emotional expression was deemed inconsistent with these ideas and participants indicated that this would impact on the quality of care provided, perhaps even being experienced as un-containing for service users if nurses were to get too emotionally involved (Menzies-Lyth, 1960). Some participants described how they believed it was an essential part of their job role to look beyond an individuals’ offence history so that they avoided passing judgement but also the potentially strong emotions that might arise through thinking about their service users’ crimes.

Participants described several ways that they managed working with this population which enabled them to distance themselves from trauma and violence, and which potentially protected them from the intense emotional responses that might have surfaced if these strategies were absent. Although these strategies were deemed essential by participants for enabling them to be an effective nurse, it is possible that this emotional detachment might impact on the therapeutic relationship. For instance nurses may notice a loss of empathy or feel drained and exhausted by their work through keeping their emotions in. This may be experienced by the service user as invalidating or they may pick up on the detachment and feel uncared for or rejected. This may impact on their level of trust and motivation which may influence whether they share their thoughts and feelings with the people caring for them.

Some participants discussed how they doubted their own abilities to engage with individuals who have experienced trauma. It is possible that having a negative self-concept might impact on the therapeutic relationship (Way, VanDeusen & Cottrell, 2007). Feeling incompetent may influence how individuals interact with and discuss trauma with service users. If discussions around trauma are avoided service users may experience this as invalidating and it may promote the idea that trauma is not safe to talk about.

4.5 Future directions

Future research evaluating the impact of organisations that promote a normalising and validating culture and are focused on growth and re-framing recovery would be useful. This would enable exploration around whether this has an

influence on the negative impact of working with trauma and violence, whether there are changes in willingness to talk about trauma or nurses' sense of self and whether there is evidence of growth. Additional research could explore the impact of introducing emotionally-focused clinical supervision provided by an external individual on nurses' experience of their work. This would be particularly beneficial in exploring whether providing nurses with a containing space facilitates disclosure of otherwise suppressed emotions. Additionally, exploring the different levels of trauma separately would be beneficial to explore the impact at each level, and whether there are differences in how each level is experienced and managed. Finally, the representativeness of the current findings could be enhanced through developing a survey and distributing these to mental health nurses working in secure care nationally.

4.6 Conclusion

This study suggests that mental health nurses working in secure care experience changes in their belief system which impact on their emotional well-being and cognitive functioning through their experience of multiple levels of trauma. Their experience appears to be defined by the idea that emotional expression is not professionally acceptable and that detachment is essential for remaining emotionally robust. Nurses have several ways of managing their work but it appears a protected space for reflecting on the emotional impact of such work is warranted. There were however positive gains reported in nurses' view of themselves, their own lives, and their approach to others.

5.0 References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: APA.

Arnold, D., Calhoun, L, G., Tedeschi, R., & Cann, A. (2005). Vicarious posttraumatic growth in psychotherapy. *Journal of Humanistic Psychology, 45*, 239 – 263.

Baker, A, A. (2012). Training the resilient psychotherapist: What graduate students need to know about vicarious traumatization. *Journal of Social, Behavioral and Health Sciences, 6*, 1 – 12.

Baranowsky, A, B. (2002). The silencing response in clinical practice: On the road to dialogue. In C. R. Figley (Ed.). *Treating compassion fatigue* (pp. 155 – 170). New York: Brunner-Routledge.

Bartoskova, L. (2017). How do trauma therapists experience the effects of their trauma work, and are there common factors leading to post-traumatic growth? *Counselling Psychology Review, 32*, 30 – 45.

Beck, C, T., LoGiudice, J., & Gable, R, K. (2015). A mixed-methods study of secondary traumatic stress in certified nurse-midwives: Shaken belief in the birth process. *Journal of Midwifery & Women's Health, 60*, 16 - 23.

Benjet, C., Bromet, E., Karam, E, G., Kessler, R, C., McLaughlin, K, A., Ruscio, A, M., … Koenen, K, C. (2016). The epidemiology of traumatic event exposure worldwide: Results from the World Mental Health Survey Consortium. *Psychological Medicine, 46*, 327 – 343.

Bion, W, R. (1962). *Learning from experience*. London: Heinemann.

Bride, B, E., Radey, M., & Figley, C, R. (2007). Measuring compassion fatigue. *Clinical Social Work Journal, 35*, 155 − 163.

Brown, J., Mulhern, G., & Joseph, S. (2002). Incident-related stressors, locus of control, coping and psychological distress among firefighters in Northern Ireland. *Journal of Traumatic Stress, 15*, 161 - 168.

Cohen, K., & Collens, P. (2013). The impact of trauma work – A meta-synthesis on vicarious trauma and vicarious trauma growth. *Psychological Trauma: Theory, Research, Practice and Policy, 5*, 570 - 580.

Department of Health. (2010). *See, think act: Your guide to relational security.* London: Department of Health.

Dickens, G., Picchioni, M., & Long, C. (2013). Aggression in specialist secure and forensic inpatient mental health care: Incidence across care pathways. *The Journal of Forensic Practice, 15*, 206 – 217.

Etherington, K. (2000). Supervising counsellors who work with survivors of childhood sexual abuse. *Counselling Psychology Quarterly, 13*, 377 – 389.

Evans, M. (2006). Making room for madness in mental health: The importance of analytically-informed supervision of nurses and other mental health professionals. *Psychoanalytic Psychotherapy, 20*, 16 – 29.

Fear, N., Bridges, S., Hatch, S., Hawkins, V., & Wessely, S. (2016). Chapter 4. Posttraumatic stress disorder. In S. McManus, P. Bebbington, S. Jenkins, & T. Brugha (Eds.). *Mental health and wellbeing in England: Adult psychiatric morbidity survey 2014* (pp. 106 – 130). Leeds: NHS Digital.

Francis, R. (2013). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry.* London: The Stationery Office.

Friel, A., White, T., & Hull, A. (2008). Posttraumatic stress disorder and criminal responsibility. *The Journal of Forensic Psychiatry & Psychology, 19*, 64 – 85.

Goldenberg, J, E. (2002). The impact on the interviewer of holocaust survivor narratives: Vicarious traumatization or transformation? *Traumatology, 8*, 237 - 255.

Green, B, L. (2000). Traumatic loss: Conceptual and empirical links between trauma and bereavement. *Journal of Personal and Interpersonal Loss, 5*, 1 – 17.

Harris, D, M., Happell, B., & Manias, E. (2015). Working with people who have killed: The experience and attitudes of forensic mental health clinicians working with forensic patients. *International Journal of Mental Health Nursing, 24*, 130 – 138.

Herman, J, L. (1992). *Trauma and recovery: The aftermath of violence*. New York: Basic Books.

Holmes, D., & Federman, C. (2003). Constructing monsters: Correctional discourse and nursing practice. *International Journal of Psychiatric Nursing Research, 8,* 942 – 962.

Hunter, S, V. (2012). Walking sacred spaces in the therapeutic bond: Therapists' experiences of compassion satisfaction coupled with the potential for vicarious traumatization. *Family Processes, 51*, 179 – 192.

Hunter, S, V., & Schofield, M, J. (2006). How counsellors cope with traumatized clients: Personal, professional and organizational strategies. *International Journal for the Advancement of Counselling, 28,* 121 – 138.

Jacob, J, D., Gagnon, M., & Holmes, D. (2009). Nursing so-called monsters: On the importance of abjection and fear in forensic psychiatric nursing. *Journal of Forensic Nursing, 5*, 153 – 161.

Janoff-Bulman, R. (1992). *Shattered assumptions*. New York: The Free Press.

Kessler, R, C., Aguilar-Gaxiola, S., Alonso, J., Benjet, C., Bromet, E, J., Cardoso, G., … Koenen, K, C. (2017). Trauma and PTSD in the WHO World Mental Health Surveys. *European Journal of Psychotraumatology, 8*, 1353383. DOI: 10.1080/20008198.2017.1353383

Killian, K, D. (2008). Helping till it hurts? A multimethod study of compassion fatigue, burnout, and self-care in clinicians working with trauma survivors. *Traumatology, 14*, 32 – 44.

Lauvrud, C., Nonstad, K., & Palmstierna, T. (2009). Occurrence of post-traumatic stress symptoms and their relationship to professional quality of life (ProQoL) in nursing staff at a forensic psychiatric security unit: A cross-sectional study. *Health and Quality of Life Outcomes, 7*, 31 – 36.

Ling, J., Hunter, S, V., & Maple, M. (2014). Navigating the challenges of trauma counselling: How counsellors thrive and sustain their engagement. *Australian Social Work, 67*, 297 – 310.

Mason, T., Lovell, A., & Coyle, D. (2008). Forensic psychiatric nursing: Skills and competencies: I role dimensions. *Journal of Psychiatric and Mental Health Nursing, 15*, 118 – 130.

McCann, I, L., & Pearlman, L, A. (1990a). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress, 3*, 131 - 149.

McCann, I, L., & Pearlman, L, A. (1990b). *Psychological trauma and the adult survivor: Theory, therapy, and transformation*. Philadelphia, Pennsylvania: Brunner/Mazel.

Menzies-Lyth, I, E, P. (1960). The functioning of social systems as a defence against anxiety. A report on a study of the nursing service of a general hospital. *Human Relations, 13, 95 – 121.*

Michalchuk, S., & Martin, S, L. (2018). Vicarious resilience and growth in psychologists who work with trauma survivors: An Interpretive Phenomenological Analysis. *Professional Psychology: Research and Practice*. Advance online publication. DOI: 10.1037/pro0000212

Morrison, E, F. (1990). The tradition of toughness: A study of nonprofessional nursing care in psychiatric settings. *Journal of Nursing Scholarship, 22*, 32 – 38.

National Health Service. (2018). *Post-traumatic stress disorder* [online]. Retrieved from: https://www.nhs.uk/conditions/post-traumatic-stress-disorder-ptsd/

Nursing and Midwifery Council. (2015). *Standards for competence for registered nurses*. London, UK: Nursing and Midwifery Council.

Papanastassiou, M., Waldron, G., Boyle, J., & Chesterman, L, P. (2004). Posttraumatic stress disorder in mentally ill perpetrators of homicide. *Journal of Forensic Psychiatry & Psychology, 15*, 66 - 75.

Pearlman, L, A., & Saakvitne, K, W. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors*. New York: W.W. Norton & Company.

Rose, J., & Walker A, L. (2018). Understanding staff to provide effective support and development. In W. R. Lindsay & J. L. Taylor (Eds.) *The Wiley handbook on offenders with intellectual and developmental disabilities: Research, training and practice* (pp. 421 – 436). New Jersey: Wiley-Blackwell.

Royal College of Nursing. (2015). *Stress and you: A guide for nursing staff.* London: Royal College of Nursing.

Sarkar, J., Mezey, G., Cohen, A., Singh, S, P., & Olumoroti, O. (2005). Comorbidity of post-traumatic stress disorder and paranoid schizophrenia: A comparison of offender and non-offender patients. *Journal of Forensic Psychiatry & Psychology, 16*, 660 - 670.

Silveira, F, S., & Boyer, W. (2015). Vicarious resilience in counselors of child and youth victims of interpersonal trauma. *Qualitative Health Research, 25,* 513 – 526.

Smith, J, A., Flowers, P., & Larkin, M. (2012). *Interpretative Phenomenological Analysis: Theory, method and research.* London: SAGE Publications Limited.

Sommer, C, A., & Cox, J, A. (2005). Elements of supervision in sexual violence counselors' narratives: A qualitative analysis. *Counselor Education & Supervision, 45*, 119 – 134.

Splevins, K, A., Cohen, K., Joseph, S., Murray, C., & Bowley, J. (2010). Vicarious posttraumatic growth among interpreters. *Qualitative Health Research, 20,* 1705 – 1716.

Stein, J, Y., Wilmot, D, V., & Solomon, Z. (2016). Does one size fit all? Nosological, clinical, and scientific implications of variations in PTSD criterion A. *Journal of Anxiety Disorders, 43*, 106 – 117.

Stevenson, D., & Farmer, P. (2017). *Thriving at work: The Stevenson/Farmer review of mental health and employees* [online]. Department for Work & Pensions and Department of Health. Retrieved from: https://www.gov.uk/government/publications/thriving-at-work-a-review-of-mental-health-and-employers

Sui, X., & Padmanabhanunni, A. (2016). Vicarious trauma: The psychological impact of working with survivors of trauma for South African psychologists. *Journal of Psychology in Africa, 26,* 127 – 133.

Tedeschi, R, G., & Calhoun, L, G. (1996). The posttraumatic growth inventory: Measuring the positive legacy of trauma. *Journal of Traumatic Stress, 9*, 455 – 471.

Tedeschi, R, G., & Calhoun, L, G. (2004). Post-traumatic growth: Conceptual foundations and empirical evidence. *Psychological Inquiry, 15*, 1 – 18.

Way, I., VanDeusen, K., & Cottrell, T. (2007). Vicarious Trauma: Predictors of clinicians' disrupted cognitions about self-esteem and self-intimacy. *Journal of Child Sexual Abuse, 16*, 81 – 98.

Wheeler, K. (2018). A call for trauma competencies in nursing education [Editorial]. *Journal of the American Psychiatric Nurses Association, 24,* 20 – 22.

Winnicott, D, W. (1960). The Theory of the Parent-Infant relationship. *International Journal of Psychoanalysis, 41*, 585 – 595.

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health, 15*, 215 – 228.

CHAPTER III

PUBLIC DISSEMINATION DOCUMENT

A META-ETHNOGRAPHIC REVIEW EXPLORING HOW THERAPISTS EXPERIENCE THEIR WORK WITH TRAUMA SURVIVORS

AND

THE EXPERIENCE OF WORKING WITH TRAUMA: A PHENOMENOLOGICAL PERSPECTIVE OF MENTAL HEALTH NURSES WORKING IN SECURE CARE

1.0 Overview

This chapter provides an accessible overview of the literature review and empirical study. The literature review focused on the experience of therapists working with trauma survivors. The empirical study focused on exploring how mental health nurses working in secure care experience and make sense of their work with trauma.

2.0 Literature review

How do therapists experience their work with trauma survivors: A Meta-Ethnographic Review

2.1 Background

Hearing about trauma can have a profound and marked impact on the individuals working with trauma survivors, leading to a significant and permeant change in their view of the world that challenges their existing beliefs. This change is pervasive across their view of themselves, others and the world and occurs following repeated exposure to trauma narratives (Bride, Radey & Figley, 2007; Pearlman & Saakvitne, 1995). This change also has an influence on individuals experience in the here and now and 'symptoms' may mimic Post-Traumatic Stress Disorder, to a lesser degree (Elwood, Mott, Lohr & Galovski, 2011). This is called vicarious trauma (McCann & Pearlman, 1990). The experience of these symptoms is likely to influence how individuals relate to others, particularly within the client-therapist relationship (Baranowsky, 2002; Herman, 1992). Despite this, some individuals can experience vicarious post-traumatic growth through an enhanced understanding of themselves and others. This enriched perspective allows individuals to respond in ways that promote satisfaction and growth in their own lives (Arnold, Calhoun, Tedeschi & Cann, 2005; Splevins, Cohen, Joseph, Murray & Bowley, 2010; Tedeschi & Calhoun, 2004).

As containment is an important aspect of therapy, therapist well-being should be prioritised (Pistorius, Feinauer, Harper, Stahmann & Miller, 2008). An exploration of how therapists experience their work with trauma survivors can highlight potential

areas of need, particularly around the level of support required. This is in line with the government's agenda following the Mid-Staffordshire scandal (Francis, 2013; Stevenson & Farmer, 2017). This meta-ethnographic review aimed to integrate the findings of existing qualitative literature which have explored therapists experience of their work with trauma survivors.

2.2 Method

A systematic search of three electronic databases was undertaken to identify relevant articles. The references section of relevant articles was also reviewed to identify additional papers. Following the application of inclusion/exclusion criteria and quality criteria (using a standardised tool) a total of 16 studies were deemed suitable for inclusion and of a reasonable quality. Noblit and Hare's (1988) approach to meta-ethnography was followed.

2.3 Findings

The synthesis identified four superordinate themes which identified that therapists presented with emotional, cognitive, behavioural and physiological 'symptoms' due to significant changes in their belief system following repeated exposure to traumatic stories. The synthesis indicated that growth and development is experienced alongside vicarious trauma through witnessing client growth and resilience. The themes were organised into a cognitive model of vicarious trauma and post-traumatic growth.

2.4 Conclusions

The results of this meta-ethnographic review highlight that working with trauma is profound and complex for therapists who are exposed to their client's pain and concurrently, their growth. It is proposed that marked changes in therapist's belief systems impact on their experience in the here and now in positive and negative ways. The themes appear to represent a cognitive model of vicarious trauma and post-traumatic growth. Although there are limitations inherent in the methodology applied in this review, the findings have enabled recommendations for supporting employee well-being and highlighted potential areas of further exploration.

3.0 Empirical paper

The experience of working with trauma: A phenomenological perspective of mental health nurses working in secure care

3.1 Background

Trauma is prevalent throughout the world and is particularly prominent in mental health and forensic populations (Kessler et al., 2017; Sarkar, Mezey, Cohen, Singh & Olumoroti, 2005). Trauma has a profound impact on the individual whose life it has touched and for some, they require admission to an inpatient setting for further support. Mental health nurses working in secure care may be exposed to trauma narratives and violence as they have the most opportunities for therapeutic engagement (Mason, Lovell & Coyle, 2008).

The profound impact of working with trauma and the potential growth/satisfaction that some individuals experience has been identified in many professional groups. There is however a noticeable absence of mental health nurses working in secure care in the current literature base. Nurses do not receive the same level of training that other professions do thus exploring the impact of engaging with trauma survivors is important. Additionally the impact of working with trauma survivors who have committed violent offences on staff well-being is worthy of further exploration. Thus, the current study aimed to explore the experience mental health nurses working with trauma and violence in a secure care context.

3.2 Method

Eleven mental health nurses were recruited from a secure care facility and interviewed about their experience of working with individuals who have experienced trauma. A qualitative research method, Interpretative Phenomenological Analysis was used to analyse the transcribed interviews following the steps outlined by Smith, Flowers and Larkin (2012). This enabled the researcher to identify the prominent themes by examining patterns within and across transcripts.

3.3 Findings

Three over-arching themes and seven sub-themes were identified. Participants spoke a lot about their experience of violence in the interviews so the following themes reflect the impact of working with service users who present with trauma *and* violence.

1) “Altered perceptions” – This reflects participant’s experience of altered perceptions following exposure to trauma and violence. This included changes in their view of the world that challenged their view of normality (“Looking out at the world”) and sense of self (“Looking in on oneself“). Participants also reflected on how their altered worldview impacted on them in the present i.e. how it constructed their view of trauma and recovery, led to hyper-vigilance to potential threat and reduced their level of sensitivity to “minor” problems.

2) “Impact on the self” – This reflects how participant’s altered perceptions (Theme 1) and exposure to trauma and violence impacted on their emotional and

cognitive experiences. Participants described trauma as intrusive and noticed the potential for it to absorb them (“Carrying the trauma”). Emotions were mostly suppressed due to a belief that expressing them is unprofessional, inconsistent with the nursing role and unsafe (“Emotional expression”). Emotions that were expressed were directed towards victims and perpetrators of trauma. Participants described feeling overwhelmed and drained. Participants were able to thrive through their altered perceptions (Theme 1) which enabled them to experience gratitude and live life to the full (“Thriving”). Integrating knowledge of trauma and violence enabled participants to be more empathic/understanding to others and more person-centered at work. Participants noticed their own resilience and experienced satisfaction and hope when service users progressed.

3) “Managing exposure” – This reflects the ways that participants manage the impact of their work (Theme 2). This included strategies to protect the self from the adverse effects of working with this population by creating emotional distance and separating work from home and trauma from their own lives (“Protecting the self”). Participants drew upon their identity as a human to normalise when they felt affected by their work. Seeking support from others to offload and feel validated, and internally processing enabled participants to make sense of their work (“Sense-making”). Participants found it difficult to receive support due to work pressures and felt that the current support systems were not meeting their needs of providing a safe space to explore their emotional response to their work.

3.4 Conclusions

Findings suggests that forensic mental health nurses experience primary (i.e. directly experiencing or witnessing) and secondary trauma (i.e. hearing about) through exposure to individuals who present with trauma and violence. Both are prevalent within secure care (Dickens, Picchioni & Long, 2003; Sarkar et al., 2005). These multiple levels of trauma appear complex and seem to have had a profound impact on the participants. Changes were evident in beliefs about the self and the world which appeared to impact on nurse's wider emotional and cognitive experiences. Working with this population is challenging, thus nurses engage in sense-making and self-protection as they navigate through their work. Nurses appeared to hold the belief that it is not professionally acceptable or useful to be emotionally expressive thus suppression was commonly reported.

Some nurses reported experiencing growth through working with this population which included their view of the self and others which generalised outward to their approach to other people and their own lives. Growth occurred through witnessing service user progression and the development of an enhanced understanding of trauma and violence. Services can support nurses working in secure care by adopting a culture that promotes normalisation, validation and growth, re-frames recovery and provides clinical supervision that focuses on the emotional impact of working with trauma and violence.

4.0 References

Arnold, D., Calhoun, L, G., Tedeschi, R., & Cann, A. (2005). Vicarious posttraumatic growth in psychotherapy. *Journal of Humanistic Psychology, 45*, 239 - 263.

Baranowsky, A, B. (2002). The silencing response in clinical practice: On the road to dialogue. In C. R. Figley (Ed.). *Treating compassion fatigue* (pp. 155 – 170). New York: Brunner-Routledge.

Bride, B, E., Radey, M., & Figley, C, R. (2007). Measuring compassion fatigue. *Clinical Social Work Journal, 35*, 155 − 163.

Dickens, G., Picchioni, M., & Long, C. (2013). Aggression in specialist secure and forensic inpatient mental health care: Incidence across care pathways. *The Journal of Forensic Practice, 15*, 206 – 217.

Elwood, L, S., Mott, J., Lohr, J, M., & Galovski, T, E. (2011). Secondary trauma symptoms in clinicians: A critical review of the construct, specificity, and implications for trauma-focused treatment. *Clinical Psychology Review, 31,* 25 – 36.

Francis, R. (2013). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry.* London: The Stationery Office.

Herman, J, L. (1992). *Trauma and recovery: The aftermath of violence*. New York: Basic Books.

Kessler, R, C., Aguilar-Gaxiola, S., Alonso, J., Benjet, C., Bromet, E, J., Cardoso, G., … Koenen, K, C. (2017). Trauma and PTSD in the WHO World Mental Health Surveys. *European Journal of Psychotraumatology, 8*, 1353383. DOI: 10.1080/20008198.2017.1353383

Mason, T., Lovell, A., & Coyle, D. (2008). Forensic psychiatric nursing: Skills and competencies: I role dimensions. *Journal of Psychiatric and Mental Health Nursing, 15*, 118 – 130.

McCann, I, L., & Pearlman, L, A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress, 3*, 131 - 149.

Noblit, G, W., & Hare, R, D. (1988). *Meta-ethnography: Synthesizing qualitative studies*. Newbury Park, California: Sage.

Pearlman, L, A., & Saakvitne, K, W. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors*. New York: W.W. Norton & Company.

Pistorius, K, D., Feinauer, L, L., Harper, J, M., Stahmann, R, F., & Miller, R, B. (2008). Working with sexually abused children. *The American Journal of Family Therapy, 36,* 181 – 195.

Sarkar, J., Mezey, G., Cohen, A., Singh, S, P., & Olumoroti, O. (2005). Comorbidity of post-traumatic stress disorder and paranoid schizophrenia: A comparison of offender and non-offender patients. *Journal of Forensic Psychiatry & Psychology, 16*, 660 - 670.

Smith, J, A., Flowers, P., & Larkin, M. (2012). *Interpretative Phenomenological Analysis: Theory, method and research.* London: SAGE Publications Limited.

Splevins, K, A., Cohen, K., Joseph, S., Murray, C., & Bowley, J. (2010). Vicarious posttraumatic growth among interpreters. *Qualitative Health Research, 20*, 1705 – 1716.

Stevenson, D., & Farmer, P. (2017). *Thriving at work: The Stevenson/Farmer review of mental health and employees* [online]. Department for Work & Pensions and Department of Health. Retrieved from: https://www.gov.uk/government/publications/thriving-at-work-a-review-of-mental-health-and-employers

Tedeschi, R, G., & Calhoun, L, G. (2004). Post-traumatic growth: Conceptual foundations and empirical evidence. *Psychological Inquiry, 15*, 1 – 18.

APPENDICES FOR VOLUME I

Appendices for Empirical paper

Appendix 1: Confirmation of ethical approval from the University of Birmingham

Sponsorship Approval RG_16-185/ ERN_16-1245

Actions

Research Governance

To: John Rose

Cc: Natalie McNeillie; 'Research Governance' [researchgovernance@contacts.bham.ac.uk]

Attachments: (4) Download all attachments
Confirmation of Insurance ~1.pdf (260 KB) [Open as Web Page]; Confirmation of Sponsorshi~1.pdf (329 KB) [Open as Web Page]; Fully signed CI declaratio~1.pdf (585 KB) [Open as Web Page]; 2016.2017 - Generic Insura~1.pdf (52 KB) [Open as Web Page]

Inbox 24 March 2017 13:24

Dear Professor Rose

Following on from the review of the Study "Working with victims of trauma: Views of forensic mental health nurses" your request for sponsorship has been approved and I have authorised the application in IRAS.

Please see attached the fully signed confirmation of sponsorship and insurance letters which need to be uploaded to IRAS together, with the fully signed CI declaration which is purely for your records.

Please ensure that you check the version control of all the documents uploaded on to IRAS prior to submission to the HRA. Please note that no changes should now be made on the form as it will invalidate our signatures and you will need to re-submit.

If you would like the hard copies, please just drop me a line and let me know what address to send them to.

Please do not hesitate to contact the research governance team should you have any further queries.

All the best with the research project!

Kind regards
Priyanka

Priyanka Batra
Research Governance Officer
Research Support Group
The Dome, C Block
Aston Webb
Edgbaston, Birmingham B15 2TT

Tel: 0121 414 7618
Email: researchgovernance@contacts.bham.ac.uk
Web: www.birmingham.ac.uk/researchsupportgroup

IRAS requests, queries and documentation should be submitted to researchgovernance@contacts.bham.ac.uk.
Please ensure that the RG reference is quoted in ALL correspondence.

Appendix 2: Confirmation of ethical approval from the Health Research Authority

NHS
Health Research Authority

Mrs Natalie McNeillie

Address has been removed

Email: hra.approval@nhs.net

04 May 2017

Dear Mrs McNeillie

Letter of HRA Approval

Study title:	**How does working with victims of trauma impact on mental health nurses working in a forensic medium secure setting?**
IRAS project ID:	**217044**
Protocol number:	**ERN_16-1245**
REC reference:	**17/HRA/1882**
Sponsor	**University of Birmingham**

I am pleased to confirm that HRA Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read *Appendix B* carefully**, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

Your IRAS project ID is **217044**. Please quote this on all correspondence.

Yours sincerely

Catherine Adams
Senior Assessor
Email: hra.approval@nhs.net

Copy to: *Dr Sean Jennings*
Miss Emma Patterson,

Address has been removed

Appendix 3: Confirmation of ethical approval from the Research & Innovation department of the participating trust

Email addresses have been removed

Attachments: 217044 Statement of Activ~1.docx (94 KB) [Open as Web Page]

Inbox 04 August 2017 13:11

- You forwarded this message on 14/08/2017 10:46.

Dear Natalie

Re: IRAS 217044 – Working with victims of trauma: Views of forensic mental health nurses – Confirmation of Local Capacity and Capability at Name of trust has been removed

This email confirms that Name of trust has been removed has the capacity and capability to deliver the above referenced study. Please find attached the agreed Statement of Activities as confirmation.

We agree to start this study on 04/08/2017.

Please note that your project now has a study record on EDGE, the Trusts local information management system used to record all research at the Trust, including real time recruitment. EDGE can be accessed at www.edge.nhs.uk. Recruitment information should be entered as per the EDGE Clinical Delivery User Guide. However, until we can confirm that you have direct access to EDGE in order to update recruitment information, please email R & I with a regular update about your recruitment progress. All queries in relation to EDGE should be directed to Katie Williams, local EDGE Administrator at

Please refer to the HRA Approval letter dated 04/05/17 (and amendments if applicable) for latest versions of approved documentation.

If you wish to discuss further please do not hesitate to contact me.

Best wishes

Interim Research Manager, Name of trust has been removed

Appendix 4: Recruitment poster

IRAS Project ID: 217044
(Version 1, 17.10.16)

Interested in taking part in research?

A qualified mental health nurse?

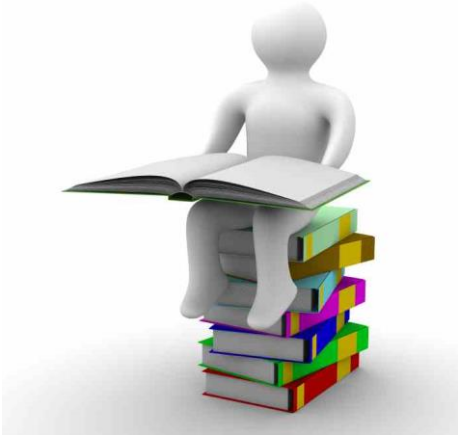
YES!!

We are interested in how **you** experience working with victims of trauma

Want to know more?

Please contact Natalie McNeillie (Trainee Clinical Psychologist) on:

Email address has been removed



Appendix 5: Participant information sheet

UNIVERSITY OF BIRMINGHAM

IRAS Project ID: 217044

Participant information sheet *(Version 3, 13.01.17)*

Title of Project: How does working with victims of trauma impact on mental health nurses working in a forensic medium secure setting?

Researchers: Natalie McNeillie, Professor John Rose and Dr Francesca Mantia-Conaty

We would like to invite you to take part in our research study. Before you decide, we would like you to understand why the research is being carried out and what it would involve for you. Please read this information carefully and contact us if you have any questions.

What is the purpose of this research?

This project is being run by Natalie McNeillie as part of her clinical psychology doctorate. The study hopes to gain an understanding of how mental health nurses experience working with victims of trauma. The study is therefore interested in hearing about your own experience of working with this population.

Why have I been invited to take part?

You have been invited to take part in this study as you are a qualified member of nursing staff working on either an Intensive Care Unit or acute ward.

What will happen to me if I agree to take part?

You will be asked to attend one interview which should last between 45 and 60 minutes. This interview will be audio-recorded. You will be asked questions about your experience of working with individuals who have experienced trauma. The interview

will take place during work hours in an interview room in the reception area to ensure privacy. Prior to the interview you will be asked to fill in a short questionnaire which is focused on collecting demographic information. You will be assigned a pseudonym to ensure that your data remains confidential.

It is possible that you may find talking about some of your work upsetting. You do not have to answer questions that you do not wish to and you can have a break at any time. If you do require support, the researcher will be on hand to provide this and can terminate the interview if you want to. If there are any concerns about the impact your work is having on you, your manager will be contacted in order to support you further.

What will happen to the information I give?

Your audio-taped interviews will be typed up and stored electronically on a password protected computer and memory stick, in an encrypted and password protected file. They will be deleted from the Dictaphone. Your interview data will be identified by an anonymous code, in a password protected file, and will be kept separately from any personal data about you. The data files will also be stored on the University of Birmingham computer system. Only members of the research team will have access to your information.

What will happen if I do not want to carry on with the study?

Your participation is voluntary - you do not have to take part in this research. You are free to withdraw at any time during the research interview. If you attend the interview and change your mind, you can withdraw your information up to two weeks after the interview.

Expenses and payments

Unfortunately, we will not be able to provide expenses or payment for taking part in this study.

What will happen to the results of the research study?

The results will be looked at by the research team and tutors at the University of Birmingham to ensure that the analysis is a fair and reasonable representation of the data. The results of the study will be written up as part of Natalie McNeillie's clinical psychology doctorate and will be held in the University of Birmingham's library. Direct quotes from your interview may be published in the write-up of the data but these will not be identifiable.

It is likely that the research will be submitted to scientific journals in order to publish the results and possible that the results may be presented at a conference. If you wish to receive a summary of the research once the findings have been analysed and written up, you can request this.

What happens if I have any further concerns?

If you have any concerns about taking part, we encourage you to discuss this with your line manager or contact the research team. Remember, you do not have to take part. If you would like to discuss any aspect of this research, please contact:

Tel: Phone number has been removed

Email: Email address has been removed

Appendix 6: Consent form

UNIVERSITY OF BIRMINGHAM

IRAS Project ID: 217044

Consent form (*Version 1, 05.08.16)*

Research site: Details have been removed

Participant Identification Number:

Title of Project: How does working with victims of trauma impact on mental health nurses working in a forensic medium secure setting?

Researchers: Natalie McNeillie, Professor John Rose and Dr Francesca Mantia-Conaty

Please initial box

1. I confirm that I have understood the information sheet dated 13.01.17 (version 3) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time during the research interview, without giving any reason. ☐
3. I understand that the research interview will be audio-recorded ☐
4. I understand that following the research interview I will have a two-week period for reflection and I can contact the researcher at any point up until this time to withdraw my interview entirely or in part, without giving any reason. ☐
5. I understand that the data collected during this study will be looked at by the researcher and relevant others at the University of Birmingham to ensure that the analysis is a fair and reasonable representation of the data. If there are any concerns about my welfare I understand that the researcher can contact my manager who will then be able to support me further. ☐

6. I understand that direct quotes from my interview may be published in any write-up of the data, and used for training purposes, but that my name will not be attributed to any such quotes and that I will not be identifiable by my comments. ☐

7. I agree to take part in the above study.

.....	.....	.....
Name of participant	Date	Signature

.....	.....	.....
Name of researcher	Date	Signature

Appendix 7: Demographic questionnaire

IRAS Project ID: 217044

Demographic Questionnaire *(Version 1, 17.10.16)*

Please can you provide information on the following:

Are you: Male Female

How old are you? _____

What is your job role and grade? _____

How long have you been qualified? _____

How long have you worked in the service/on the ward? _____

Prior to working in forensic secure care, what experience did you have?

_____

_____

_____

_____

_____

Appendix 8: Sample of IPA stages 1-3 for Jodie

Emergent themes	Transcript	Coding
Desensitisation	Interviewer: And how does working with trauma impact on you personally? Jodie: [Pause]. Well [sigh], I think, where I work, the, the clientele I've chosen to work with, um I think I've done that purposely because of how comfortable I think, or how I boundaried I think I am in terms of my own emotions … to be able to manage it. I think if I heard about trauma and met a six year old little girl … or if I heard about trauma and met with a eighteen year old boy whose deeply distressed, I think that would affect me much greater … than it does when I hear about trauma with middle aged men … However, um it still does affect me but I feel that because I'm so used to hearing stories now.	Emotional boundary – essential for managing work Frequently exposed to hearing about trauma – desensitised?
Externalising Depersonalisation	Interviewer: Mmm. Jodie: It's kind of like looking, when you are a, it's kinda like either being a surgeon and taking two approaches. So, you can either met the ser, the patient before the surgery, get to know them, get to know their family, all the kids they've had, what they do as a job and then know that you're gonna focus on their heart during surgery. And then you have all that in the back of your mind, all that panic like ooh, I could ruin his career if I, you know … make this slit wrong. Or you could just go in there and do it, seeing the body as sort of a machine and knowing what you've got to do. Interviewer: Yeah.	Not finishing sentences, hesitation – hard to talk about? Comparison to a surgeon – justification for approach Pronoun use "you" – externalising? Body as a machine – reductionist, depersonalised

Detachment Externalising	Jodie: And um I think working here sometimes you get into a routine of, right what's their past history, what's their risk? … Umm, what do I need to take into consideration? Ok so they need to go on this level of obs. What medication are they on? Um and then you meet them, what's their index offence? And you just try and link everything together. Interviewer: Mmm.	Focus on procedure, routine – detachment? Pronoun use "you" – externalising? Focus on violence
Detachment Externalising	Jodie: As opposed to meeting them, speaking to them, seeing what emotion's attached to it … cause I think, when you speak to people and you see the emotion attached to things and um they actually open up to you, personally I think that affects you a lot more … than taking a sort of urr what's the word? Analytical sort of approach and just you know what are the … main factors here? Um and I think at the moment I take what are the main factors here. Interviewer: Yeah.	Not meeting with service user and allowing them to open up – indicates that they might bare it all which may affect her Pronoun use "you"– externalising?
Exhaustion Externalising Unable to detach Emotional burden Detachment	Jodie: I used to when I was on the rehab ward be very who is this person? … And I found that completely taxing, exhausting um, especially your mental health, you'd fight for things and fight for people to get certain things and you'd push them and you'd exhaust yourself, stay behind your hours and … then it's a cycle and it happens all again. And then what do you do with that emotion that you've invested all this time into something or somebody? … And then … they don't, they don't care. So I think after a couple of experiences like that you kind of think right maybe I should just do the safer route for … myself. Which is to be who is this you know, what … what do I need to look at here etc? Interviewer: Yeah.	Person-centered – too emotionally involved? Exhaustion Pronoun use "you"– externalising? Working extra hours – difficult detaching? Left with the emotion and not sure what to do with it Safe route – focus on procedure, detach?

Desensitisation	Jodie: Umm I think it's made me quite desensitised to umm crime, mental health … risk, people's fears. Umm I think, so I'm a very black and white. Umm quite rigid. Interviewer: When you say desensitised can you give me an example of something that you?	Desensitised
Team identity	Jodie: So if I, if someone get, if we get a referral and it's like oh murdered the mother umm, bludgeoned her with knife 79 times … umm, they're coming in now it's like ok [claps hands]. Right let's meet this man then.	Use of we – in it together, part of a team Focus on violence
Desensitisation	Interviewer: Yeah.	Not affected by story? Just get on with work
Depersonalisation	Jodie: It's not oh my god how's his mum? Is she still alive? … where is she? You know, how old was she? What does she do? Does, does, does he have any brothers or sisters? … You know what's the rest of the family think? All of those thoughts that completely are, didn't even come to me. They don't occur at all. Interviewer: Yeah.	Absence of thoughts about family – depersonalised? Not finishing sentences – hard to talk about?
Desensitisation	Jodie: So even if I'm outside of my job role, and you read newspaper articles about so and so being kidnapped or um tortured, young female and an older adult. It's kinda like oh completely, the emotions attached to it are, they're diminished. Interviewer: Mmm.	Outside of work, lack of emotional response to stories of extreme violence
	Jodie: Not all the time … but generally and I think I do it as a coping mechanism anyway. Interviewer: Because you're exposed to it so much?	Not all the time – when aren't they diminished? Coping

Externalisation Avoidance of emotional expression	Jodie: Because you're exposed to it and I think if you, you have to sort of find the balance between um taking in the emotion and being able to cope with it. But at the same time being able to do your job role properly … and I think if you're too consumed in emotion. I mean if you can imagine if there's a really serious incident and someone runs off crying … it just looks unprofessional, it just looks like you're not capable of dealing with the service. Um and you seem like a bit of a liability. So the next time they'll be like don't have so and so because she can't you know, deal with whatever or … You'd think ooh she might do this so let's just put someone else in place.	Pronoun use "you"– externalising? Focus on violence Being consumed by emotion means she can't do her job properly It is unprofessional/ unacceptable to cry and is a sign of incapability You might be excluded from work activities if you are deemed too emotional – is this her view or does she worry that this is how people will react?

Appendix 9: Sample of IPA stage 4 for Jodie for the theme "Impact on the self"

Theme: Impact on the self	**Relevant quotes**
Feeling drained	Line: 373 – "I used to when I was on the rehab ward be very who is this person? … And I found that completely taxing, exhausting um, especially your mental health, you'd fight for things and fight for people to get certain things and you'd push them and you'd exhaust yourself, stay behind your hours and … then it's a cycle and it happens all again"
Unable to detach	Line 910 - "The reason I had such a problem with rehab was cause it was like having a conversation with the average member of public sometimes … so things would resonate with you more and you'd think oh my goodness, then you'd take it home and you'd think ohh you know they cried today. Why did they cry? I feel so bad they cry you know" Line 941 – "Some people, some people say well you're not at work anymore [laughs]. I'm like ahh yeah. Yeah, I know, thank you" Line 1007 – "Or thank god I can speak to them about that tomorrow. Um or in the middle of the night oh we didn't, he mentioned that well I'll pick up on that tomorrow … whereas if you're not in you think ooh god. You know I've got to wait until next Wednesday, I'm gonna forget. It's not gonna be relevant then. It might trigger something. What if he does something in the meantime?"
Lack of emotional response	Line 411 – "So even if I'm outside of my job role, and you read newspaper articles about so and so being kidnapped or um tortured, young female and an older adult. It's kinda like oh completely, the emotions attached to it are, they're diminished" Line 555 – "I think there's lack of emotion … I think it's definitely created a lack of emotion. A lack of … emotional response to things. Probably not lack of emotion. Cause I can go home and reflect on it but that instant response that people should have … Well not should but you'd expect somebody to have. It's not there …and I'm sure it used to be. I'm sure it did. I'm sure it did"

Lack of emotional response	Line 1144 - [talking about reflective practice] “I think it’s just the whole service really. Emotions are probably one of the very far from me … pushed aside … aspects of the job here … understandably”
Emotions *should* be suppressed	Line 419 – “Because you’re exposed to it and I think if you, you have to sort of find the balance between um taking in the emotion and being able to cope with it. But at the same time being able to do your job role properly … and I think if you’re too consumed in emotion. I mean if you can imagine if there’s a really serious incident and someone runs off crying … it just looks unprofessional, it just looks like you’re not capable of dealing with the service. Um and you seem like a bit of a liability. So the next time they’ll be like don’t have so and so because she can’t you know, deal with whatever or … You’d think ooh she might do this so let’s just put someone else in place” Line 1044 – “Sometimes I’m mulling over it, sometimes I completely push it to the back of my head … I think I’ve developed this, I don’t know where the emotion goes. Um I think that’s why sometimes my memory’s quite bad. Because I literally just forget it. I just try and completely forget it … and block it out … um I think that’s my coping mechanism. Just it goes” Line 1158 – “I think it just manifests itself in my behaviour and ability to … well my ability of how I deal with emotion cause I don’t really deal with emotion anymore … So, like I was saying to somebody the other day I can’t remember the last time I cried. I think that’s just what happens. Because I’ve got so used to the routine of go home, take your clothes off, emotion gone … A lot of people also vent their emotions to me … and I think right well push yours away let’s deal with so and so … Umm, yeah … I don’t really deal with them to be honest” Line 1199 – [talking about clinical supervision] “Because you know most of your clinical supervisors, they’re either friends, they’re either people you’ve worked with, people who know other people … you don’t have that really free boundary of going all the way, out in the open with anything you’ve got to say … you still are restricted slightly … Um so having a awareness of that sort of minimises what you would discuss”

Wearing a mask	Line 957 – “Because when I’m in work it’s very, it’s more of a, professional thing but also being a mental health nurse you have to be quite assertive umm not domineering but you can’t show intimidate. You know if … you feel the patients intimidating you … personally I wouldn’t show that I feel that you’re intimidating me … cause to me I don’t think that’s useful in any way. Not for me, not for them, not for the team” Line 751 – “I don’t know if this is a judgement I’m making but I feel like a lot of mental health nurses, and then especially nurses that work in forensics, you develop this sort of um, this is just a projection but I think it’s true, you develop this sort of, not defensiveness but this … like a mask that’s like a hard mask … and after a while it’s not a mask it kind of becomes part of you. And then you think oh I’m only in work mode [laughs]. And then you think wait no, this is me now … like this isn’t, I’m not joking anymore like I can’t, you know I don’t know even remember what I used to be like. Umm so I think you kinda develop that mask and it’s very hard faced”
More open-minded	Line 1345 – “And being able to listen to and understand people and not be affected by the stories they tell you … so you can actually focus on the person rather than be clouded by the fact they’ve told you they’ve raped somebody … cause it doesn’t even affect you anymore … which, is a negative but at the same time it’s quite positive ... cause you can extract that part of their history … and just focus on them” Line 1400 – “So the index offence doesn’t affect you … which is something I think needs to happen. I think if you find out someone’s a rapist and then you treat them differently … that’s a problem … Um be desensitised to it slightly and then finding out somebody’s a rapist, it doesn’t even come into, you think great ok that’s the index offence, anyway let’s focus on the present … Um so I think to be able to develop that and not let people’s history or past or anything cloud your judgement of them is a good skill to have … because I don’t you know, you hear, see people judging on the internet. They’re like oh they deserve to die and things like that and you think what? … What are you talking about?”

Empathy	Line 901 – “If anything’s genuine … um then it affects me … doesn’t matter how small it is … if it’s genuine, you know someone breaks down crying and it’s not in like a psychotic break it’s a genuine emotion there, they’ve got capacity, they’re quite stable, then it affects me. If it’s like having, actually I’ve put the nail on the head. The reason I had such a problem with rehab was cause it was like having a conversation with the average member of public sometimes … so things would resonate with you more and you’d think oh my goodness, then you’d take it home and you’d think ohh you know they cried today. Why did they cry? I feel so bad they cry you know. Whereas if someone’s psychotic it’s so much more easier … to have a conversation. To deal with the emotions because you know that this person hasn’t got a stable mental state …But if someone is stable and they’re actually experiencing all this type of emotions and … it’s exactly the same as you experiencing these emotions sort of thing … um, and you can identify much more”
Resilience	Line 1336 – “A reward is personal resilience … definitely. I don’t think there are many people that work in forensics that couldn’t say they were resilient” Line 1342 – “And another reward would be in your development and your ability to work in crisis situations and situations with high tension … and being able to listen to and understand people and not be affected by the stories they tell you” Line 1371 – “Um because I think resilience you can take anywhere and I don’t think you just, you’re not born with it. You have to develop it … So once you’ve developed quite a high level of resilience, I think you can do quite a lot of things … I think you’ll find life a bit easier … I think … because of the arena that we work in and we find it so normal, when you go anywhere else you come in at a level of already you’ve dealt with so many things that are quite, what’s the word? Umm they’re just, what’s the word I’m looking for? Horrendous things”

Witnessing progress in service users	Line 1251 – “Meeting the same person who say you, had put someone in restraint, seen them two weeks them saying hello to you … they’re getting well now or look how well they’ve done. That makes you feel like better, so being able to see even a slight improvement or some sort of … recovery. Saying hello to someone at seclusion hatch and them responding … little things like that really make a big difference”

Appendix 10: Sample of IPA stages 6 for the subtheme "Emotional expression"

Theme: Impact on the self	Sample of relevant quotes
Subtheme: Emotional expression	**Shock** Michelle (Line 255) "I think you have your initial shock factor … when you first join" Luke (Line 245) "I guess early on I'd probably be like, there'd be some situations where I'd kinda like be shocked and … hold kinda certain prejudices. Yeah certain crimes or whatever. But now I mean I dunno now I just kinda like try and like just focus on the person really" **Anger** Paul (Line 760) "I guess you just process it, you try to make sense of things. How could somebody … do something. And the hardest ones I guess are the ones when you can't make any sense of it … and you can't you know, I can't for the life of me understand why somebody would do that or why somebody would behave that way … And then you just get angry then because you just, you know and then they start talk in the office and they're like ooh what happened and you're like you know they should just lock that person up and throw away the key or what have. You know, these sort of clichés coming out because, you know we just hadn't, people don't necessarily mean, but it's kind of anger isn't it that? … You feel that, you know that they shouldn't be people like that in society that can do things that are so wicked" Katie (Line 211) "And then I get quite angry cause I feel that someone's done that … to this person … and now he's left with, you know at a really young age a really crap prognosis probably … It's like he'd always be in a service cause of his risk and his illness … you know, so I feel quite sad but it does tend to with me transpire into anger"

	Sadness Rob (Line 156) “But it was just incredibly sad because his upbringing was, it wasn’t as bad as the others I’ve read but clearly he was more susceptible to fractures … in his personality and just when they would cope and then the index offence occurred. And he couldn’t move forward. And I suppose I just find that very sad” Katie (Line 201) “I feel sad. My initial response is I feel really sad. Like this morning with the, the thing that I was sitting on this morning. You know at some point in that person’s life there's been a significant trauma … Unfortunately now it's all jumbled up in the context of his psychotic illness … but I know it's there because … it’s clearly somethings happened to him and it’s not been very nice. And I just feel really really sad for the person” Chantelle (Line 352) “And a bit of sadness here and there. Sad for them … you know that’s happened to them” **Emotions are overwhelming** Luke (Line 384) “I probably got quite worried at a certain point that like I was probably taking on too much emotionally” Katie (Line 155) “I notice that I can start to become really really over, overwhelmed. It's like an internal feeling of [sigh] I don't know it's like something that I need to suppress … So it's like I just have to push it back down but I know it’s still there. So I'm constantly trying to battle [laughs] battle … with it. And I'm not saying it's directly related to that but I think some of it is. Cause it's almost like I can feel all these things … going in. And all this misery going in [laughs]” Chantelle (Line 323) “I don’t want to talk about it at that particular moment because what I tend to do is cry … cry cry and then, then I can’t talk”

	Emotions should be controlled and suppressed Avoidance of talking about emotions when asked - Luke, James Paul (Line 1094) “It helps you keep a little bit more objective and … keep your emotions in check a little bit more … and not take it so personally” Michelle (Line 504) “Probably not as in touch with my emotions as I should be … I don’t, rarely like cry and stuff … And I don’t talk about emotions … I find that I don’t talk about emotions as much … I think I’ve learnt to just switch things off” Katie (Line 598) “I wouldn't say I'm overly emotional but, in the thing, we were doing this morning I felt myself becoming really tearful … for him really … But I tend to keep that obviously cause I'm at work and then I get home, on the way home and I sometimes cry” Lucy (Line 157) “So I came into a room where this guy was being held and I literally had to kind of like hold, my emotions in. Cause I felt very sad. This was a guy that was, handcuffed and I mean I've never seen handcuffs that thick actually. I think he had about two pairs on … and he looked very, he looked lost and scared” Jodie (Line 555) “I think there’s lack of emotion … I think it’s definitely created a lack of emotion. A lack of … emotional response to things. Probably not lack of emotion. Cause I can go home and reflect on it but that instant response that people should have … Well not should but you’d expect somebody to have. It’s not there …and I’m sure it used to be. I’m sure it did. I’m sure it did” **Emotional expression is professionally unacceptable** Sophie (Line 173) “It can be horrible to hear these things but you have to think of it as a professional and kind of don’t let it affect me. I have to see what I can do to help them. This is their problem, it’s not my problem. It shouldn’t be upsetting me because I need to be in a good position to be able to help them”

	Michelle (Line 1134) “If it became more socially acceptable for people to have, to discuss emotions it may make it easier for people to … deal with their own emotions. Rather than shut it away and not deal with them” Michelle (Line 640) “Knowing that … you need to be like this because everyone else is like this” Luke (Line 731) “I think oh people with my experience this and kind of almost like had a bit of a cry. I was like ahh. Yeah, I know mental health nurses shouldn’t be like needing … CBT or need to be using it myself that kind of thing so … That you should be like you know, the person helping out not the … not needing help so” Jodie (Line 419) “Because you’re exposed to it and I think if you, you have to sort of find the balance between um taking in the emotion and being able to cope with it. But at the same time being able to do your job role properly … and I think if you’re too consumed in emotion. I mean if you can imagine if there’s a really serious incident and someone runs off crying … it just looks unprofessional, it just looks like you’re not capable of dealing with the service. Um and you seem like a bit of a liability. So the next time they’ll be like don’t have so and so because she can’t you know, deal with whatever or … You’d think ooh she might do this so let’s just put someone else in place” Jodie (Line 638) “So what are the main things that you’re gonna take to make you a good nurse and a, you know an adequate nurse to be able to be good at your job and work well for patients? Um and I think if you get the wrong things, not saying, no if you get the right things some of that is leaving behind a lot of emotion. Cause you can’t do your job effectively if you’re an emotional … wreck. That would not work well for anybody”

	Self-protection Paul (Line 519) “I guess after working on the ICU forensic unit for a couple of years I guess I became hardened … And then you kinda realise that you’ve you know that you develop this kind of a little you know it’s a bit cliché isn’t it? But you do, you do develop a little bit of a shell, don’t you?” Katie (Line 782) “Mentally just completely exhausted. Like I've got nothing left to give to … anyone. I feel like I give everything here and then I get home … I'm conscious of it so I make sure it's masked for my daughter so she feels … like we're doing things but you know she goes to bed and … I've got no energy for my … relationship” Peter (Line 622) “Any emotion towards them. I’m having to like kind of like mask, mask that the best way I can … because sometimes they I don’t know, they might be feeling a bit paranoid or they might if they see some emotion, they might judge me … So it’s a matter of trying to like urr mask any emotion I’ve got … cause they don’t in my view, they don’t need to know about my feelings … cause they’ve got their own feelings to deal with” Jodie (Line 957) “Because when I’m in work it’s very, it’s more of a, professional thing but also being a mental health nurse you have to be quite assertive umm not domineering but you can’t show intimidate. You know if … you feel the patients intimidating you … personally I wouldn’t show that I feel that you’re intimidating me … cause to me I don’t think that’s useful in any way. Not for me, not for them, not for the team” **Feeling drained** Paul (Line 1038) “It’s more draining I guess” Michelle (Line 884) “I think it’s quite emotionally draining … because you go through [pause] you have so many ups and downs in one day.

	Sophie (Line 265) “It can be really draining … Sometimes you get home from work and you just wanna go straight to bed. You’re absolutely shattered … I guess emotionally fatigued is the phrase … I go home to my other half and I’m like I don’t even … wanna hear about your day like I’m so [laughs] … We’ll talk tomorrow I’ve got no, it sounds really bad but no compassion left … 13 hour shifts of trying to work with people that have had these traumatic pasts. You get home and you just kind of want to literally do nothing … Just sit in front of the TV and [laughs] … not think about other people” Luke (Line 638) “It's kind of a strange kind of work really in the sense that like if you work in a factory, you're physically exhausted … but definitely like sometimes you can be quite emotionally tired … by the end of the day” Katie (Line 759) “And it's just the motivation. Sometimes I don't have the motivation. I feel utterly like zapped … of energy sometimes yeah … like brain tired … So I used to go to the gym all the time … Just don't have the energy anymore. I just feel … utterly drained” Lucy (Line 505) “I have a lot of alone time cause you need to … Sometimes when I finish work I don't, I'm so mentally drained I can't talk to anyone, I don't want to … I need a few hours to kind of like recuperate” Jodie (Line 373) “I used to when I was on the rehab ward be very who is this person? … And I found that completely taxing, exhausting um, especially your mental health, you’d fight for things and fight for people to get certain things and you’d push them and you’d exhaust yourself, stay behind your hours and … then it’s a cycle and it happens all again”

Appendix 11: Outline of themes with contributing participants

Superordinate theme	Subtheme and contributing participants	Sample of relevant quotes
Altered perceptions	Looking out on the world Jodie and Lucy did not contribute	Chantelle (Line 161) “It’s opened up my eyes a little bit. In terms of obviously I haven’t experienced those sort of things but it sort of like opens up my mind to what’s happening throughout the world” James (Line 88) “There’s quite a few actually over the years in terms of how damage sort of a human can be” Katie (Line 424) “You almost feel like this is how the world is. That actually … everybody’s you know they have a … But you forget that there is like a normal, existence … other than a trauma existence [laughs] … I'm quite paranoid … but … I will presume probably, lots of people are sex offenders [laughs] until proven otherwise. Like you know I always suspect people have had horrific childhood's even when maybe they haven't” Michelle (Line 329) You’ve got an awareness of … things aren’t airy fairy in the big wide world. Lots of bad things happen” Paul (Line 704) “You’d maybe have some thoughts in your head about how horrible some people can be in, you know in this world” Peter (Line 462) “It has changed my view of the world a bit. Umm, cause it just highlighted that you know everyone goes through a lot of things … which is what contributed to their mental illness” Rob (Line 140) “You’d read it through notes, he’d tell you himself and you didn’t feel like … he would ever move on”

Superordinate theme	Subtheme and contributing participants	Sample of relevant quotes
Altered perceptions	Looking in at oneself All of the participants contributed	Chantelle (Line 216) More suspicious [laughs] … about everything” Jodie (Line 923) “If someone is stable and they’re actually experiencing all this type of emotions and … it’s exactly the same as you experiencing these emotions … you can identify much more” Katie (Line 322) “I've worked with men that have pulled their own intestines out … and other than stop the bleed and deal with it on a physical level I don't even know when I've gone back to speak to them. I felt I've had good relations with these people but I still don't know what to say to them … I don't wanna make anything worse and I'm not trained” Lucy (Line 457) “I'm more protective … over my family … cause I understand that … there's a lot of things that can happen and stuff” Luke (Line 368) “Sometimes people'll talk about issues like friends or whatever and they seem like why is that a such a big deal. You know I know that like these … things are happening … in the world” Michelle (Line 342) “I do find myself doing things outside and thinking ah [expletive] I haven’t got an alarm here [laughs]. Because you’re so used to putting yourself in these risky situations … all the time that you forget that it’s not really like that over the big fences … Um you probably need to be a bit more careful” Rob (Line 143) “He successfully took his life despite … different interventions from psychology and OT … nurses and medics. We weren’t able to help him … He sticks with me”

Superordinate theme	Subtheme and contributing participants	Sample of relevant quotes
Impact on the self	Carrying the trauma James, Luke and Michelle did not contribute	Chantelle (Line 74) “The patient that has been through trauma through being a child solider … he’s sort of like described … like being around dead people … You know like gun noises and … Cause I’ve tried to picture that and it’s … and I don’t think it’s a pleasant situation to be in … so that sort of one thing that stuck in my mind” Jodie (Line 910) “The reason I had such a problem with rehab was cause it was like having a conversation with the average member of public sometimes … so things would resonate with you more and you’d think oh my goodness, then you’d take it home and you’d think ohh you know they cried today. Why did they cry? I feel so bad they cry you know” Katie (Line 166) “Cause it's almost like I can feel all these things … going in. And all this misery going in [laughs] … And all this suffering. And then people's own problems because then they you know, you get, they’ve had their own experience of trauma so that's triggered something for them. So I've got their problem and the patients problem” Lucy (Line 493) “It depends on … how you've left that person. Sometimes you will go home and you will worry about someone. You know they've told me this, they feel really low, they wanna do this and you're thinking to yourself oh my gosh. You know in that period of space where I'm not there … are they gonna be able to just manage?”

		Paul (Line 583) “So when you can see a person that’s not managed to do that [found a way of functioning] you know that’s kind of … still suffering … Um that kinda sticks in your head a little bit more” Peter (Line 357) “If I feel bad for the patient … depending on their circumstances … I try not to take them home too much … Umm, and there might be times where things might play on my mind but they don’t really last that long” Rob (Line 584) “I don’t do it often … but when somebody’s got to me that’s definitely what I do … I don’t think about it all the time but I do think about it [at home]” Sophie (Line 573) “If I’ve got to be in the next day and it’s been a horrible day, sometimes it can take ages to fall asleep”

Superordinate theme	Subtheme and contributing participants	Sample of relevant quotes
Impact on the self	Emotional expression All of the participants contributed	Katie (Line 733) “I never quite know how I'm gonna respond whether it's a burst of anger or floods of tears” Lucy (Line 505) “I have a lot of alone time cause you need to … Sometimes when I finish work I don't, I'm so mentally drained I can't talk to anyone, I don't want to … I need a few hours to kind of like recuperate” Luke (Line 638) “It's kind of a strange kind of work really in the sense that like if you work in a factory, you're physically exhausted … but definitely like sometimes you can be quite emotionally tired … by the end of the day” Michelle (Line 525) “I find if you don’t talk about it, it goes away … I’m not very good at seeking supervision and stuff either … I am very much don’t talk about it” Rob (Line 397) “I feel a bit sad … Just a little bit like that, I don’t cry or anything like that … but I do feel it” Sophie (Line 265) “It can be really draining … Sometimes you get home from work and you just wanna go straight to bed. You’re absolutely shattered … I guess emotionally fatigued is the phrase … I go home to my other half and I’m like I don’t even … wanna hear about your day like I’m so [laughs] … We’ll talk tomorrow I’ve got no, it sounds really bad but no compassion left … 13 hour shifts of trying to work with people that have had these traumatic pasts. You get home and you just kind of want to literally do nothing … Just sit in front of the TV and [laughs] … not think about other people”

Superordinate theme	Subtheme and contributing participants	Sample of relevant quotes
Impact on the self	Thriving All of the participants contributed	Chantelle (Line 495) “I think to see the improvement … cause over a certain period of time you’re able to see if someone’s improved or not. So I think that improvement is sort of like rewarding … I feel like ohh actually we’ve, we’ve done something here … even though it’s a small thing here and there but you feel like, that’s rewarding to me” James (Line 470) “Because I think to see someone locked up in somewhere like this and forced meds and try to break the rule and you’re implementing the rule and it’s a, yeah. A battle. But to see them on the other side. Even just seeing them growing up. It’s you know … it’s almost like a job well done, I think … I guess them moving on … And maybe getting on with their life” Jodie (Line 1371) “Um because I think resilience you can take anywhere and I don’t think you just, you’re not born with it. You have to develop it … So once you’ve developed quite a high level of resilience, I think you can do quite a lot of things … I think you’ll find life a bit easier … I think … because of the arena that we work in and we find it so normal, when you go anywhere else you come in at a level of already you’ve dealt with so many things that are quite, what’s the word? Umm they’re just, what’s the word I’m looking for? Horrendous things” Katie (Line 1013) “Nursing's rewarding … We have people in that are so unwell that they can't even meet their basic needs like going to the toilet … on their own or you know and to see them get better and to be up and about and, yeah if you get like really difficult behaviours that then come because … they're starting to show their personality as it is but it’s still really rewarding to see that”

		Lucy (Line 290) “Luckily for me I have a lovely life outside of work where I have beautiful children so I do have somewhere where I can switch off” Luke (Line 918) “When a service user … achieves change … even if it's like a small thing. I think that’s one of the things that like I’ve really had to learn. I probably haven’t mentioned this actually is that um sometimes we look for the big change but the small change is just as important” Michelle (Line 305) “You can understand why they’re where they are and why they’ve got the thought processes that they’ve got … um so I suppose you appreciate and have empathy for the problems” Paul (Line 1110) “I feel a little bit like people have had a little bit of a bum deal with being here from society … They’ve been marginalised or they’ve not had a great upbringing … and might be society maybe doesn’t really care about them and so they’re a little bit the underdog and little bit a part of me that feels like you know that, feel some sense of, I dunno prides the right word but in kind of giving a leg up to somebody who’s perhaps not got that from anybody else” Peter (Line 512) “When people on my ward would actually act [aggressively] on a daily basis … and I’m able to adjust and work with them” Sophie (Line 478) “Especially as like a lot of the guys on our ward can be really tough nuts to crack when it comes to getting them to open up … so it’s nice to share that you’ve managed to get someone to open up”

Superordinate theme	Subtheme and contributing participants	Sample of relevant quotes
Managing exposure	Protecting the self Only Rob did not contribute	Chantelle (Line 137) “When I’m not at work … and then I tell myself no I should be thinking about this when I’m back in at work … and then I tell myself I’m human so it’s bound to come to my mind at any point” Jodie (Line 1080) “If there is something that’s really um affected me or something that I really need to mull over or discuss I’ll talk to somebody about it while my uniforms on … and then I’m like right I’m going to have a shower, take my uniform off now … and that’s it. If someone brings something to me when I haven’t got my uniform on that causes me major distress and … I just get really stressed in my head. I just start to get a headache or … I think I can’t even process this right now. I feel overwhelmed” Katie (Line 388) “I tend to over work. So when I don't wanna think about stuff I work constantly. So, I'll work until eleven o clock at night and then I go to bed and then I'll wake up at three, and I'll start working again … and then I gotta get up at five thirty … and I'll work again … I over work all the time and I think that's one of my coping mechanisms … although it's not a healthy one of dealing with what I'm feeling … or not actually cause I avoid it” Lucy (Line 400) “But now it's like, it doesn't really phase me, people's index offence or their … I just naturally just try to work with people the best way I know how to … I don't really look too much into the, because we have so many people come through the doors now it's almost like, I don't know. I don't really put too much thought into it”

		Luke (Line 616) “I'm pretty good at leaving work in work … So I'll be driving home, listen to some music in my car and … it's gone really by the time …” Michelle (Line 643) “But it’s like all the bad things [inaudible] it’s almost like … they’re not really that bad at all … just so you can make it really easy to, to deal with” Sophie (Line 557) “Kind of meet up [with a friend in a similar position] and share horror stories. And that can be quite fun cause you kind of make light of the situation and try and out-do each other with [laughs]. You think that’s bad”

Superordinate theme	Subtheme and contributing participants	Sample of relevant quotes
Managing exposure	Sense-making All participants contributed	Chantelle (Line 35) “Obviously I can’t talk to him [her partner] about … what’s happening here” James (Line 369) “I normally cover for the staff to go to reflective practice … I don’t go unless there’s a you know serious incident … I might pop along. But I tend to let staff go” Jodie (Line 1242) “Having someone who can identify with me, having somebody who works at the same service as me and understands completely … um, having someone who has the same view as me … is very helpful … and it shows that there is normality there” Katie (Line 704) “I do [have supervision] but I mean it's, I talk about managerial stuff … and if anyone say's is there anything else, I say no … cause I don't feel comfortable doing that … and I don't wanna discuss my business with my manager … I just don't think it's appropriate” Lucy (Line 598) “I think that forensics should have … like a, not an emotional wellbeing group but just a outside group of people that people can talk to … without feeling like they're gonna be penalised by saying something at work cause, nothing, we have, I mean we all know that we've got confidentiality but there's not very much confidentiality in this building if I'm totally honest … So people generally just don't really talk about much, just get on and just do what we have to do”

		Michelle (Line 479) “Because you can’t take it home. Um and if you’re talking to people that don’t work in the same setting as you, they don’t quite get it anyway … They don’t get the risky situations that you’re putting yourself in” Paul (Line 452) “Generally, as nurses we find a safe place to ventilate that really. So we would probably go to an office or something and we’d have a bit of a complaint to each other. Um a bit of a moan, get it off our chest. Maybe you know kind of sort out some plans about ok, this is becoming a bit of a problem what’re we gonna do about it” Peter (Line 399) “I wouldn’t say anxious but obviously if I feel like a bit worked up … umm then I’ll probably approach someone and have a chat. Just to blow off a bit of steam” Rob (Line 843) “I don’t get a great deal of time anymore for my own clinical [supervision] … um I wouldn’t even care to think it … I seek it out on an as needs but formalised, no” Sophie (Line 661) “[a group for newly qualifieds] was kind of useful just to hear what other people … in the same boat were about. Um. And it just makes you think that you’re not alone if you are having a tough time … cause all these other people are having that as well … Um but that’s finished now so [laughs]”