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Clinical psychologists' experience of trauma and trauma-related disclosure: perspectives and experiences from the profession

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**Clinical psychologists' experience of trauma and trauma-related disclosure:
perspectives and experiences from the profession**

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**Dissertation submitted to the University of Chester for the Degree of Master of Science
(Psychological Trauma) in part fulfilment of the Modular Programme in Psychological
Trauma**

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Abstract

A high percentage of individuals will experience a trauma in their life time. A clinical psychologist's work is often to provide intervention for those experiencing high levels of distress following a trauma. However, understanding of psychologists' own experiences of trauma and trauma disclosure within the profession are unknown. This dissertation focuses on gaining deeper understanding of trauma-related experiences, and how clinical psychologists make sense of trauma within the profession. Semi-structured interviews were conducted and data was analysed using Interpretative Phenomenological Analysis (IPA). This study found that trauma of psychologists was rarely spoken about and complex interactions between anticipated, internalised and perceived stigma were evident. Anticipated stigma presented as the most dominant in influencing disclosure of trauma by clinical psychologists. This research recommends psychologists consider their own levels of openness about their personal trauma and experiences of trauma related disclosure. Psychologists need the understanding and support that psychologists offer to their clients, removing stigma and promoting openness in the profession is a vital step to supporting psychologists who have experienced trauma, with the profession as a whole learning from each others' experiences.

Declaration

This work is original and has not been submitted previously in support of any qualification or course

Signed:

A handwritten signature in black ink that reads "L. Middlebrook". The signature is written in a cursive style with a large, prominent initial "L".

Laura Jane Middlebrook

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Table of Contents

Abbreviations

National Health Service (NHS)

American Psychiatric Association (APA)

Post-traumatic stress disorder (PTSD)

Child and Adolescent Mental Health Services (CAMHS)

Post traumatic Growth (PTG)

Table of figures

Table 1 – Superordinate Themes and Emergent Themes

Table 2 – Superordinate Theme 1 – Variables to Disclosure

Table 3- Superordinate Theme 2 – Unpredictability

Table 4 – Superordinate Theme 3 – Personal experiences

Table 5 – Superordinate Theme 4 – Challenges and Changes

Chapter 1 – Literature Review.....5

Chapter 2- Methodology.....21

Chapter 3- Results.....32

Chapter 4 – Discussion.....52

Chapter 5- References.....75

Chapter 6- Appendices.....87

Chapter 1

Literature Review

Introduction

This section will critically examine existing literature, exposing the need for and potential contribution of this research. Relevant themes and issues will be carefully considered, bringing the key literature together, enabling the justification and a clear focus for this empirical research.

Traumatic Experiences – Definition, Prevalence and Effects

Criterion A is one of eight criteria (ranging from A to H) required for a diagnosis of Post-Traumatic Stress Disorder (PTSD), seen in medical terms as a pathological response to stress (Brewin et al, 2009). The definition of a traumatic experience has evolved over time, from the American Psychiatric Association's (APA) definition in the DSM-IV, which included the '*threat to physical integrity*' (APA, 2000) and must have involved '*intense fear, helplessness or horror*' (APA, 2000), both of which were removed and replaced with '*actual or threatened death, serious injury, or sexual violence*' (APA, 2013) in the DSM-5. At the time of writing, the World Health Organisation's ICD-10 classification of a traumatic experience is '*Exposure to a stressful event or situation of exceptionally threatening or catastrophic nature likely to cause pervasive distress in almost anyone*'. (World Health Organisation, 1992).

With two definitions of a traumatic experience in use worldwide, one of which has changed twice over 13 years, it could be claimed a sceptical approach to PTSD diagnostic criteria is justified. Kilpatrick, Resnick and Acierno (2009) stated Criteria A to have been controversial from the outset. Despite this, official definitions have enabled a consistent approach for scientific research into various traumatic experiences. For example, Thompson et al. (2003) found the rate of psychopathology was significantly higher for those who had experienced sexual trauma, regardless of whether the trauma occurred during childhood or adulthood, compared to a control group, who had experience no sexual or physical abuse. Numerous researchers support this finding of the high rates of psychopathology following sexual trauma (Cutajar et al, 2010; Kessler, Sonnega, Bromet, Hughes & Nelson, 1995; Norris, 1992). Frans, Rimmö, Åberg and Fredrikson (2005) studied 1824 randomly selected men and woman concluding, along with sexual trauma, physical assaults and multiple traumas had a significant impact on mental health, while road traffic accidents by comparison produced the least impact. Further insights from numerous studies (Jonas et al., 2011; Sugaya et al, 2012; Schalinski et al, 2015), conclude childhood trauma has the greatest impact on an individuals' mental health. Van Nierop et al (2015) found the impact of childhood trauma extends across diagnoses, with an increased risk of a combination of anxiety, depression and psychotic symptoms present throughout the life span.

Whether or not an individual meets PTSD criteria, empirical evidence shows that trauma can cause guilt and shame (Dorahy & Clearwater, 2012) and feelings of loneliness (Shevlin, McElroy & Murphy, 2015) to diagnosis of mental illnesses such depression (Heim, Newport, Mletsko, Miller & Nemweoff, 2008) anxiety disorders (Kuo et al, 2011), conditions highly comorbid with PTSD (Fan, Zhang, Ying, Mo & Liu, 2011), also schizophrenia (Matheson, Shepherd, Pinchbeck, Laurens & Carr, 2012) and borderline personality disorder (Elzy, 2011). Numerous researchers have found high rates of traumatic experiences in individuals receiving

support from mental health services (Elhai, North & Frueh, 2005; Subica, Claypoole & Wylie, 2012; Tagay, Herpertz, Langkafel & Senf, 2005; Subica, 2013) adding weight to empirical research on the impact of traumatic experiences on mental wellbeing.

Obtaining accurate data on trauma within the general population is challenging due to the difference in trauma types, trauma impact, frequency and perceived distress across studies. Some researchers (Frans et al, 2005) used the DSM-IV, whilst others (Lukaschek et al, 2013) used the ICD-10, more recent studies (Hafstad, Thoresen, Wentzel, Maercker & Dyb, 2017; Shevlin et al, 2018) are now using the ICD-11 and DSM- 5. Therefore, generalising findings across studies is difficult, despite this such research provides an insight into objective trauma prevalence. Lukaschek et al, 2013, found 40.5% of 3,080 individuals from Sweden, had experienced a trauma. Many researchers have reported similar findings (Kessler, Sonnega, Bromet, Hughes & Nelson, 1995; Vrana & Lauterbach, 1995). In England, 62.7% of individuals reported having experienced at least one traumatic event (Fear, Bridges, Hatch, Hawkins & Wessely, 2016). Prevalence varied across England, for example 78.2% of 1,698 adults in South East London had experienced a trauma (Frissa et al, 2013). Despite, variations and mixed data across studies, the presenting evidence supports traumatic experiences to be a fairly common occurrence.

Empirical research shows that despite an increased likelihood of mental health difficulties for individuals who have experienced trauma, a majority do not meet the criteria to result in a mental illness diagnosis (Frans et al, 2005; Lukaschek et al, 2013), even in traumas research specifies as most damaging to mental wellbeing, such as sexual abuse. For example, Cutajar et al, (2010) compared 2,759 sexual abused children's medical records at two ages, 12 years and again at 43 years of age, finding 76.7% of individuals did not require mental health services intervention as adults.

Empirical research has shown support for the subjective nature of trauma, with common occurrences such as bereavement being experienced as traumatic. For example, Gold, Marx, Soler-Baillo, & Sloan (2005) found two-thirds of 454 undergraduates defined the death or illness of a loved one as traumatic, with more individuals who did not meet Criteria A having more severe PTSD symptoms than those who met criteria A. Other researchers (Bodkin et al, 2007; Rasmussen, Rosenfeld Reeves & Keller, 2007) have documented similar findings. More recently, the subjective nature of a traumatic death resulted in depression and complex grief, with an objective traumatic death found not to relate to either (Tang & Chow, 2016). This highlights the often-subjective nature of experiences, and the difficulty of accurately objectifying the definition of a traumatic experience without consideration of the personal meaning of the experience to the individual. More recently, Boals (2018) found only 37% of defined objective traumas were experienced as subjectively traumatic and 73% of subjectively traumatic events met the objective trauma criteria. Therefore, more individual may be experiencing trauma related symptoms than the majority of empirical research shows.

The Clinical Psychology Profession

Clinical psychology Clinical psychology can be defined as a health care profession and a scientific discipline (Carr, 2012; Toogood, 2010). The profession involves implementing scientific knowledge derived from psychological theory in clinical settings to help reduce psychological distress (Toogood, 2010). The Division of Clinical Psychology of the British Psychological Society states part of the clinical psychologist's role is in leadership, helping to develop the skills of colleagues in other disciplines and facilitating organisational change, along with taking a key role in supervision and consultation (Toogood, 2010).

Trauma within the therapeutic professions

Traumatic histories have been found in 34% of 160 social workers (Michalopoulos & Aparicio, 2012), 76% of clinicians treating both survivors and offenders of sexual abuse (VanDeusen & Way, 2006) and 60% of trauma therapists (Pearlman and Mac Ian, 1995). Specific to the psychology profession, Feldman-Summers and Pope (1994) found 23.9% of 330 psychologists reported childhood abuse, with 36.6% reporting adulthood abuse (Pope & Feldman-Summers, 1992). More recent research of 564 trainee psychologists found 159 had experienced a trauma in the last 12 months, with 20 trainees meeting the at-risk criteria for PTSD (Makadia, Sabin-Farrell & Turpin, 2017). Comparing these figures to the general population, proves difficult. Pearlman and Mac Ian (1995) and Michalopoulos and Aparicio (2012) used a single question 'Do you have a trauma history?' (pp.559) to determine the prevalence of trauma, whereas VanDeusen and Way (2006) focused on childhood maltreatment only. General population research has used ICD-10 (Lukaschek et al, 2013), DSM-IV (Frans, Rimmö, Åberg and Fredrikson, 2005) and DSM III-R (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995), providing various rates of trauma prevalence, ranging from 50-80%. Therefore, it cannot be accurately concluded the prevalence of trauma is higher in those who pursue a therapeutic career and it proves even more challenging to decipher trauma's relevance to career choice.

Elliott and Guy (1993) found the presence of childhood trauma alone was an independently significant factor to choosing a therapeutic career and was not a result of an education in trauma or having received therapy. Despite the possibility of report bias in some areas of enquiry such as parental substance abuse, these findings were supported by the demographic and family history variables such as the traumatic death of a family member. More recently, psychology undergraduates who wanted to work clinically were found to have higher rates of abuse than other psychology students (Nikcevic, Kranilisova-Advani & Spada, 2007). However, assumptions cannot be made, as psychological distress of a family member was also more

likely in clinical psychologists (Murphey & Halgin, 1995). Regardless of trauma, personal experience of mental illness was found to be one of the most cited reasons influencing individuals to work as therapists (Conchar & Repper, 2014). With an apparent over focus on negative life experiences, Murphey and Halgin (1995) reported strong interpersonal alliances and professional and personal development to drive the career choice of 250 psychologists, with only slight differences between social and clinical psychologists.

Subliminal influences are more difficult to consciously recognise and articulate but may also play a part in influencing an individual to pursue a therapeutic career. For example, higher rates of narcissistic injury from parent-child relationships in therapists compared to the general population have been reported (Halewood & Tribe, 2003), leading to deeply ingrained traits such as higher levels of sensitivity to the emotional pain of others and putting others' needs first (Halewood & Tribe, 2003). With desire to help often being cited as the incentive to pursue a therapeutic career (Ivey & Partington, 2014), this could explain why Norcross and Farber (2005) found very few therapists openly report narcissistic injuries informing career choice. The influence of other life experiences, such as mental illness, may be easier to articulate. Personal understanding of motives for choosing a therapeutic career also changes over time. Barnett (2007) reported that professional maturity aids individuals to understand, with hindsight, why they choose to become therapists.

It is realistic to assume there will be individuals who have experienced trauma, in clinical psychology. It is difficult to conclude trauma influences career choice, especially because separating the effects of traumatic experiences from other life experiences both in childhood and adulthood that would shape an individual's characteristics and behaviour and thus their career choice, is problematic. Also, the subjective nature of life experiences could potential mean any life experience, negative or positive could trigger an interest in a therapeutic career.

Resilience

The route into clinical psychology is highly competitive (Scior et al, 2014). This raises the question what factors help to support resilience to trauma's negative impacts.

Collishaw et al, (2007) found peer relationships, high quality adult friendships and a stable loving relationship led to higher levels of resilience to mental illness following childhood maltreatment, with 2,307 individuals following up during adolescence and midlife.

Hyatt-Burkhart (2014) concluded mental health services are still orientated towards negative views of mental illness, supported by others (Zoellner & Maercker, 2006; Joseph, 2004). A review of 10 years of literature on child abuse from the years 1988 to 1998, showed strong focus on symptoms (Kaplan, Pelcovitz, & Labruna, 1999), with Kaplan, Pelcovitz & Labruna (1999), concluding further research should now focus on resilience factors. Meyerson et al (2011) supports a resilience focused approach, with a systematic review only recently being possible (most studies cited were produced after 2011). Boanno (2004) argued that the presence of resilience is often neglected due to mental health professionals being exposed predominantly to those who have experienced the greatest dysfunction following trauma. Therefore, individuals' working in mental health may neglect resilience factors or underestimate their influence.

Potential Effects of Trauma on Therapeutic Work

A personal history of trauma has been one of the most common factors investigated in attempts to predict likelihood of vicarious trauma (Dunkley & Whelan, 2006).

Vicarious trauma causes emotional changes due to empathetic connection with an individual's trauma narrative. Secondary traumatic stress leads to the experience PTSD symptoms following hearing the traumatic experience of another (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). Both vicarious trauma and secondary traumatic stress are defined as

normal responses to empathetic engagement to which anyone could be vulnerable to (Pearlman & Saakvitne, 1995) and a normal response to trauma work (McCann & Pearlman, 1990).

Some concluding personal history of trauma leads to more vicarious trauma (Pearlman & Mac Ian, 1995; Stevens & Higgins Adams & Riggs, 2008; Ghahramanlou & Brodbeck, 2000) while others have found no relationship between the two (Kadambi & Truscott, 2004; Brady, Guy, Poelstra and Brokaw, 1999; Michalopoulos & Aparicio, 2012). With specific reference to the psychology profession, personal history of trauma was not significantly related to vicarious trauma in 564 clinical psychology trainees (Makadia, Sabin-Farrell and Turpin, 2017). Findings should be interpreted with caution as some researchers used self-reporting measures of childhood abuse (Stevens & Higgins, 2002), others screened for PTSD symptoms (Makadia et al. 2017). Vicarious trauma, secondary traumatic stress, compassion fatigue and traumatic countertransference are often used interchangeably (Dunkley & Whelan, 2006; Collins & Long, 2003), potentially leading to difficulty generalising findings.

A recent meta-analysis of 28 studies found a small significant effect size for personal history of trauma and presence of secondary traumatic stress, the level of significance the same as found for the impact of caseload (Hensel, Ruiz, Finney & Dewa, 2015). Though researchers stated it is important to understand such effects to help workers function well (Gomez & Michaelis, 1995), the neglect of protective factors could be questioned, as they are factors that could potentially prevent vicarious trauma, regardless of trauma history.

Focus on trauma history could have potentially impacted perspectives on the influence of personal trauma, purely due to lack of research in other areas. For example, Michalopoulos & Aparico, (2012) found that 73% of the 33% who had experienced trauma, had therapy, again the impact of this on protecting against developing vicarious trauma is unknown.

Greater disruptions in schemas have been found in those who had a trauma history (Pearlman & Mac Ian, 1995) but, it can't be concluded poor clinical practise automatically follows. Pearlman and Mac Ian (1995) found newer therapists showed more disruptive schemas than therapists who had worked long-term with trauma, with experienced trauma survivors showing the least disruptive schemas of all groups of therapists. Working with trauma may come as less of a shock to those who have a trauma history, leading to less distress or therapists may be less affected as their feeling of competence increases.

Recovery

It could be argued that psychologists who are not being impacted by their personal trauma have to some degree recovered from trauma. Recovery is defined as '*a return to a normal state of health, mind, or strength*' (Oxford Dictionary, 2011). Some researchers use phrases such as 'worked through' (Collins & Long, 2003) as an alternative to recovery. Empirical research has shown uncertainty amongst psychologists in identifying when an individual has 'recovered', (Zerubavel & Wright, 2012; Ivey & Partington, 2014) and how that would appear in psychologists who are not exhibiting any obvious signs of mental illness. As previously stated, trauma can lead to a range of effects not captured by diagnostic criteria, such as guilt and shame (Dorahy & Clearwater, 2012), and feelings of loneliness (Shevlin, McElroy & Murphy, 2015), making 'recovery' outside a mental health diagnosis difficult to define and quantify.

Research conducted on psychologist choosing applicants for the psychology clinical doctorate training looked for evidence negative effects of adversity had been worked through to a certain degree to ensure constructive learning from the experience, regardless of type of adversity (Ivey & Partington, 2014). This is supported by other authors who state, characteristics of self-awareness (Mander, 2004; Wolgien & Coady, 1997) also self-reflection (Lavender, 2003), and

being in an emotional place to think objectively and subjectively about a client's experiences (Barnett, 2007) were most important, irrespective of experiences.

The definition of recovery, then, when taking into consideration the role of Post-Traumatic Growth (Tedeschi & Calhoun, 2004; Linley and Joseph, 2004) could be an entirely different experience.

Post-Traumatic Growth (PTG)

Post-Traumatic Growth (PTG) occurs when an individual experiences positive changes following a trauma, including higher resilience and new connections with others but does not eliminate the negative effects of trauma (Tedeschi & Calhoun, 2004). Linley and Joseph (2004) concluded that high levels of distress do not necessarily mean low levels of growth.

With focus on possible signs of PTG in therapists during therapeutic intervention, Pope and Feldman-Summers (1992) questioned if competency in trauma therapy was linked to an individual's own experiences of abuse and increased empathy. With regards to PTG in the therapeutic context, it cannot automatically be concluded that increased empathy in therapists leads to growth in respect to therapeutic competency. From empirical research, there is evidence to support therapeutic competency can follow PTG. For example, Wolgast and Coady (1997) found therapists described as 'good therapists' by colleagues, cited personal difficulties increased empathy, sensitivity and helped them normalise human problems, adding credibility to the association between distress and effective therapy. Others described the benefits of more patience and tolerance when the healing process for others is slow and a deeper understanding of painful experiences (Zerubavel & Wright, 2012). Evidence therefore suggests increased empathy can lead to PTG in the form of new ways of connecting with clients, that can improve therapeutic relationships and thus therapeutic competency.

Recent empirical research also suggests PTG and distress do not sit at separate ends of a continuum and can co-exist. For example, Charlemagne-Odle, Harmon and Maltby (2014) interviewed clinical psychologists who had experienced recent distress, from bereavement to relationship difficulties. The distress was varied in nature, including depression and anxiety. Charlemagne-Odle, Harmon and Maltby (2014) found psychologists described more negative emotions in sessions with clients, such as feelings of uselessness, but revealed their distress also led to a greater understanding of client's experiences and greater levels of empathy. As evidence supports distress and PTG commonly co-exist, the process to facilitate PTG may therefore require a different approach to alleviate distress, which would be significant when considering how to best support psychologists following trauma to promote PTG.

A recent systematic review by Schubert, Schmidt & Rosner (2016) found more evidence of PTG in individuals with PTSD compared to those who had experienced a trauma and no PTSD. This systematic review only consisted of 19 studies and Schubert, Schmidt & Rosner (2016) highlighted the lack of research into PTG within those specifically diagnosed with PTSD. Seligman, Rashid and Parks (2006), and Hyatt-Burkhart (2014), state a diagnostic label naturally shifts focus towards eliminating symptoms. This could explain the lack of research focus specifically on PTG and PTSD, a greater exploration of which would widen understanding of the broad range of posttraumatic reactions. Research into areas of PTG that could potentially challenge any stigmatising perspectives of mental illness and could lead to more opportunities to help psychologists develop from personal traumas, due to more acceptance and openness regardless of the presence of a mental illness diagnosis.

Stigma, Disclosure and Social Support

Although the experience of trauma does not automatically mean an individual has mental health difficulties (Cutajar et al, 2010) it is possible the strong link between trauma and mental illness influences an individual's view about disclosing trauma to others.

Clement et al (2015) carried out a systematic review on impact of stigma on the help-seeking behaviour of those with mental health difficulties, using research from 1980 to 2011, and concluded stigma had a moderate effect on help-seeking behaviour. Clement et al (2015) highlighted the vast range of stigmas present from anticipated stigma, experienced stigma, internalised stigma and perceived stigma. Empirical research highlights the presence of stigmatising attitudes towards those with mental health difficulties as an ongoing societal issue. For example, Macedo *et al* (2016) found despite efforts to tackle stigma, its effects have remained consistent. Research supports that public stigma is often internalised into self-stigma in those with mental illness (Macedo et al, 2016; Rusch, Corrigan, Todd & Bodenhausen, 2010). Macedo *et al*, (2016) found stigma to negatively impact an individual's self-concept and levels of social interaction. Rusch, et al. (2010) also found mental health stigma to lower self-esteem. Therefore, regardless if a trauma preceded a mental illness or not, individuals may anticipate the presence of stigma. The presence of stigma has been linked to worries about seeking support for mental health difficulties (Sickel, Seacat & Nabors, 2014). Thus, it is important to evaluate why this might be. Empirical research suggests levels of anxiety about stigma varies depending on the type of trauma disclosure. This anticipation of stigma maybe justified. For example, the psychologists assessing the clinical psychology doctorate applications of applicants who had disclosed sexual abuse were concerned about fluctuations in behaviour (Ivey & Partington, 2014), the vulnerability of the individual was also questioned (Zerubavel & Wright, 2012). This adds weight to researchers (Charlemagne- Oldle & Harmon, 2014; Zerubavel & Wright, 2012) who state a disclosure of trauma is often viewed as a possible indication of professional impairment even before exploration into any influence on therapeutic

work has been explored. Therefore, stigma possibly presents itself in subtle ways within the psychology profession. Oz & Ogiers (2006) stated the same level of openness about sexual abuse compared to other traumas is not accepted within the therapeutic profession and argues the message sent is one that stigmatises and pathologizes, despite the therapist wish to enable a client who has experienced sexual abuse not to feel ashamed. Therefore, therapists potentially perpetuate any stigma, purely with the act of silence.

A systematic review has found shame to mediate disclosure of sexual abuse in children (Lemaigre, Taylor, and Gittoes, 2017) and also in undergraduate psychology students who had experienced a sexual assault (Decou et al, 2017). Feelings of shame could exacerbate the anticipation of stigma from others. Therefore, psychologists who have experienced sexual trauma may be even less inclined to considering disclosing.

Stigma has been claimed be a barrier to gathering accurate data on disclosure of distress in mental health professionals (Cain, 2000). There is empirical evidence to support Cain's (2000) claim. For example, Benatar (2000) recruited 12 trauma psychotherapists, six of whom had child sexual abuse (CSA) history and agreed to speak about their experience. Benatar (2000) found it took more months to recruit the CSA group: the dropout rate was high and participants appeared more anxious regarding confidentiality, with one participant specifying they felt it was not appropriate to discuss CSA with colleagues.

Other ways stigma may be reinforced could be neglecting a therapy trainee's background, reported by Murphy and Haigin, (1995), along with the encouragement of personal therapy by supervisors (Elliott & Guy, 1993; Halewood & Tribe, 2003; Malikiosi-Loizos, 2013; Glass, 1986). Although personal therapy is potentially beneficial, it could add subtly to the stigma of disclosing trauma, as adversities are seen as separate to therapeutic work, rather than an important part to embrace. Therefore, leaving trauma unspoken about could be preventing

clinical psychologists from learning from the lived experience of each other, not only missing the potential for the development of therapeutic skills from past personal experiences, but also the much-needed opportunity to challenge any stigmatising attitudes within the profession, whether the internalised stigma from the potential disclosee of trauma or the stigma of the listener.

Empirical evidence of the impact of positive social support for those following a traumatic experience has included over incidence of less psychological difficulties (King et al, 1998; Collishaw et al, 2007), including decreased suicidal behaviours and thoughts (Panagioti et al, 2013) and fewer PTSD symptoms (Bisson & Andrews, 2009). A systematic review highlights that sharing ones' experiences can initiate a sense of hope and belonging, strengthening social networks (Kelly, Magill & Stout, 2009). Other research has found disclosure can decrease depression and anxiety, along with leading to a more resilient self-concept (Hemenover, 2003). Recent research by Zhou, Wu and Zhen (2018) found social support for adolescents following an earthquake increased self-esteem and feelings of hope leading to PTG. Linsley and Joseph (2004) also found the higher self-esteem and optimism of individuals the more growth following trauma. Linsley and Joseph (2004) concluded intervening events and processes are more likely to influence growth than purely time passing since the trauma. Macedo *et al* (2016) concluded social inclusion would be the appropriate action for change. Considering this research, having an environment in the psychology profession where trauma disclosure is embraced could lead to numerous benefits and opportunities to help increase the wellbeing of individuals who have experienced a trauma.

Andrews, Brewin & Rose (2003) found the impact of negative social responses from friends and family following violent crime negatively impacted trauma symptomology six months post trauma, with the impact of negative responses greater than the positive. In relation to the

psychology profession, post trauma responses could, therefore, potentially help or hinder recovery or the management of trauma symptoms.

Research Rationale

With research supporting both the existence of objective trauma (Thompson et al, 2003; Sugaya et al, 2012) and subjective trauma (Gold et al, 2005; Tang & Chow, 2016), the rates of trauma reactions may be higher than captured in empirical research. Due to differences in data collection between studies, comparing the research of the rates of trauma in the general population to that found in the therapeutic profession, proved difficult, and even more challenging to decipher its relevance to choosing a therapeutic. Therefore, from this literature it could only be concluded that there would be therapists who had experienced trauma working in the profession. Authors report a natural bias towards negative views of mental health (Hyatt-Burkhart, 2014) and a high prevalence of stigma around mental health to still exists (Macedo et al, 2016). Such focus could lead to a damaging overshadowing of positive changes following trauma to psychologists in the profession. Research finds psychologists favour applicants for psychology doctorate training who have experienced adversities (Ivey & Partington, 2014), though the presence of trauma was viewed with caution, leading to questions about trauma and trauma disclosure are experienced in the psychology profession. Charlemagne-Odle, Harmon and Maltby (2014) describe numerous difficulties specific to the psychology profession that could prevent disclosure of trauma, including a culture of coping and hiding distress, a superficial image of perfection, being around high achievers, marginalising own needs to cope with the pressures of training, and equating difficulties with failure in a highly competitive career. This research led to some insights of general issues regarding disclosure in a clinical setting but there is a lack of literature on impacts in relation to disclosure of trauma specifically, presence of stigma, colleagues' reactions and effects on clinical work in the psychology profession. More understanding could enable confidence in sharing adversities that could

benefit and inspire the next generation to learn positively from their experiences, turning adversity into professional strengths. Understanding perspectives of trauma within the psychology profession, and understanding ways the profession could improve its approach to trauma, if necessary, could have a substantial positive impact within the profession and also, potentially, for clients as well.

Chapter 2

Methodology

Introduction

The exploration and critical evaluation of the current literature in Chapter 1 provided strong evidence for the collection of empirical data as specified in the research rationale.

The following objectives for this research were generated due to the evident gaps in understanding how trauma and trauma disclosure is experienced within the clinical psychology profession.

Research Question

How do clinical psychologists make sense of trauma and trauma-related disclosure by those in the profession?

Research Objectives

1. Critically evaluate current research relevant to understanding psychological trauma within the clinical psychology profession
2. Explore clinical psychologists' current perspectives of trauma and trauma disclosure within the profession

3. Explore the relevance of psychological trauma to the pursuit of a career in psychology and the perceived influence of trauma to the psychology profession, including clinical work
4. Explore perspectives on support currently offered and support psychologist feel should be available to psychologists who have experienced trauma
5. Formulate a deeper understanding of perspectives on psychological trauma in the profession

Research Paradigm and Approach

The methodological stance taken in any research is determined by the epistemological position of enquiry (Salkind, 2010). It is therefore essential to understand the theoretical basis of this research in relation to the chosen research strategy and methods selected.

An objectivist epistemology is based on positivism (Salkind, 2010). If an objectivist epistemology was taken in this research, the drive would be to establish facts of social reality, a reality independent of the researcher (Dyer, 2006). In the positivist theoretical position, including post-positivism, whether qualitative or quantitative, the objective would be to test a theory created via deductive reasoning (Heit, 2000). This position starts with a concept of reality deemed to exist outside of that constructed socially via interaction with others and one which is stable, rather than consistently evolving. The definition of psychological trauma is still evolving and changing, both in terms of what constitutes a traumatic experience, as well as what would constitute a trauma reaction (Dalenberg, Straus & Carlson, 2017). Taking this into account and considering the explorations and research evaluated in Chapter 1, understanding any impacts of trauma perspectives within the clinical psychology profession therefore needs to acknowledge this evolution. Clinical psychology as a profession is also still

in its infancy, and there is little research to date investigating factors surrounding trauma disclosure, possible stigma and, in addition how these may influence psychologist's general experiences of understanding trauma and visa versa. Adding to this, the researcher's influence in shaping knowledge produced via exploring psychological trauma cannot be ignored (Salkind, 2010), especially due to the sensitive nature of the topic, which could influence how comfortable participants feel in sharing their perspectives and experiences. Due to this, a positivist approach, attempting to discover 'facts' or relationships between factors is not efficient for this particular research question as there is not yet enough evidence available to explore or attempt to justify a particular hypothesis.

The research question - 'how psychologists' make *sense* of psychological trauma' is constructivist in nature, in line with qualitative enquiry. As such, research sets out to explore how psychologists experience the concept of trauma within their profession, and thus construct meaning. Crotty (1998) explained how in qualitative enquiry meaning is inductively constructed as opposed to discovered. Therefore, there was an element of iterative development of the question.

Taking these marked differences in epistemological and theoretical approaches to knowledge into consideration, how trauma perspectives are shaped within the psychology profession have yet to be understood, therefore a constructivist epistemology was deemed most appropriate and thus was adopted for this research.

Research Design

Qualitative enquiry encompasses a range of approaches, including narrative, phenomenology, grounded theory, ethnography and case studies (Creswell & Poth, 2018). Narrative approaches focus on one or two individuals with lived experiences reported in story form to gain insight into an individual's subjective experience (Carless & Douglas, 2017). This research aimed to

explore psychologists' experience of making sense of trauma collectively, thus the narrative approach would be insufficient.

Grounded Theory, also used in quantitative enquiry, focuses on the inter-relating categories gathered from individuals to create a theory of actions and processes from these categories (Creswell and Poth, 2018), its main focus is on social interactions. This research was focused on descriptions and meaning made from an experience in the psychology profession, as opposed to looking at interactions between individuals, or developing a theory regarding trauma, consequently, grounded theory would have not been appropriate.

Case studies often involve the collection of in-depth information on a specific issue effecting an individual or a group of individuals, often over time, with numerous data collection techniques (Creswell and Poth, 2018). This research question did not explore a specific issue but was an exploration of current perspectives held regarding trauma of clinical psychologists, thus an in-depth deductive investigation of one aspect may limit the variety of insight of the experiences collected from a diverse selection of psychologists. Data would typically also be collected over one interaction and method, which would not be in line with the case study approach.

Ethnography seeks to understand the worldview of a culture of individuals in a group (Creswell and Poth 2018). It could be argued psychologists do have their own culture, though the psychologists in this research were situated in different groups at various locations that rarely interact with one another, thus ethnography approach, despite exploring perspectives would not have been sufficient to explore the research objectives.

Phenomenology is the study of human experience and how these experiences are perceived (Langdrige, 2007). A phenomenology approach gives the opportunity for an individual to have a voice regarding a particular experience they may have never attempted to articulate,

offering new opportunities for insight for the researcher and the participant (Finlay, 2011). To understand how psychologists', make sense of how they perceive trauma within the psychology profession, focus must be on the experience itself. With the experience of trauma being an issue of extreme complexity, this research was driven to explore the qualities that make up the experience of making meaning of trauma within psychology. The phenomenological approach enabling the study of an unstudied phenomenon (Reiners, 2012) of everyday experience within the profession. Phenomenology enquiry was therefore the most appropriate approach for this research, giving the opportunity to explore the essence of this experience through various individual perspectives and the researcher participant interaction.

Research Methods

As phenomenology is focused on human experience (Langdridge, 2007), the research method must enable rich descriptions of how trauma is perceived by the participant. Interviews were deemed to be the preferred method (Reid, Flowers & Larkin, 2005), as in-depth descriptions, thoughts and feelings of the experience need to be obtained. Interviews enable the researcher the opportunity to probe deeper, enquiring further as interesting topic areas unfold (Smith, Flowers & Larkin, 2009). This was essential for gathering the current trauma perspectives of participants and how it was experienced in the workplace, including perceptions on its influence in a therapeutic setting.

Three types of interview techniques exist- structured, semi-structured and unstructured. A structured interview would produce quantitative data, with the interviewer following a questionnaire to find 'facts', with fixed options for the participant to choose select from (Pope & Mays, 2006). Using this research method, with assumptions on how trauma is experienced would have to be made, and thus goes against the phenomenology methodology and the

exploration of the participants' experience. Unstructured interviews remain on the participants train of thought and agenda, rather than the researchers to produce rich data (McCann & Clark, 2005). Whether an interview can be truly unstructured has been questioned (Pope & Mays, 2006), with a loose structure often implemented (McCann & Clark, 2005; Pope & Mays, 2006). With one question posed at the beginning, the participant is directed back to the main points mentioned, the structure evolving from the participant's first response (Smith, Flowers & Larkin, 2009). Despite unstructured interviews strong inductive nature, this method is not advised for a new comer to interviewing (Smith, Flowers & Larkin, 2009). For participants who expressed they had experienced a trauma, it was important to guide the participants to ensure rich data was collected on their experience. Looking at interview methods more on a continuum (Brinkmann, 2013), a semi-structured interview lies somewhere in the middle. Detailed data can be obtained in an informal but guided manner (Coolican, 2004), using opened ended questioning to obtain descriptions of the participants' experiences and insight into how they are making sense of these experiences, which was paramount for this research. Less inductive than unstructured interviews (Smith, Flowers & Larkin, 2009), semi-structured interviews for this research enabled a balance between comfortable interaction and open and descriptive data collection.

Data Collection

Following convenience sampling, interviews were carried out with eight psychologists working with in the Children and Adolescent Mental Health Services (CAMHS) in Wales.

Qualitative research usually involves recruiting a small number of participants. Participants were purposely selected, as a homogeneous sample was required. Participants needed to be within the clinical psychology profession in order to have experienced making meaning of trauma in the profession.

Inclusion Criteria

- 1) To enable clinical psychologists who may have experienced trauma to volunteer anonymously, the inclusion criteria included all clinical psychologists working within CAMHS including assistants.

- 2) Psychologists had worked within the psychology profession for at least six months

Exclusion Criteria

- 1) Psychologists who did not work clinically with clients. As this study aimed to gather the perspectives on numerous settings, such as perspectives with colleagues, as well as therapeutically with clients. It is therefore essential all participants undertook clinical work so all aspects could be reflected on during the interview.

- 2) Any psychologist who had experienced a subjective trauma in the last 3 months prior to interview were excluded, as acute distress could still have been present. This gave some leeway on the month time scale recommended, to minimise the possibility of increased distress during or proceeding the interview.

- 3) Acute Stress is common following trauma and can be present up to one month, after this time scale, Post-Traumatic Stress Disorder can be diagnosed if symptoms persist (APA, 2013). If a subjective trauma had occurred in the last year, participants were asked to reflect on whether they felt sufficiently grounded to engage in the research and

to rate their level of distress from 1-10. Any rating over 5 was grounds to decline their wish to participate. If an individual needed to take a break from certain types of clinical work with clients who had experienced a similar trauma, due to the impact of their own trauma, these individuals were also excluded.

Ethical Considerations

Ethical consent was obtained by Chester University's Ethics Committee and permission from the National Health Services (NHS) Ethics Committee was obtained in order to recruit clinical psychologists and clinical psychology assistants within the NHS (see appendix B)

Participant recruitment

With management consent, all participants were e-mailed with a brief introduction to the research. They were informed questions would relate to trauma and that there would be no direct questions regarding personal trauma experiences. The first eight psychologists who responded and met the inclusion criteria were recruited and sent the initial information sheet (see appendix C) and an interview date was arranged.

Informed consent and Confidentiality

Informed consent (see appendix D) was obtained from all participants before interviews commence, including consent to record the interview. The informed consent consisted of essential information on participant's right to withdraw from the research up until the time the results were written. Clear contact details for the researcher were provided in order to contact the researcher to withdraw their data if required. Due to the sensitive nature of the topic, confidentiality was reiterated and that the data would be kept confidential and published data would be anonymised.

Pilot study

A pilot study was carried out to ensure the clarity of questions and that the data obtained would meet the research objectives. Questions that are too vague lead to data too broad, with less opportunity for in-depth exploration (Smith & Osborn, 2008). During the pilot interview, the participant often needed bringing back to focus on traumatic experiences of clinical psychologists, as opposed to clients. Therefore, questions (see appendix A) were subsequently adapted and made more specific to ensure the participant focused on traumatic experiences of those within the profession. Following the pilot interview, the order of question delivery was also revised as originally the first question asked the participant to define trauma. Following reflection, due to the sensitive nature of the topic, questions specifically about trauma were moved to later in the interview, to allow time for the participants to ‘settle in’ to the interview with less direct questions to start with. The funnelling approach was adopted, with more general questions at the beginning as recommended by Smith (2017). For example, ‘*describe your job role?*’ was moved to the beginning, replacing ‘*what do you believe constitutes a traumatic experience?*’ Due to the possible stigma around trauma and mental health difficulties, the pilot study enabled a test to ensure questions were not leading, essential to ensure participants did not feel their response would be judged. Thus, the pilot interview enhanced the credibility of the research.

Data Analysis

Interpretative Phenomenological Analysis (IPA) focuses on a phenomenon in a particular setting (Smith, Flowers and Larkin, 2009), thus a purposeful small sample size is most appropriate enabling highly detailed analysis (Larkin, Watts & Clifton, 2006). Typical sample size for qualitative research usually ranges from 1-10 participants (Creswell & Poth, 2018). For IPA there is no exact recommended number (Smith, Flowers and Larkin, 2009). The large amount of data collected enables the recruitment of fewer participants (Morse, 2000). Therefore, eight participants were chosen for interview, which enabled the comparison of

similarities and differences between participants to be possible. A too large sample size would decrease the validity of this research because there would be too much data to analyse in sufficient depth (Creswell & Poth, 2018). IPA seeks to provide deep analysis of the data and provide understanding of how participants make meaning of their experiences (Smith, Flowers & Larkin, 2009). Due to the subjective nature of trauma (Tang & Chow, 2016) understanding individual experiences was paramount for the validity of this research methodology.

Once interviews were transcribed they were analysed on three levels (descriptive, linguistic and conceptual) (Smith et al, 2009). In line with Smith et al's (2009) recommendations, initial notes were made from the transcripts and the audio recordings were listened to numerous times. Emerging themes were produced, grounded in the participants accounts before connections between the emerging themes of participants were compiled (see appendix E -H) with the creation of four superordinate themes, each with six subordinate themes across all participants data.

Reflexivity

IPA is a multi- directional analytical process (Finlay, 2013), thus the researcher engaged in a double hermeneutic process (Smith et al, 2009). A reflective diary was kept due to the topic being emotive, as well as for the purposes of transparency and reflexivity to be included in the dissemination of the research. It was essential to balance the researcher's interpretation with the ability to immerse themselves in the participants' world. Ensuring both emic and etic perspectives were taken, this enables new insights and the ability to interpret the data considering current theories (Smith, 2017). This is essential due to the lack of research relating to the experience of trauma within the psychology profession, new insights must not be overshadowed by the researchers own perspectives. Due to the researcher working as an

assistant psychologist within the profession, the double hermeneutic was of benefit to understanding the meaning-making processes of the participants. The advantage of this was that the researcher also already had lived experience of the clinical psychology profession. This helped not only generate relevant interview questions but also supported a deeper understanding of the lived experience of the psychologists within the research, aiding the interpretation of the data.

Chapter 4

Results

Overview

The analysis resulted in four superordinate themes, themes set out in the table below and named using participants own words to capture their experiences as closely as possible.

Table 1 – Superordinate Themes and Emergent Themes

Superordinate Themes			
Variables to Disclosure; (1) <i>‘Depends on if they see it as disclosing a trauma or not’</i>	Unpredictability; (2) <i>‘What might be more difficult today might be different to what might be difficult in a year’</i>	Personal Experiences; (3) <i>‘you never going get rid of that trauma, that emotion it is always going to be there but...sometimes you manage that’</i>	Psychology Profession; (4) <i>‘we should at least have a sense of openness... we expect our clients to don’t we’</i>
The subjective nature of identifying a traumatic experience	Uncertainty of disclosing	Reported insight from own trauma	Challenges
Recognising Trauma	Shattered Assumptions	Reported insight from others trauma	Current responses
Perceptions of Self	The Effect of Trauma	Adversity	Working through trauma
Stigma	Behaviour	Drawing from experience without disclosing	Reflection
Context and Time	Effect of any Experience	Greater appreciation of how people see the world	Psychologist’s role
Relationships	Own reactions to disclosure by colleagues	Childhood	Looking to the future

Each superordinate section is presented with a table, showing subordinate themes and the prominence of each theme across participants.

Each participant is represented by a number, shown in brackets.

An ellipsis ... is used to represent the omission of words from the original text.

Superordinate Theme 1:

Variables to Disclosure: ‘Depends on if they see it as disclosing a trauma or not’

This theme revealed the complexity of factors involved in understanding trauma disclosure within the profession.

Table 2 – Superordinate Theme 1 -Variables to Disclosure

Participants	Variables to Disclosure					
	The Subjective Nature of Identifying a Traumatic experience	Recognising Trauma	Perceptions of Self	Stigma	Context and Time	Relationships
1	✓	✓	✓	✓	✓	✓
2	✓	✓	✓	✓	✓	✓
3	✓	✓	✓	✓	✓	✓
4	✓	✓	✓		✓	✓
5	✓	✓	✓	✓		✓
6	✓	✓			✓	✓
7	✓	✓	✓	✓	✓	✓
8	✓	✓	✓	✓	✓	✓

Subordinate Theme 1 - The Subjective Nature of Identifying a traumatic experience:

‘What can be traumatic for one person, is it going to be for other people?’

It was important to first appreciate how participants defined trauma to understand how they would attempt to recognise a disclosure of trauma.

Participants identified the experience of trauma as *'common'* (2), with *'all experiencing small ts and big Ts'* (1) and stating that *'most people will experience trauma'* (4), *'anyone could be affected'* (2) expressing trauma can be *'anything'* (3). Additionally, participant 4 captured the broad nature of the definition of trauma that it is *'probably more on a continuum really'* including *'hearing about other people's trauma'* (4) during clinical work. Psychologists *'not always [being] in a position to make a huge change'* (4) was a defining factor in an experience resulting in a trauma response to a disclosure. Others added that it also involves feeling *'out of control'* (5) and that it is *'unexpected'* (7).

Participants expressed that trauma is *'very much in the eye of the beholder'* (4), with people having *'different thresholds'* (3). Participant 8 described how they believed what constitutes a trauma is *'fairly subjective'* and *'maybe it is about what it does to you rather than what it was'* (8). Participants reported the *'breadth and variation'* (5) of experiences during contact with service users and research participants.

Participants described defining trauma as being *'a mine field'* (8) *'sometimes really hard'* (1) and *'difficult'* (3). One participant could see *'why they struggle with it in the DSM'* (8)

Subordinate Theme 2- Recognising Trauma: *'depends if they see it as disclosing a trauma or not'*

All participants described their experience of recognising trauma as difficult. They explained with such a *'variety of symptoms'* (6), it is *'not...easy to recognise [trauma]...unless someone tells you'* (8) or via *'direct questioning'* (1). Six participants referred to PTSD symptoms, such as colleagues *'saying they were having nightmares'* (5) or *'reporting PTSD symptoms'* (6).

All participants expressed no experience of psychology *'colleagues telling'* (2) them about a traumatic experience. Participant 4 shared that they had *'noticed we don't do it [share trauma experiences] a lot'* (4). They wondered, maybe they are *'working with people who have had*

trauma' (1) and if the colleague felt they 'couldn't talk or it [just] hasn't happened' (6). However, participants did report colleagues disclosing 'difficult life events' (4) and 'relationships' (2), 'deaths' (2) and difficulties 'dealing with client's trauma' (7). Participants expressed a level of ambivalence while questioning if the disclosure of a difficult 'birth' by a colleague (3) or a 'relationship break up' (8) particularly if 'the level of distress was quite full on' (8), would therefore 'constitute a trauma' (2), unless the colleague personally 'sees it as disclosing' (3) a trauma.

The narratives captured participants ambivalence in accepting not only what they specified as, 'an individual thing' (6) but also the 'broadened' (8) perspective of defining and embracing trauma as wholly subjective. Participants' wondered 'what is the difference between...a negative experience and a trauma...where do you draw the boundary' (8).

Participant 5 explored 'semantics' and the use of the word trauma in 'our lay language...bandied around...anything that was just a bit... upsetting' (5), while others verbalised the struggle separating subjectivity with the possible semantic change of the word trauma - 'gradually leaked out...more common place things... bullying...but there are levels of bullying aren't there' (8).

Subordinate Theme 3- Perception of Self: 'I think it was more my thoughts I put on to it'

In reference to disclosure, participants' perception of self was expressed as 'people first then psychologist's second' (1) leading to 'being able to disclose a little bit about yourself' (1)

Participants own 'insecurities' (3) were expressed as variables in disclosure. A sense that 'struggling makes you feel vulnerable' (4). It being 'fine' to talk about their trauma if there were no feelings of 'shame or guilt' (8).

The perspectives of the self, described following the participants own traumas, echoed participants general perceptions of the effects of trauma such a *'low self-esteem'* (3), *'feelings of shame'* (4, 5) and *'feeling inferior to those around you'* (1).

Participants stated colleague's responses when disclosing trauma were *'the same as with clients'* (8) with the person often expecting *'that you are going to judge them badly'* (8), even *'if that is not true, the person who has the trauma might feel those judgements'* (7) particularly if the trauma was *'sexually related'* (7).

Two psychologists in particular spoke about *'commitment'* (2,7) to their work, wanting to *'fulfil my obligation'* (2). Another described the *'guilt about missing work'* (7). Being perceived as *'competent'* influenced their perception of the outcome of disclosure, such as not being seen *'as professional respected... if I let too much of my personal stuff out'* (2), with a worries around *'over disclosing'* (3) due to the possibility of *'compromising professional respect'* (2).

Participant 7 asserted that disclosure impacts the self, regardless of others, leaving the individual feeling *'more vulnerable...more emotional'* (7), with disclosure itself possibly *'effecting their self-esteem'* (7).

Subordinate Theme 4- Stigma: *'you don't talk about this stuff unless it is in quiet corners'*

Participants discussed stigma as a relevant influence in disclosure and *'something to do with society as a whole'* (2), leading to *'people who have been through difficult things...start to believe...they are not copers'* (5). Stigma was described as *'a deep issue'*, with mental health services not immune to its effect as *'we sometimes inadvertently reinforce stigma'* (1) and end up *'perpetrating stigma we are trying hard to avoid'* (2) with *'unspoken rules that we follow'* (3) leading to *'a sense your supposed to do it [disclosure trauma] quietly'* (8) even when you *'don't feel personally it is a difficult thing to talk about'* (8).

Participant 3 described what they see as an *'unspoken rule'* as they compare their expectations of clients to the perceived behaviours of individuals working in mental health -

'families...we are expecting them to...talk about their traumas...yet we are so closed ourselves that we don't feel able to tell colleagues and people we are a bit closer to us as we might be judged or whatever' (3)

Participant 8 stated that *'people worry it is going to have a negative response but it isn't, I can't think of any times that it has'* (8). This, along with the expressed influence of personal *'insecurities'* (3) during disclosure, the possible effects of trauma on *'self-esteem'* (3) and general self-perceptions such as appearing *'competent'* (2), all led to participant's questioning their own perceptions of reality. The influence of variables in disclosure were deemed difficult to draw apart, leading to a sense of ambivalence in narratives. Participant 3 captured the ambivalence around disclosure stating-

'Personal...experiences I probably wouldn't tell...interesting as it should be ok...not being judged...worry it might happen...then in reality probably wouldn't but then again... it might' (3).

Subordinate Theme 5 - Context and Time in Disclosure: *Why here, why now'*

It was suggested that disclosure is easier in the context of *'training'* (2). Participant 4 described a professor as *'probably more open than most people because...he was teaching us'* (4)

All participants verbalised that disclosure should be used in a *'helpful'* way (8, 4, 1), to *'educate...To dispel the myth... doesn't mean you can't overcome it'* (1) providing a sense of *'hope'* (3, 1) to others. Also, to understand each other, helping colleagues to *'adapt'* (7).

In the context of therapy, disclosure was described as a *'technique'* (1) and *'a way to bring people in'* (1), also to *'break down barriers'* (3).

Participants saw it as *'absolutely crucial'* (6) that trauma be *'talked about in supervision'* (4) *openly'* (6).

Along with context, time was also relevant variable raised, having *'years behind me, don't feel like I need to perform'* (6), whilst others questioned whether it is safe to disclose, *'before qualifying'* (8), which reflected participant 3 who felt they *'couldn't say anything in my first assistant role'* (3). This overlapped with the idea age influencing disclosure –

'I think it has to do with my age...as you get older...this is who I am, this is my life, my experience... at my age...actually it is ok to say I am struggling' (3).

At the other end of the spectrum, the youngest participant described age to influence support following trauma disclosure -

'young or new to the profession, people might offer you more support... they may see you as more vulnerable or more naive... they do notice my age' (7)

Time as a variable was prevalent across many aspects of disclosure from the realisation of trauma *'at any age'* (2), *'influencing whether they can talk about it or not'* (2) to individuals disclosing as *'they are struggling'* (4), to the importance of *'giving time'* (2) whether *'time off'* (1, 3, 6, 7) or *'some time to come and talk'* (1), *'not having time will influence you not to disclose'* (2).

Several participants (2,6,7,8) mentioned that trauma happening whilst in post may result in others *'being aware of it'* (7), managers asking *'why are you off'* (2) and talking in supervision *'when I needed to'* (6).

Subordinate Theme 6 – Relationships: *'Are they a bit of a friend as well'*

All participants spoke about *'the relationship they have'* (1) with others as a factor, preferring to disclose to *'friends'* (5, 8). Disclosing was described as *'an integral part of having*

relationships' (5), feeling you *'can talk to them about things'* (7), and as a *'marker of becoming a bit closer to somebody'* (8)

Other participants described it as a *'dilemma'* (2) questioning *'how much of friend and how much of a professional relationship it is'* (2) and the difficulty in defining *'where the boundary is'* (4).

Superordinate Theme 2:

Unpredictability: *‘What might be more difficult today might be different to what might be difficult in a year’*

Throughout the narratives, participants highlighted the unpredictable nature of trauma with in the profession; from the reactions following a trauma, concerns about how disclosure would be received, to uncertainties by those responding to the trauma of colleagues and the longer-term effects of trauma within the profession.

Table 3 – Superordinate Theme 2- Unpredictability

Participants	Unpredictability					
	Uncertainty of Disclosing	Shattered Assumptions	The Effect of Trauma	Behaviour	Effects of Any experience	Own Responses to disclosure by Colleagues
1	✓	✓	✓	✓	✓	✓
2	✓		✓		✓	✓
3	✓	✓	✓		✓	✓
4			✓	✓	✓	✓
5		✓	✓	✓	✓	✓
6	✓		✓	✓		✓
7	✓	✓	✓	✓		✓
8	✓	✓	✓	✓	✓	✓

Subordinate Theme 1- Uncertainty of Disclosing; *‘Might pop up later down the line’*

Participants verbalised *‘the anxiety, the worry’* (1) about how a disclosure would be received, and the possibility of *‘over fragilizing people’* (1).

The presence of ‘judgements’ (1, 6, 3), concerned participants, along with changes in how others ‘might see you’ (6), possibly ‘totally changing that relationship’ (3) and ‘how capable people think they are’ (7).

Many participants asked ‘why’ (1, 6,4) disclose, giving the sense, it was something under the control of the individual. They considered ‘what is the rationale behind it’ (1), and it’s ‘function’ (4). Despite this, these participants acknowledged the unpredictability of what may affect a psychologist, regardless of the presence of trauma, and that ‘We are all activated by things we don’t even know yet’ (1).

Those with the experience of disclosure described the unpredictability that ‘certain things might come out that you wouldn’t have shared’ (2), distancing themselves with the use of ‘you’ instead of ‘I’. Another described ‘telling more people than I intended to, it kind of just spills out’ (8). The unpredictability of triggers was also raised, when ‘Something happened that reminds you of it again and your struggling...sometimes they do just comes up’ (3) and ‘pop up later down the line’ (7).

Two participants stated they would view a disclosure by another ‘as a positive about that person, their strength, resilience, openness’ (3) and also ‘feel privileged to be told’ (1).

Subordinate Theme 2- Shattered Assumptions; ‘Floored me what happened had happened anyway’

Unpredictability was shown from the shattering of assumptions evident in numerous scenarios shared. Firstly, seeing service users just ‘get on’ (1), with ‘some of the experiences they have had, I think crikey’ (3), ‘this has to have traumatised this child’ (1). Participants expressed being ‘astounded by the resilience’ (1) recognising ‘assumptions we make as adults’ (1).

Personal research of trauma in the general population led to ‘surprise’ at ‘how well some of them seemed to have coped’ with experiences ‘severely traumatic’ (8)

Secondly, the reactions of others to a participant’s own trauma shattered assumptions as, they described being ‘pleasantly surprised’ at ‘how understanding’ (7) colleagues were.

Participant 7 also considered how a psychologist who had ‘lived a sheltered life... privileged’ may experience ‘how the other half lives’, as a ‘shock’ (7).

Lastly, participant 5, addressed assumptions to a colleague’s trauma disclosure, from being ‘shocked she had endured such a horrific thing’, to being ‘shocked’ by the response of others, being left thinking ‘where is any compassion and thoughtfulness for this person’. They went on to say - ‘that is what really upsets me.... ultimately the kind of like nuts and bolts of the area that you work in and you didn’t get the validation and the care and the support that you deserved’ (5). Consequently, they reflected on the work itself ‘how little we know what we are doing, what we are dealing with, who we are dealing with’ (5).

Subordinate Theme 3 - The Effect of Trauma: ‘The Yin and the Yang’

Potentially ‘helpful’ (3,8, 6) effects of trauma on clinical work leading to ‘more understanding of trauma related difficulties’ (1) and a ‘real insight’ (5). It was also described as ‘easily’ being ‘unhelpful’ (3,6,8) or a ‘challenge’ (5).

Participant 2, explored ‘the yin and yang’ (2) of trauma, with the helpful and unhelpful aspects occurring simultaneously - ‘triggered by something going on for the client...at the same time really constructive aspect...you have that insight...you can draw on that’ (2).

The unpredictability of trauma’s effect on an individual’s mental health, such as ‘anxiety’ (6,3,4), ‘depression’ (4,6), ‘panic’ (3) and ‘PTSD’ (6) was explored by participants. There was ambivalence about the impact on clinical work, for example, ‘if you have been a psychiatric

inpatient suffering from psychosis ...but then actually meeting someone in that situation... actually it wouldn't...I think you would be a great person to talk to that person' (2). Participants described it as *'different'* if you have *'actually got trauma...as a condition' (7)* or have *'PTSD' (5)* as a mental health professional.

Subordinate Theme 4 – Behaviour: *'a bit more erratic behaviour'*

Participants described behavioural extremes of how trauma can present, such as appearing *'hypervigilant' (7,6)* *'restless' (7)*, but also possibly *'slowed down' (7)*, *'shut down'* or *'detached' (4)*, *'gravitating towards or away from certain client groups' (6)*, *'repeatedly mentioning it' (5)* or *'clear avoidance of wanting to talk' (5)*. Possibly becoming *'dismissive of people' (4)* *'avoiding aspects of work' (4)* but also possibly *'becoming overly attached' (6)*.

Other behaviours described were: *'sudden distress' (8)*; *'flying off the handle' (7)*; being *'emotionally up and down' (7)*; *'certain words can trigger and you can see it in the room' (6)*; *'physiological and physical differences' (5)*

Subordinate Theme 5 - Effects of any Experience: *'I think there is all sorts of things that could stir things up'*

Six participants reflected on the unpredictable impact of *'other types of difficulties' (5)* during work, which *'might impact them' (5)* and *'direct understanding' (5)*. Trauma was said to be *'much like a lot of experiences really' (8)*, *'any aspect of personal life' (4)* and *'the same as any other upset or family difficulties that might be going on' (5)*. Participants stressed *'it is about being aware of...how it makes it more or less difficult during our interactions' (4)*, being *'thoughtful' (5)* and having *'reflective capacity' (2, 5)*. Participants concluded people should

be ‘*anticipating that sometimes we are all going to struggle*’ (4) and be ‘*activated by things we don’t even know yet*’ (1).

Participant 5 captured her experience of the unpredictability of life experiences-

‘It has surprised me what has...unsettled me... you didn’t realise that bothered you until it comes back to the surface when someone tells you something’ (5)

Subordinate Theme 6 – **Own reactions to Disclosure by Colleagues:** *‘what might be more difficult today might be different to what might be more difficult in a year’*

Participants had limited experience of dealing with psychology colleagues trauma disclosures, leading to theoretical responses. They suggested they would be ‘*non-judgemental* (3, 6, 2) ...*as you would with a client*’ (6) offering ‘*support*’ (4,1), showing ‘*compassion*’ (1,2), giving ‘*space*’ (8) and ‘*time to talk*’ (1), also to ‘*check in*’ (1,3, 8) every so often.

Numerous participants automatically responded in a supervisory role and reiterated any disclosure would be ‘*taken seriously*’ (1), ‘*working towards solutions together*’ (2) ‘*considering whether work is effected*’ (2, 1, 5). Participants considered the effects of their own responses and specified ‘*no pressure to return to normal*’ (1) and not to ‘*reinforce the message it is shameful or wrong*’ (5), ‘*not to make assumptions*’ (8) and avoid ‘*immediately going down the competency route*’ (1).

Other participants reflected that disclosure may ‘*bring things up for me*’ with it being ‘*hard to predict reaction...might unhinge me*’ (2) and expressed concern if the disclosure was ‘*unexpected*’ (2), how you would react depending on current circumstances, as ‘*what might be more difficult today might be different to what might be more difficult in a year*’ (2).

Participant 3 said it was '*hard to answer how I would handle it, as not experienced it*' (1) with participant 2 hoping to '*hold on to all the things I have just been talking about*' (2) but verbalised how nature of the trauma, such as hearing '*sexual abuse as difficult*' or '*something I haven't even thought of might be shared and then I would be thinking... that is really difficult for me*' (2).

Participant 5 described their, '*surprise and... shock*' and feeling '*traumatised hearing*' the details of a colleague's disclosure. They described the experience as '*incredibly upsetting*' and '*most difficult in terms of the feelings it brought up*' (5). These aspect, along with a lack of '*control*', which a supervisor can '*create...for supervisees*' (5) echoed descriptions of traumatic experiences such as feeling '*out of control*' (1), '*helpless*' (1) with '*elements of shock*' (7) and being '*unexpected*' (7).

Superordinate Theme 3

Personal Experiences; *‘you never going get rid of that trauma, that emotion it is always going to be there but...sometimes you manage that’*

This theme explored participant’s views on the impact of their own personal experiences in relation to their behaviour and understanding of trauma as clinical psychologists.

Table 4 – Superordinate Theme 3- Personal experiences

Participants	Personal Experiences					
	Feelings of insight from own trauma	Feelings of insight from others trauma	Adversity	Drawing from experience without disclosing	Greater appreciation of how people see the world	Childhood
1						✓
2		✓	✓	✓	✓	✓
3			✓	✓	✓	✓
4		✓	✓	✓	✓	✓
5		✓				✓
6	✓			✓		✓
7	✓		✓			✓
8	✓		✓	✓	✓	✓

Subordinate Theme 1 – Feelings of insight from own trauma; *‘I am being triggered, now I know what that means a bit more’*

Two participants defined their trauma as subjective and one participant had experienced a trauma that would fall under the DSM-5 Criteria A. Another participant spoke about disclosing numerous adverse experiences, not openly defining them as traumatic, but had experienced adverse reactions due to them.

‘Positives’ (7) were described by all participants who expressed having experienced a trauma, whether objective or subjective trauma. Participants described how they had *‘learnt so much’* with effects that *‘will last a life time’*.

Participant 8 reflected on two insights from trauma. Firstly, what *‘it feels like to have comes to terms with something shocking and difficult’*, helps them *‘connect with someone sincerely’*. Also, they found they could *‘access some of those emotions more easily’* and *‘to get to that place... kind of feel what you are saying’* (8). Second, regarding insight into trauma related symptoms they recalled *‘oh that is what a trigger is like, so part of me was really upset by it but... now I know what that means a bit more’* (8). They described *‘replaying it, the story of it from start to finish...my mind was just on a bit of a loop...I didn’t know that would happen’* (8).

Subordinate Theme 2 - Feelings of insight from the trauma of others; *‘long way to go in terms of how we treat colleagues’*

Participants experience of trauma disclosure within the psychology profession was scarce. Participants’ described learning from these scarce experiences of trauma disclosure, describing disclosure as important to understand another’s *‘perspective’* (4). Participant 2 stated that disclosure by academics *‘left an impact on me...opened me up to things’* and *‘helped me understand’* (2).

Two participants had experience trauma disclosure by a colleague of a different profession. Participant 5 described the experience as *'informative'* that *'the psychological care of colleagues is often not good enough'* and reiterated *'the importance of caring for colleagues'*. They described how the experience taught them *'how we shouldn't as a team respond'* with *'plenty more could have been done'* determined they *'won't do the same again'* (5).

Subordinate Theme 3 - Adversity; *'I think everyone has some level of adversities sometime and that is helpful in itself'* (4)

Five participants introduced positives from experiences of adversity, such as *'being a single mum...sometimes helps'* (3). Participant 3 used personal experiences of *'being strict with eating'* to illustrate how they became able to relate to client experience of anorexia

Participant 2 echoed this idea that *'working through some emotional stuff whatever level and whatever that is'* (2) can be *'helpful'* (2). Participant 3 argued that *'that emotion [...] is always going to be there but...sometimes you manage that'* (3). The narratives offered insight into the ability to *'think about more than we have lived directly ourselves'* (5)

Participant 8 stated *'adversity'* perhaps helps people be *'self-reflective'* (8) and used to think *'people.... who hadn't had some kind of adverse experiences aren't really that interested in psychology.... adversity helps... way of thinking'*.

Subordinate Theme 4 – Drawing from experiences without disclosing; *'you can draw on that without spelling it out'*

Participants talked about their experiences giving them something to *'draw on'* (8, 2), *'without spelling it out to the client'* (2). Participants spoke about *'more understanding'* (3, 4), and not *'just empathy'* (3). Participant 3 described how *'struggling with spelling'* made them *'more aware of other people's strengths'* and participant 4 reflected on that her *'parents separated'* and despite having never *'talked about that with a young person'* they had been able to

'acknowledge some of the difficulties' (4). Participant 8, described how having *'low self-esteem'* a part of their *'disposition'* that has led to being *'non-judgemental'* as *'I don't see myself as more expert and I think that may help with engagement'* (8).

Subordinate Theme 5 – **Greater appreciation of how people see the world;** *'see the world in different concepts and in different ways'*

Participants described a diverse range of personal experiences, outside of trauma and adversity, affecting their perception of the world, most notably *'being a parent'* (2, 3, 8) and as a consequence being a *'lot more empathetic towards parents'* (8). Participant 2 cited *'being bilingual'* (2) as helpful to *'appreciate'* the difficulty when your *'first language isn't English'* and how *'names we have for things that may affect how we think'* (2).

Others described their *'experience outside...the NHS... being with people who might be accessing services'* (4) and knowing *'what it is like to sit in a school with kids that are self-harming...and to feel like CAMHS weren't doing anything'* really helped *'perspective'* (4). Lastly, the experience of trying out therapies, including *'mindfulness and ACT'* (8), helped participants *'see how they have made a difference...so you can feel quite passionate about explaining it to other people'* (8).

Subordinate Theme 6 – **Childhood;** *'I didn't know anything about CBT but if I reflect back I did use a lot of CBT because that is what my mum and dad did'* (6)

All participants unprompted reflected on their experiences of childhood at various points during the interviews. Developing an interest in psychology was linked with childhood, having *'grown up in a family where the culture was... very stiff upper lip'* (5), to having *'got quite down'* (8). The former stating it was *'nice to have found a whole area where you are allowed*

to think and talk about the things that often aren't spoken about' (5) and the latter becoming 'a bit introspective... something about that made me...quite like to study psychology' (8).

Participant 3 described *'wanting to help people'* due to *'mental health difficulties in family'* (3). While *'being the eldest'* (2) with a *'childhood partly looking after younger siblings'* (2) seemed to influence areas of work, such as *'looking after younger children'* (2) in CAMHS.

Participant 7 cites their childhood's influence on their skills such as being *'taught emotional understanding, openness'* and to *'regulate'* emotions *'from a young age'* (7). Participant 6 cites having parents who had *'incredible calm'* and who were *'quite psychologically minded'*, which has led to using *'a lot of CBT because that is what my mum and dad did, looking for alternative explanations, so I naturally did that...had that way of thinking all my life'* (6). Participant 6 recalled how their dad, who *'would never criticise anybody'*, made them *'more alerted to staff members...being critical'* (6). Playing sport *'all my life'* (1) was described as it *'enhanced fundamental social skills'*, *'resilience'* and *'at times lead the team'*. (1) Participant 1, likened this to dynamics *'which you will see play out in the world of work'* (1).

Participants articulated that there may be *'more in that than we think, like repeating that childhood experiences we had without realising'* (2), with it being *'probably more that unconscious'* (3). Participant 4 considered if *'there was an element of trying to solve your problems through helping other people'* they stated honestly *'I wouldn't know if that's what I am doing'* (4)

Superordinate Theme 4

Challenges and Change; The Role of Psychology; ‘It is almost like we don’t have trauma’

This theme focused specifically on the views of the challenges of addressing trauma within the profession, the perceived role psychologists should take and looking to the future, including the importance of working through trauma and the role of reflection.

Table 5 – Superordinate Theme 4:Challenges and Change

Participants	Challenges and Change; The Role of Psychology					
	Challenges	Current responses	Working through trauma	Reflection	Psychologists Role	Looking to the future
1	✓	✓			✓	✓
2	✓	✓	✓	✓	✓	✓
3	✓		✓	✓		
4	✓		✓	✓		✓
5	✓	✓		✓	✓	
6	✓	✓	✓	✓	✓	✓
7		✓			✓	
8		✓	✓	✓	✓	✓

Subordinate Theme 1 – Challenges; ‘services could be set up much better for everyone’

Challenges to efficiently addressing trauma within the profession described by participants included services being ‘very target driven’ (1), with ‘appropriate supervision... quickly dropped if there is a clinical need’ (1), With services stated to be ‘very problem focused and

psychiatric' (5), and *'could be set up much better for everyone'* (2) with services described to *'covertly discourage'* (2) people to share, with *'not enough of an emphasis on looking after each other, psychology staff or the other staff'* (2,3) With reflection was seen as *'important'* (6) but *'it is not valued'* (2).

Another challenge raised was the *'problem with diversity as a profession'* with the *'breath of life experience'* not *'that wide'* (4), with *'specific gaps around trauma... might be helpful to have more people with those experiences in our profession just from an understanding point of view'* which helps with having *'different perspective on things'* (4) Participant 4 reflected that they *'can't imagine'* may people from the *'refugee population'* or *'kids from looked after backgrounds'* (4) become psychologists. With the risk of becoming *'more elitist...how many more talented and helpful people for the profession does that cut out'* (4).

Participant 6 reflected on the challenge of feeling you have to *'portray this person that is squeaky clean'* (6), being left to *'feel you are not allowed to have been through a traumatic event'* (6), expressing *'we don't even acknowledge it...it is almost like we don't have trauma'*. In fact, *'we don't have a system in place where we can...address it overtly'* (6) One participant stated challenges are a *'deep issue ...not easy to change'* (2).

Subordinate Theme 2 – Current Responses; *'at the moment we don't do anything do we? We don't offer anything actually'*

This theme explored perspectives in responses to trauma experienced. With a focus on disclosure, participant 2 felt pressure to tell, their manager who stated *'why are you off'* (strong tone) (2). Despite this, their manager was described as *'really supportive...actually'* (2) and participant 7's supervisor helped them to *'reflect on things'* (7). As time went on following trauma, another felt *'the onus was probably on me to say if it was a problem'* (8).

It was stated that as a profession it isn't often thought about, *'how psychologists should be treated'* (7) and that *'we don't get it right all the time'* (1), with it reported to take *'something big to happen for them to go... oh they have been struggling for a while'* (1) despite the individual mentioning *'the impact of the trauma'* (1). Following a conversation with someone outside the profession, participant one reflected on that *'we don't tend to attend to that stuff that perhaps other people think we should'* (1). Some described responses that *'just shouldn't be'* (5), with an incident on training of *'a GP asking... to be off for three weeks'* described as being met with *'oh well if you get this and this handed in first, and are you practising your mindfulness'* (5) from a lecturer. Some wondered *'if what we do now is alright'* (8) deciding *'it probably isn't...variable...isn't very systematic'* (8), another participant stated *'we don't offer anything actually'* (6) Participants *'have a responsibility to resolve and manage [trauma]...for themselves and clients'* (5).

Participant two said *'especially in our profession... if we can't get it right with each other then what's the point saying we are good at getting it right with anybody really'* (2), a statement also reiterated by participant 5- *'if we can't do it each other...why are we assuming we are good at it with anyone else'* (5)

Subordinate Theme 3 – Working through trauma; 'it's hard to quantify or define specifically...it's a feeling'

Five participants spoke about how *'important'* (6) it was for trauma to be *'worked through and resolved'* (2,6) in the profession and then it can *'influence in a positive way'* (3). Participant 2 also reiterated it *'could be really constructive...that awareness'*, being *'less blind to possibilities as well'*. (2). Having *'two sides'* of understanding of *'how psychological trauma*

would inform or influence your practise' was described as being '*transformational for clients and services*' (2)

Various other phrases were used by participants to describe working through the effects of trauma, such as '*got through it...managed it, come through it, lived it*' (3), also '*adapted and adjusted*' (6). Participants stated it to be '*hard to quantify or define specifically*' (2), with it being '*a feeling*' (2), of thinking '*I'm not where I was*' (2) Participant 6 described how they understood their own feeling of resolve -

'it wasn't until...I thought, why not me..., I felt like I had resolved any kind of sense of being punished or this was a hardship' (6)

Participant 6, not moving their '*professional journey into psychologist*' until they felt they had '*resolved issues*' (6). Some participants questioned '*resolved*' with it being '*hard to know when to a good enough way*' (2), '*how would you know you are well enough to be in work...I don't know how I would know*' (8). Participant's explored ideas such as looking at it '*in terms of diagnostics*' (2) and not '*meeting criteria for depression*' (2), not having '*a massive heightened emotion to it*' (3) and '*functioning well*' being a '*good measure*' (2). Others reflected on '*how do we get through to the other side*' (4) and is it '*being able to have a more coherent story*' (4).

Despite having '*worked through trauma*' being '*respected*' (2) and '*really important*' (6), participant 2 stated they '*wouldn't judge anyone who haven't work through it either...as they may have not had the opportunity*' (2).

Subordinate Theme 4 – Reflection; 'it's just that being mindful and reflective'

Reflection was described as an important aspect of dealing with trauma. Participants described being '*mindful and reflective*' (3) and '*aware*' (3) of '*what you are bringing*' and '*aware*

of...attachment styles...how that links with... experience of trauma' (4). With 'reflective groups on the course' (5), 'you are constantly asked to think about yourself and your experience' with 'a kind of an acceptance, a culture around, that whatever a mess you're in, just bring it' (5). Participants explored that maybe reflection is 'what it's all about' (2), having 'lived life in a reflective way' (5), 'being able to reflect on...own experiences' (8) and reflecting on your own trauma 'with other people' (8) and how it 'might impact' (5).

Subordinate Theme 5 – Psychologist's Role; *'we should at least have a sense of openness... we expect our clients to don't we'*

Participants responded to addressing trauma in the profession was one of 'leadership' (1,6) getting 'a solution to it and drive it forward (1) and 'being in the forefront of developing some of the services' (8). Being 'not afraid to challenge' was stated as an important and to 'reflect back to... government' (4). Drawing 'on our critical skills' (4), being 'dynamic and driven' (7) and 'critical of the courses' (4), it being 'about that equity for people in psychology' and 'looking out to the wider landscape' (5). Also, to 'at least have a sense of openness and acknowledge things that get in the way of our practise...we expect our clients to be'(6) and 'recognise the long-term nature of trauma' (7) within our profession.

Participant two identified they 'respect anyone who has got to the point of being a psychologist...difficult to get there in the first place' (2), with a 'responsibility to help each other' (5). Participant five stated the importance of not to 'empty everyone's jug all the time' and to 'help support the process' that individual is going through.

Subordinate Theme 6 – Looking to the future; *'I am going to be looking to address how we look after each other' (1)*

Participants spoke about the future and the changes that could be made to support psychologists who had experienced trauma such as a '*system in place*' (6) to be '*open*' (6) about trauma experiences. Also '*getting together as a group*' (6) and '*talking*' (4,6), not '*about specifics*' (6) but having a '*specific session on wellbeing and disclosing your own trauma...giving examples of what that might be like*' (2) and '*away days*' (4) on the topic of trauma.

Regarding supervision, a supervisor '*more actively following up... to support*' (8) and '*check... protective systems*' (4) with individuals having a '*space...purposefully*' (2) set up. With talking about trauma being the '*thing to do*' (2), it being '*encouraged through that training and through structures*' (2), this '*would influence psychologists...to take up that offer*' (2). Participant 6 expressed that sharing could be '*therapeutic in itself*' (6).

Trauma informed services were described as '*maybe closer than we think*' (2) with psychologists '*informed... educated*' (2) by people in the profession '*who have experienced trauma themselves*' (2)

Participant 4 expressed the way forward would be to '*go back to recruitment processes, which is pretty rubbish*' (4). Using an example of '*a charity in Manchester who supports refugees*' and trains '*refugees to...do trauma counselling*' (4). Participant 4 reflected on '*that person brings the knowledge... more valuable to somebody than something I can do*' (4), thinking from a '*service users*' perspective '*what might be more comfortable*' (4)

Participant 4 proposed in the future to '*fight against*' clinical psychology becoming a paid course '*to at least give people a chance*' (4) with '*the broader and the more diverse in terms of... life experience... the more likely you are to challenge.... you have so many more perspective and...experiences of how the world works*' (4).

Chapter 3

Discussion

This section will summarise the research findings, drawing on the literature review where relevant, to arrive at conclusions and offer recommendations for future avenues of research.

Defining Trauma

The literature review identified two ways to define of a traumatic experience. These are to define it objectively (Lukaschek *et al*, 2013) or subjectively (Boals, 2016). In the literature there is a wide spread controversy and scepticism over the definition and use of Criteria A in the DSM and ICD-10 (Kilpatrick, Resnick & Acierno, 2009). Regardless of whether trauma is defined objectively or subjectively, the way people experience subsequent symptoms can be very similar (Lukaschek *et al*, 2013; Bodkin *et al*, 2007). Following trauma several symptoms are usually identified, including anxiety (Kou *et al*, 2011) and depression (Heim, Newport, Metsko, Miller & Nemweoff, 2008). Thus, to ensure clear understanding of the perspective that participants held about trauma, first exploring how trauma was defined by psychologists in this study was paramount. How trauma is defined was understood to influence participant's

‘recognition’ of trauma, whether they felt they had been the recipient of a trauma disclosure from a colleague or if they themselves would view their own disclosure as a disclosure of trauma.

All participants defined a traumatic experience as subjective and defining trauma in this way was said to have been influenced by their clinical experiences. Participants explained that they recognised the high level of distress in clients following events that would not typically fall under Criteria A.

Participants stated it would be ‘*unusual to find a psychologist who has had no (personal) experience*’ of trauma. This was in stark contrast to the findings when asked about their experience of trauma disclosure within the profession. Two participants expressed having experience trauma disclosure by colleagues of other professions. All participants expressed having no experience of psychology colleagues disclosing trauma to them. Two explanations, for this were provided by one participant, who observed either the colleague felt they ‘*couldn’t talk or it hasn’t happened*’. Another explanation could be the participants’ ambivalence in truly embracing trauma as wholly subjective, subconsciously considering the objective definition of Criteria A when trying to recall possible trauma disclosure. A third explanation might be that a trauma had been disclosed but the experience was not explicitly stated to have been traumatic or symptoms of trauma were not explicitly stated, such as ‘*having nightmares*’, leaving participants unsure if a disclosure had taken place. Participants reflected on ‘*difficult life events*’ that had been disclosed, questioning if it was in fact a trauma for that colleague, especially if the level of distress was high. Therefore, embracing the subjective nature of trauma did not come without its own challenges. Participants appeared to be left ambivalent on when to ‘*draw the boundary*’ between a trauma and a negative experience, which echoes the wide spread controversy over Criteria A (Kilpatrick, Resnick & Acierno, 2009).

Disclosure

Due to an absence of trauma disclosure by psychology colleagues, the majority of participants spoke theoretically about how they would react. Overall, participants spoke about hoping, if a disclosure did happen, they would be non-judgmental, compassionate, and give the colleague time to talk if needed. Some participants stated they would '*feel privileged*' if a colleague shared their traumatic experience with them, and a generally stated view was disclosure was positive ('*a positive about that person, their strength and resilience*'). These responses reflected the experiences of the four participants who had disclosed trauma to colleagues, all reporting overall positive responses. For example – being '*pleasantly surprised*'.

Despite the apparent congruence between positive responses to disclosure, both in theory (as a receiver of a colleague's trauma) and experienced in practice (by participants who had disclosed a trauma), there was a discrepancy as all participants expressed uncertainties around disclosing their own trauma, regardless of positive responses, in theory and in practise. The anxiety of being judged and worries about how capable people will perceive them to be if they disclosed trauma was dominant across narratives. The influence of stigma provides one explanation for the discrepancy.

Macedo et al., (2016) spoke about public stigma being internalised into self-stigma. Participants who had disclosed their own trauma provided supporting evidence for the presence of internalised stigma. For example, participants described how their negative metaperceptions actually turned out to be their own '*insecurities*' and '*thoughts*' influencing how they believed their disclosure would be received. Those receiving the disclosure recognised the presence of anticipated stigma, stating there was an expectation that they were going to '*judge them badly*'. Perceived stigma was also present, for example, participants expressed judgement to be felt '*even if it is not true*'. Therefore, this research finding supports the presence of stigmas,

including, anticipated stigma, internalised stigma and perceived stigma that Clement et al, (2015) recognised often co-exist together. No participant felt stigmatised by other colleagues following disclosure, consequently internalisation of public stigma may best explain the discrepancy across the narratives between the perception of disclosure and the experience.

Participants described how any trauma experienced has the potential to leave an individual feeling '*inferior*', with '*feelings of shame*' and '*low self-esteem*', in line with empirical research finding shame and low self-esteem are often present following trauma (Dorahy & Clearwater, 2012; Kucharska, 2017). Therefore, the internalising of stigma in participants could have potentially been perpetuated by the effects of trauma itself. Participants also described '*depression*' and '*anxiety*' as common effects of trauma. Mental illness was also found to be connected with both trauma symptoms (Fan, Zhang, Ying, Mo & Liu, 2011) and low self-esteem (Sowislo & Orth, 2013). As public stigma has also been found to lower self-esteem (Rusch, Corrigan, Todd and Bodenhausen, 2010) it can be concluded influences affecting trauma disclosure are complex, entwined, and multi-layered. The complex interaction between the effects of trauma and/or mental health difficulties, public stigma, perceived stigma, and internalised stigma may provide an explanation for the presence of ambivalence around disclosing trauma. For example - '*I probably wouldn't tell...interesting as it should be ok...not being judged...worry it might happen...then in reality it probably wouldn't but then again... it might*'. Participants stated stigma is a '*deep issue*' and that mental health services are not immune. Despite this, participants' ambivalence about whether to disclose their own trauma or not provides evidence stigma may be more ingrained than participants could consciously express. Shera and Ramon (2013) stated mental health workers should be reflecting on their own stigmatising attitudes. These findings suggest that amongst psychologists this does occur. Four participants reflected on how they may end up '*perpetrating*' and '*reinforcing stigma*' they are '*trying hard to avoid*'. Despite this insight, a barrier in understanding how participants

are specifically reinforcing stigma could be a lack of conscious awareness of the array of different stigmas and their influence on trauma disclosure within the psychology profession. Without a deeper understanding of stigma's complex presentation inadequate methods could be adopted to address stigma within psychology and within mental health services as a whole, resulting in minimal change. Therefore, these findings may help to explain Macedo et al's (2016) research that found despite efforts to tackle stigma, its affects have remained consistent.

In spite of potential difficulties understanding stigma, participants were aware that simply leaving trauma unspoken about is unhelpful in tackling stigma. They described '*unspoken rules*' they follow, yet '*we expect them [families] to talk about their traumas...yet we are so closed*'. This echoes Wall (2001) who found therapists do not always apply what they preach when it comes to being open and addressing trauma within their own lives.

This research demonstrates that the unpredictability of the impact of trauma disclosure on both the listener and the individual disclosing trauma is potentially underestimated within the profession. Participants who had not experienced disclosing their own trauma to a colleague questioned the rationale for disclosing and its function (disclosure was mostly a conscious choice, in the control of the individual). For example, disclosure was described as being used by participants to provide a sense of '*hope*' to others or to help colleagues understand one another and help them '*adapt*' to one another's needs. This was in stark contrast to the four participants who had disclosed trauma and described the experience as out of their control, using phrases such as '*spills out*' and '*things...come out that you wouldn't have shared*'. Such phrases suggest, at times, disclosure is a much more unpredictable experience than expected, one dictated by emotion rather than conscious choice. For some participants, being able to separate work and their personal life was important and disclosing trauma jeopardised work as a '*safe heaven*'. The unpredictability of when a disclosure could occur, especially if their own disclosure comes as a surprise to themselves, may also increase any feelings of distress. One

participant described how the realisation of trauma can happen at any time, affecting whether that individual will disclose or not. It is important to note that all participants who disclosed a trauma found the presence of the trauma affected their ability to work in their current role, which influenced the need to disclose the trauma and their ability to hide the event from others. So, whether participants would disclose such events in future is unknown, and, indeed, whether all four participants would have kept them hidden if they could, one participant stated that they would have.

Charlemagne-Olde, Harmon and Maltby (2014) stated that some challenges are more prominent within the psychology profession than in other professions, such as perfectionism and the hiding of distress, with psychologists equating difficulties with failure. While unable to confirm whether these factors are more prominent within psychology than within other professions, this research provides evidence for their existence. For example, numerous participants expressed general perceptions of self as wanting to appear '*competent*'. Participants linked trauma disclosure with the potential of '*not looking professionally competent enough*', which caused its own distress. The use of the words '*not looking*' could reflect that the participant was not primarily concerned about their competence in providing therapy to clients but, instead, other colleague assuming their competence must be affected due to trauma.

The prospect of being judged mediated decisions to disclose in all participants. Less expectation of being judged led to greater disclosure, with fear of judgement preventing disclosure. As an example of the former, a lead psychologist described feeling they did not need to '*perform*' anymore. In contrast, one participant stated they felt they could not disclose in their first assistant role for fear of being perceived as incapable. Another participant wondered if it was as safe to disclose before qualifying. All trauma disclosures by other psychologists were experienced by participants in a learning setting, by lecturers, providing

further evidence of the possible influence of length of career and/or status. This influence potentially leads to feeling their capabilities are less likely to be judged by others, and, therefore, they are more likely to disclosure trauma. Consequently, an alternative explanation for changes in an individual's view of disclosing trauma could be the effect of age. For example, participants described with age came greater acceptance of the self, which left them less concerned about being judged and let to more disclosure. Another described feeling they were being perceived as '*more vulnerable*' due to being younger than colleagues. This participant then went on to express feeling '*mothered*' by colleagues following a trauma.

Therefore, a link made by participants between disclosing trauma and not appearing competent at work, along with evidence of the potential of being judged, mediated decisions to disclose at all stages of the participant's careers. It is a possibility the process of disclosing trauma could be even more challenging for psychologists purely due to high expectations of the self, regardless of their reflection of reality, increasing the negative impacts of perceived and internalised stigma. Empirical research by D'Souza, Egan and Rees (2011) found clinical psychologists who placed a high level of perfectionism on themselves experienced greater levels of stress and stress related burnout than other psychologists. Evidence suggests that not addressing perceptions of trauma related disclosure in the profession could be detrimental to the wellbeing of psychologists, leading to sick leave being taken, high stress levels and burnout, impacting their ability to provide a service to clients.

Akin to the experience of disclosing trauma, dealing with trauma disclosure from a colleague appeared another unpredictable experience. One participant experienced a disclosure from a colleague of another profession and did not anticipate finding the experience as '*incredibly upsetting*'. Assumptions about the behaviours of colleagues and management seemed to be shattered, as this participant questioned '*where the compassion was*' from them. This participant began to question '*if we can't get it right with each other then what's the point*

saying we are good at getting it right with anybody really'. This participant's experience reflects the theory of shattered assumptions (Janoff-Bulman, 1992) which proposes an event results in information incongruent to current beliefs shattering current assumptions an individual holds about the world, leading to distress (Janoff-Bulman, 1992). The shattering of assumptions is evident for this participant following a colleague's disclosure of trauma. Interestingly, this participant described the '*shock*' on hearing trauma had happened to a colleague. The fact this participant expressed shock strongly contradicts all participants stating everyone '*experiences small t and big T*' traumas. This reflects a psychological distancing from trauma as common mechanism to protect the self, the disclosure by a colleague making the actuality of trauma more tangible. The feeling close to the disclosee also appeared a factor in the level of distress experienced. Despite the participant stating the information itself was not materiallly different than they would experience with clients, they expressed holding this colleague '*in high regard*'. This reflects the theme of relationships across narratives as influential to disclosure. Disclosure was seen as '*an integral part of having relationships*' and a '*marker of becoming closer to someone*; though s '*dilemma*' was expressed in understanding when a colleague was a '*bit of a friend as well*' and, consequently, it was seen by participants as easier disclosure adversities.

Interestingly, the participants who had disclosed a trauma were the individuals who reflected on that the experience may be difficult for the listener, especially if it was '*sprung on them*'. Another reflected, it may '*unhinge*' them. Therefore, even disclosing a trauma has provided insight into the potential difficulties for both disclosee and for the listener, providing valuable insight could be informative for the profession as a whole in understanding how to manage any difficulties that arise.

The relevance of trauma to the pursuit of a psychology career

Participants cited a range of experiences influencing their career choice. One participant expressed an adult trauma led them into psychology, supporting research by Elliott and Guy (1993) who reported trauma alone to be an independent significant factor relating to occupation choice. Two of the eight participants cited a mental health difficulty as a factor directing career choice, one of a mental health difficulty experienced by the participant and the other spoke of mental health issues within their family. Mental health, was found the most cited influence to choosing to work as a therapist stated by Conchar and Repper (2014) and Murphey & Halgin, (1995). Another two participants expressed being influenced by more general family dynamics, such as caring for siblings and having a family who didn't talk about problems. The remaining three participant offered more general influences such as enjoying psychology at A level. Participants were not blind to potential subconscious influences as they reflected on *'repeating childhood experiences'* and influences coming from *'more the subconscious'*. Participants acknowledged it is difficult to know all influences. Some researchers have questioned the strong focus on psychological distress and career choice (Murphey & Halgin, 1995) and this could be justified. For example, the participant who expressed an adult trauma resulting in them pursuing a psychology career also spoke about their parents using *'a lot of CBT...looking for alternative explanations, so I...had that way of thinking all my life'*. Therefore, this childhood experience could have been just as likely an influence in their career choice as the experience of trauma, be it more difficult to consciously articulate and recognise the connection.

Unprompted, all participants reflected on their childhood. Negative experiences were mentioned by five participants either influencing their career choice or informing their current clinical skills. The influence of positive childhood experiences were mentioned by three participants, from being *'taught emotional understanding from a young age'* to playing sport, which one participant described helps them lead a team. The current impact of childhood

experiences was subconsciously expressed in participants use of language. For example, the switch from the past tense '*in a family were the culture was*' to the present tense- '*no-one has the direct conversation, no-one just deals with things*' during the same sentence. The unpredictable effect of past experience was acknowledged by the majority of participants. One participant reflecting '*we are all activated by things we don't even know yet*', regardless of trauma.

Akin to research findings, that trauma within childhood has the greatest impact on mental health (Sugaya et al.,2012), particularly sexual trauma (Thompson et al., 2003), participants mentioned what happens in childhood to have a '*massive impact*'. Despite this, a participant who carried out a research project of sexual abuse in the general population was surprised at '*how well some of them seemed to have coped*'. Another participant was surprised at the '*resilience*' of children following abuse. One possibility for these responses could be the subtle influence of a symptoms orientated perspective of the impact of trauma within mental health services, with less focus on facilitative aspects of trauma, potentially due to participants being exposed predominately to individuals with the greatest dysfunction following trauma (Boanno, 2004). Alternatively, the lack of focus of research on resilience (Boanno, 2004) especially in children (Meyerson et al, 2011), could explain the surprised reaction by participants. Some authors (Oz & Ogiers, 2014: Briere & Elliott, 2003) argue there has been an over concentration in research on topics more easily explored in therapists, such as sexual abuse, since the scientific definition of trauma was introduced, with other areas, such as the effect of being adopted on a family therapist receiving very little attention (Oz &Ogiers, 2014), which could come with its own challenges. Oz and Ogiers (2014) stated this leads to more stigmatising attitudes within the profession. In this research there was no evidence of stigmatising attitudes particularly around sexual abuse, as stated by Oz and Ogiers (2014), though due to sexual abuse's link to shame and mental health difficulties, the level of anticipated stigma may be

more influential than with other traumas. This could explain the lack of disclosure within the profession, for example, sexual abuse was stated by participants to potentially be the most difficult to disclosed, one participant guessing ‘*some of them [colleagues] would have been [sexually abused]*’ due to it being fairly ‘*common*’. Due to the psychologist’s role in implementing scientific knowledge to a clinical setting (Toogood, 2010), the understanding of current scientific findings and how this is impacting perspectives in the clinical setting and during the selection of applicants for psychology doctorate training is paramount, especially as the psychologists in Ivey and Partington’s (2014) research applied psychological knowledge, for example, knowledge about the impact of narcissistic injury when choosing applicants.

The perspective that psychologists must have ‘*worked through*’ their trauma resonated across five interviews. The findings of this research reinstated that it is ‘*hard to know*’ when trauma has been worked through ‘*to a good enough way*’, the same difficulty stated by other researchers (see Zerubavel & Wright,2012; Ivey and Partington, (2014). Participants also used words such as ‘*come through, adapted and adjusted*’ to explain the same concept, overall concluding ‘*worked through*’ as difficult to ‘*define*’. Despite this emphasis, only participant spoke about their own resolve following trauma, specifying it as feeling of not ‘*being punished*’ anymore. Participants echoed the words of authors who voiced that regardless of the type of adversity, acceptance (Wolgien & Coady, 1997), self-reflection (Kouriatis & Brown, 2014) and awareness (Mander, 2004) are essential.

The effect of trauma on clinical work

Overall, participants viewed their own adverse experiences as ‘*helpful*’ to their clinical work, providing a more ‘*direct understanding*’ of clients’ experiences. Only one participant directly disclosed a concern about working with a case due to worries regarding the effect an adversity may have on their ability to help a client. Participants only hinted at their own struggles within

clinical work, which could reflect a concern that assumptions regarding impairment to clinical work naturally follows a disclosure of distress (Charlemagne- Oldle & Harmon, 2014; Zerubavel & Wright, 2012). Some participants used the third person to explain the potential impact of general life adversities, for example, *'might impact them'* and *'responsibility to resolve and manage for themselves'*. Other participants were more direct and included themselves in their explanation, for example *'how it makes it more or less difficult in our interactions'* and *'sometimes we are all going to struggle'*. Therefore, it cannot be ruled out that even in the confidential environment of the interview, some participants felt they could not be completely honest about the negative emotions that had arisen with clients due to adversity, even when the presence of such emotions may in reality have minimal impact on their ability to provide intervention. Cain (2000) speculated stigma was barrier to collecting accurate data on distress amongst colleagues, which also cannot be ruled out in this research.

Lima and Desteno (2016) found evidence for the more severe the adverse experience, the greater the compassion and higher the empathetic concern for another's welfare. Comparing the participant who experienced a trauma that met criteria A of the DSM to the participants who described a subjective trauma, the former appeared to experience the most distress, supporting evidence the DSM criteria is reliable in recognising those in the most distress. This participant also described the most insights from their experience. They described the benefits of understanding trauma symptoms such as a *'trigger'*, and an ability to *'access emotions more easily'*, being able to *'feel what you are saying'* helping to *'connect with someone sincerely'*. This supports research showing that high levels of distress do not to automatically lead to low levels of growth (Linsley & Joseph, 2004) and that distress and growth can co-exist as described by Tedeschi and Calhoun (1995) and can also increase empathy (Wolgien & Coady, 1997).

Looking to the future

Three participants reflected on the lack of consideration given to personal trauma within the profession. One participant stated ‘*we don’t offer anything actually*’... it is like ‘*we don’t have trauma*’. Therefore, the opportunity to increase the resilience of individuals working in mental health, who have a history of trauma is being missed.

Two participants in this study expressed benefits of positive social support following responses by supervisors who helped them to ‘*reflect on things*’ and also challenge any negative appraisals of the self. One participant felt supported enough to say ‘*am I the right person*’ to help a client, following discussing their concerns with their supervisor due to the likeness of the client’s experience to their own. This echoes research findings of the positive influence of social support (Collishaw et al, 2007) and supports that social support can increase self-esteem (Zhou, Wu & Zhen, 2018) and also that professional growth can occur with appropriate social support. In contrast, some expressed colleagues were treated with less care than shown to clients, some reflected it would ‘*take something big to happen*’ before colleagues realised the extent of another colleague’s struggles. This is supported by the lived experience of the participant who felt shocked at the lack of compassion for a colleague following a trauma. Empirical research has found the influence of negative responses following trauma to outweigh positive responses, leading to increased trauma symptoms in individuals (Andrews, Brewin & Rose, 2003). Participants’ narratives also included observation of other psychologists experiencing dismissive responses within the profession following disclosing distress, including from lecturers on training and from other colleagues. This reveals that despite the overall expression in theory by participants that they would be compassionate in reality may make this harder than anticipated. One possibility could be, as previously explored, that mental health workers need to distance themselves from the actuality of trauma to protect the self, in a profession where trauma and the abuse of children is talked about daily, this could be more prominent than consciously considered, and thus could lead to a subconscious avoidance of

distress in colleagues. Compassionate fatigue may also play a role, or potentially subconsciously reverting back to defining trauma as objective, leading to failure to recognise distress of colleagues.

An overarching theme covering seven of the eight narratives was psychologists should take more '*responsibility*' to address trauma within the profession, using their '*leadership*' skills and be the at the '*forefront*' of change around how trauma is addressed. There was also a recognition that psychologists have a role in the PTG of colleagues who have experienced trauma, with trauma being '*fostered and encouraged*'. One participant stated that if psychologists do nothing else to address trauma to '*at least have a sense of openness and acknowledge things that get in the way of our practice*'. Making sharing trauma the '*thing to do*' possibly being '*therapeutic in itself*'.

Participants stated the current diversity within the profession needs to be challenged, due to the '*breadth of experience*' not being '*that wide*'. Participants reflected on the magnitude of the challenge to facilitate change, with a need to '*fight against*' clinical psychology becoming a paid course to helping to support diversity within the profession.

Participants stated it was important from an '*understanding point of view*' to recognise trauma histories of psychologists to help the profession have '*a different perspective*' and therefore more likely to challenge the '*status quo*' than an individual without those experiences. One participant reflected they could not imagine there are lots of '*kids from looked after backgrounds*' or '*refugees*' in the profession, cutting out individuals who would add '*more perspectives on how the world works*', to the benefit of both clients with personal experience and colleagues. The lived experiences of others, which was described as leaving '*impact*', following one participant hearing psychologists within the profession talk about their experiences of trauma openly, an experience they specified all psychologists should have.

Conclusion

This research has deepened the understanding of psychologist's experience of trauma and trauma related disclosure within the psychology profession.

All participants verbalised defining trauma as subjective. Whether participants truly experienced seeing trauma as subjective regarding trauma within the profession was more difficult to establish, with numerous contradictions, from embracing a broad definition of trauma, and its high prevalence within the profession to then expressing no experience of trauma disclosure by psychology colleagues. However, four participants had disclosed a subjective trauma to colleagues. Colleagues possibly subconsciously revert to experiencing seeing trauma as objective within the profession, potentially explain why the distress of colleagues was expressed to be sometimes missed. Participants were more inclined to talk about the negative impacts of trauma and managing these impacts, as opposed to a natural focus on post-traumatic growth within the profession but there was little evidence of conscious stigma.

Second, this research highlights that trauma of psychologists was rarely spoken about by participants, in spite of the majority of participants having experienced an objective or subjective trauma. Without direct communication, the experience of recognising the impact of trauma on colleagues was extremely challenging.

Third, this research highlights the interaction between different stigmas, bringing a deeper awareness of the entwined presentation of stigma within the profession; such insight could support a process of tackling stigma with more accuracy. Participants experience of stigma was surrounding mental health difficulties, as opposed to the stigma relating to a certain trauma, though sexual trauma was deemed the most difficult to disclose. The fear of negative

judgements was a prominence theme for all participants mediating trauma disclosure, strongly linked to the drive to appear competent.

This research highlights that purely a lack of speaking about trauma within the profession could be preventing the breaking down of any stigma present, [or silently reinforcing existing stigmas] especially anticipated stigma, which appeared most conspicuously yet is in reality the least complicated of the stigmas to address. For example, participants who had experienced disclosing trauma, experienced positive changes in their perspectives on the assumptions of how others would respond, which was ultimately a positive learning experience for these individuals, addressing the presence of anticipated stigma. The absence of open communication leaves perspectives an individual may have on the views of others unchallenged, preventing positive change. Participants were aware that by not talking about trauma, psychologists are not helping challenge stigma and support individuals within the profession who have experienced trauma.

Participants general focus was on positive influences of their negative experiences. The participant with the most severe trauma described how it helped them empathise more deeply with clients. Being in an environment where sharing experience is more accepted could have a profound impact on tackling stigma, an also be an opportunity to but the opportunity to learn from colleagues who have either experienced trauma, the process of disclosing trauma, or dealing with a disclosure of trauma by a colleague. Learning was evident from experiences that would be of benefit to share within the profession, such as the striking difference between theory and reality of disclosing trauma. Lived experienced challenging participants theoretical view that disclosing trauma was a conscious choice. This information could be taken forward to help normalise the unpredictability of trauma and how it may present. Greater insight from personal experience is evident from the participants who had disclosed and who recognised that it could be a process difficult for the listener.

The participants appeared keen to start addressing the lack of openness about trauma within the profession and provide better support. It could be argued individuals who have experienced trauma who have been successful getting into the psychology profession, have already shown high levels of resilience, determination, and ability to cope. Therefore, addressing trauma from a PTG perspective may be most helpful for psychologists, not only for their own wellbeing but for the positive influence this could have on their self-esteem and the way they implement their understanding during therapy, and ultimately, it is hoped that this positive influence may extend to the psychology profession as a whole.

Limitations

First, this research can not be generalised across the profession and broader claims regarding the topic cannot be made. This research has aspects of transferability enabling other researchers to make connections between the participant's experience and their own.

Second, experiences of participants were not compared to other professions, thus it can not be confirmed that the psychology profession would be different in their experiences and perspectives of trauma disclosure than other professions. Not directly asking about personal trauma enabled participants to distance themselves from questions, thus making it difficult to establish if sometimes they were talking about themselves or others.

Third, participants distanced themselves from disclosing their own journey of working through trauma or reflecting on the negative impacts of their own traumas on clinical work. Participants spoke predominately about the positives of their own experiences or distanced themselves by using the third person. This could have reflected anticipated stigma even within the interview distorting their true experiences of trauma reactions.

Recommendations

It is recommended that psychologists be made aware of the complexity of stigma surrounding trauma disclosure within the profession in its numerous forms and their influence on the wellbeing of psychologists who have experienced trauma. Due to anticipated stigma being the most pronounced, and easiest to address, it is highly recommended psychologists consider their own levels of openness about their own trauma and trauma related disclosure enabling the profession to benefit from their insight. This recommendation is further supported by the lack of evidence from stigmatising attitudes in the profession and the motivation participants expressed to make changes to help support psychologists who experience trauma.

Further Research

The profession would benefit from further research into how stigma presence in the profession, along with interviewing psychologists who have experienced objective traumas, enabling comparisons to be made against subjective traumas, and their influence. It would be beneficial to conduct this research in other areas of psychology, for example in forensic and adult mental health settings.

Chapter 5

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Chapter 6

Appendices

Appendix A

Interview Schedule

- 1) Describe your job role?
- 2) Tell me about your journey to becoming a psychologist?
- 3) Can you tell me about your strengths and characteristics that you find helpful within your clinical work?
- 4) Can you tell me about your experience of talking openly about your life and your experiences with your colleagues in clinical psychology?
- 5) What do you believe constitutes a traumatic experience?
- 6) How would you recognise the symptoms of psychological trauma in someone, including colleagues?
- 7) What do you think makes a good psychologist stand out from other psychologists?
- 8) Are there any life experiences you feel make psychologists more or less skilled in their work?
- 9) What is your experience of trauma related disclosure in the profession?
- 10) What do you feel would influence a clinical psychologist in deciding whether to disclose trauma in the profession?
- 11) What are your thoughts on psychologists who have personal experience of trauma?
- 12) What are your thoughts on the influence of psychological trauma on a psychologist's clinical work?
- 13) How do you feel trauma should be treated in our profession?
- 14) How would you respond to a colleague/ trainee/ assistant who had experienced a trauma?

15) How do you feel a supervisor should respond to a supervisee who discloses a trauma?

Prompts – Can you me more about that? Do you have any further examples? What do you mean by that?

Appendix B – R and D approval letter



GIG
CYMRU
NHS
WALES
Bwrdd Iechyd Prifysgo
Betsi Cadwaladr
University Health Board

Panel Arolygu Mewnol Y&D R&D Internal Review Panel

Betsi Cadwaladr University Health Board
Ysbyty Gwynedd
Clinical Academic Office
Bangor, Gwynedd
LL57 2PW

Dr Nikki Kiyimba
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Chairman/Cadeirydd – Dr Nefyn Williams PhD, FRCGP
Email: lyne.grundy@wales.nhs.uk
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12th October 2017

Dear Dr Nikki Kiyimba

Re: Confirmation that R&D governance checks are complete / R&D approval granted

Study Title The impact of psychological trauma within the psychology profession - An explorative study of Clinical Psychologists' perspectives of psychological trauma related wounded-ness of psychologists within their profession and its effect on clinical practice

IRAS reference 226793

Thank you for submitting your R&D application and supporting documents. The above research project was reviewed at BCUHB by the R&D Internal Review Panel (IRP) proportionate review (PR) process.

The Panel is satisfied with the scientific validity of the project, the risk assessment, the review of the NHS cost and resource implications and all other research management issues pertaining to the revised application. *A full list of documents included in the review is attached as an appendix.*

The R&D Office, on behalf of the Internal Review Panel, is pleased to confirm that all governance checks are now complete and to grant approval to proceed at Betsi Cadwaladr University Health Board sites as described in the application.

All research conducted at the Betsi Cadwaladr University Health Board sites must comply with the Research Governance Framework for Health and Social Care in Wales (2009). An electronic link to this document is provided on the BCUHB R&D WebPages. Alternatively, you may obtain a paper copy of this document via the R&D Office.

Attached you will find a set of approval conditions outlining your responsibilities during the course of this research. Failure to comply with the approval conditions will result in the withdrawal of the approval to conduct this research in the Betsi Cadwaladr University Health Board.

If your study is adopted onto the NISCHR Clinical Research Portfolio (CRP), it will be a condition of this NHS research permission, that the Chief Investigator will be required to regularly upload recruitment data onto the portfolio database. To apply for adoption onto the NISCHR CRP, please go to:
<http://www.wales.nhs.uk/sites3/page.cfm?orqid=580&pid=31979>.

R&D
Research & Development
301, Deodar Road, Brighton BN1 3DQ

Cyfeiriad Gohoblaeth ar gyfer y Cadeirydd a'r Prif Weithredwr / Correspondence address for Chairman and Chief Executive:

Swyddfa'r Gweithredwyr / Executives' Office,
Ysbyty Gwynedd, Penrhosgamedd, Bangor, Gwynedd LL57 2PW
Gwefan: www.pbc.cymru.nhs.uk / Web: www.bcu.wales.nhs.uk

Y&D
Thechnol a Datblygu
Elycwr, Penrhosgamedd

Appendix C

Version 3
IRAS ID: 226793

Participant Invitation Sheet

Introduction

My name is Laura Middlebrook and I work as an assistant psychologist in Flintshire CAMHS and I am doing a Masters in Psychological Trauma at the University of Chester.

I would like to invite you to take part in my Msc Psychological Trauma dissertation project. Through this research, I hope to gain greater understanding of attitudes to psychological trauma of clinicians within the psychology profession, which has received very little attention in research.

Who can take part?

Psychology assistants, trainees and qualified psychologists including those working in senior, consultant and lead positions can take part in this research.

You must have worked within the profession for at least 6 months and work clinically, providing therapeutic interventions.

If you have experienced a traumatic event within the last three months you will not be able to participate in this research due to the possible presence of acute stress. If you have experienced a subjective traumatic experience in the last year, you will be asked if you feel sufficiently grounded to engage in this research and asked to rate your level of distress from 1-10, with any rating over 5 being grounds to decline your participation.

What you will have to do if you agree to take part?

Your participation is voluntary and you may withdraw yourself from the interview or withdraw your data at any stage via contacting me by telephone or e-mail 2 weeks before the 26th April 2018 when the research will be submitted.

If you wish to take part, please e-mail your interest to 0606425@chester.ac.uk or laura.middlebrook@wales.nhs.uk

- 1) I will contact you to arrange a time to meet and you will have the opportunity to ask any further questions.
- 2) We will arrange to meet at either at your place of work and I will book a private therapy room or if you wish to participate outside of your place of work, we can arrange to meet in Flintshire CAMHS.
- 3) There will be one interview lasting around 60-90 minutes, within which you will be asked 10-13 open-ended questions. The answers will be recorded with a Dictaphone.

- 4) When the interview is complete you will be fully debriefed on the full nature of the research.
- 5) On completion of the research, I will provide a summary of findings, which can be sent to you on request if you are interested.

Will the information be kept confidential and my identity be kept anonymous?

I can confirm that I will comply with the requirement of the UK Data Protection Act 1998 with regard to the computer storage and processing of participants' personal information and ensure confidentiality of data supplied and generated in the course of the research.

If you agree to participate, all data will be kept confidential, deleted from the recording equipment following its transfer to a password protected computer. Your identity will be anonymised by using numbers to identify you during interpretation and for publication. All information including consent forms, email addresses and telephone numbers will be kept separate from the anonymised data and shredded and permanently deleted following completion.

Are there any risks?

I stress there will be no direct questions regarding personal traumatic experiences at any stage though there is the possibility distress may occur as you may reflect on your own personal experiences and possibly their influence on your professional life.

If you do become distressed during the interview we can have a break or stop the interview completely and your data can be destroyed. You will also be provided with the Betsi Cadwaladr University Health Board Occupational Health Department number if you feel you may require further support.

What are the advantages?

You may find the project interesting and the opportunity to reflect on the impact of trauma generally within the psychology profession and gain a greater awareness of your own views on the topic.

If you have any questions, please do not hesitate to contact me. My email address is 0606425@chester.ac.uk and my number is 07912679123. If following this conversation, if you choose not to participate, no further contact will be made.

Any complaints will be acknowledged within 3 working days of receipt in writing and can be sent directly to the research supervisor Nikki Kiyimba at n.kiyimba@chester.ac.uk or Professor David Balsamo, Dean of Social Sciences at d.balsamo@chester.ac.uk

Thank you,
Laura Middlebrook
Msc Psychological Trauma Student
University of Chester

Appendix D

IRAS ID: 226793

Version 3

Participant Identification Number for this trial:

CONSENT FORM

Title of Project: Clinical Psychologists' and psychological trauma: perspectives within the profession.

An exploratory study using IPA

Name of Researcher: Laura Middlebrook

Please
initial box

1. I confirm that I have read the information sheet dated..... (version.....) 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 without giving any reason
3. I understand that the information collected about me will be used to support other research in the future, and may be shared anonymously.
4. I confirm I consent to the use of a Dictaphone to record the interview
5. I agree to take part in the above study.

Name of Participant Date Signature

Name of Person Date Signature

Appendix E

emerging themes from Interview 6

- Managerial work (6)
- Developing good relationships with colleagues, across the system and other agencies (183)
- Being approachable (189)
- Boundaried but open door (190)
- Listening and not stepping in too quickly, unhelpful to system (195)
- Responding strategically (196)

Personal experience led to psychology (9-15)

- Managing emotions (19)
- Sense of loss (21)
- Quite traumatic (22)
- Skill coming from personal experience (30), clarified by others (31)

Personal experience as a strength

- Personal experience helps containment (32)
- Learnt to reflect a lot (33)
- Reflection as a strength (33)

Childhood experiences

- Very supportive family (36)
- System worked together (37)
- Reflect on family (38)
- Incredibly calm, never dysregulated (39)
- Psychologically minded mother (41)
- Sort of thinking all my life (43)
- Strong characteristic from parents (48)

Influence in clinical work

- More alert to staff members being critical (51)
- Training as well (54)

- Always remain calm (31)
- Never panic (31)
- Expect things will be difficult (31)

Sharing

- Quite comfortable (59)
- Cautious who to share with (59)

- Talk more to senior members (60)
- Helpful in context with colleague (67)

Motivation for sharing (62)

- Why want to talk (62,66)
- Something about yourself that might be helpful (69)

Supervision

- Share in supervision when needed to (63)
- Share only for self in supervision (71)
- Colleagues confident to admit and acknowledge in supervision (116)
- Crucial to talk about it in openly in supervision (285)
- Acknowledge in supervisory relationship (290)
- Worth acknowledging (290)
- Working through it is really important (290)
- Feel can't work with client, talk about it in supervision, be open to that (292-293)

Defining trauma (school trip example)

- Subjective (73)
- Individual (76)
- Effects unpredictable (77-82)

Recognising trauma

- Varies/individual (84)
- Report PTSD symptoms (85)
- Avoidance (87)
- Word that can trigger – see it in the room (89)
- Depression/anxiety present (88)
- Hyper vigilant/alert (91)
- Sensitive to noise (90)
- Variety of symptoms (91)
- Childhood influences (95) – attachment problems, emotional dysregulation (96-97), effected brain development (97) Time of trauma (100-105)
- Lots of different presentations (98)
- Looked after children unique group (101)
- Difficult behaviours due to life experiences (101)
- Lack of trust (102)
- Not believing people care (102)
- What happened in their lives, massive factor (105)

Recognising in colleagues

- Noticing in colleagues as important (109)
- Gravitate towards or away from certain client groups (110)
- Become overly attached or overidentify with certain a presentation (111)
- Happens a lot in teams (111)
- I encourage them to talk about it (113)

Appendix F
Themes Across Cases

DEFINING TRAUMA/RECOGNISING TRAUMA

Interview	Defining Trauma	Recognising Trauma
1	<ul style="list-style-type: none"> • Out of the blue (178) • Unpredictable (179) • Out of control (179) • No opportunity to talk/ reflect (179) • Prolong sustained stuff (181) • Powerless (182) • Helpless (182) • Inferior to those around you (183) • Subjective (183, 189) 	<ul style="list-style-type: none"> • Hard (192) • Direct questioning (193) • Use diagnostic labels (197) • Value of using PTSD (200)
2	<ul style="list-style-type: none"> • Trauma as a continuum (150) • Difficult events (139) • Types of trauma (148) • Effects physical and emotional wellbeing (141) • Not thought about before (139) • Constitutes suffering (144) • Questioning what constitutes a trauma (261, 269, 265) 	<ul style="list-style-type: none"> • Dilemma of spotting symptoms alone (161) • Need know of the trauma helps (157)
3	<ul style="list-style-type: none"> • Subjective (152, 163) • Personal (152) • Difficult to define (155) • Different thresholds (156) • Depends on previous experience (160) • Experience young people have, happened to self, difficult to get over (165) • Avoidance (171) 	<ul style="list-style-type: none"> • Anxiety (168) • Low self-esteem (168)
4	<ul style="list-style-type: none"> • Subjective (123-125) • Feel unsafe (124) • Vast (124) 	<ul style="list-style-type: none"> • Appearing distracted (181) • Unsettled (185) • Don't feel safe (186)

	<ul style="list-style-type: none"> • Fear (140) • Shame (140, 173) • Not always intentional (141) • Depends on how it was dealt with (141) • Avoiding trauma reinforces traumatic nature of experience (142) • Build up of stress as traumatic regardless of event (206) • Trauma as a continuum (208) 	<ul style="list-style-type: none"> • Detached (187) • Compassionate fatigue (188) • Avoidance to protect self (189) • Distractibility (189) • Low mood (190) • Anxious (190) • Poor attention (190) • Erratic behaviour (190) • Interacting differently (201) • Avoid aspects of work (202) • Dismissive of people (202) • Shut down to cope (202) • Behaviour change (213)
5	<ul style="list-style-type: none"> • Quite hard (166) • Semantics (168) • Lay language (168) • Extreme end of the spectrum – out of control (172) • Perceived or real risk (174) • Broader than criteria itself (175, 179) • Learn from experience with families (175) 	<ul style="list-style-type: none"> • Avoidance (186) • Repeatedly mentioning it (187) • Seen as physiological and physical differences (191) • Quality of how it is talked about – still here and now (195) • Explicitly expressed trauma response (194)
6	<ul style="list-style-type: none"> • Subjective (73) • Individual (76) • Effects unpredictable (77-82) 	<ul style="list-style-type: none"> • Noticing in colleagues as important (109) • Gravitate towards or away from certain client groups (110) • Become overly attached or overidentify with certain a presentation (111) • Varies/individual (84) • Report PTSD symptoms (85) • Avoidance (87) • Word that can trigger – see it in the room (89) • Depression/anxiety present (88) • Hyper vigilant/alert (91) • Sensitive to noise (90) • Variety of symptoms (91)
7	<ul style="list-style-type: none"> • Element of shock (44) • Unexpected (44) • Emotionally painful (45) • Lasting consequences (45) • Multi-layered (50) • Complicated (173) 	<ul style="list-style-type: none"> • Effect how present you are (52) • Focus (52) • Absences in conversation (53) • Emotionally up and down (54) • Restless (55) • Vigilant (55) • Tired (56)

	<ul style="list-style-type: none"> • Been through traumatic experience but not got trauma (177) • Trauma as a condition (178) 	<ul style="list-style-type: none"> • Stressed (56) • Pressure building (125) • Anger (126) • Distracted (195) • Slowed down (197) • Vacant (197) • Preoccupied (198) • Flying off the handle (200) • Crying (200) • Shouting (201) • Walking out (201) • Trauma hard to recognise without knowing about it (57)
8	<ul style="list-style-type: none"> • Definition of trauma changing (99) • Definition of trauma broadening (100) • More common place things as trauma (101) • Repeated low level as trauma (101) • Wonder the difference between negative experience and a trauma (102) • Boundary between negative experience and a trauma (102) • Trauma defined by impact (105) • Trauma defined by symptoms not easily resolved (105) • Trauma as having PTSD (108) • Trauma as subjective (110) • Sexual abuse as subjective (112) • What it does to you rather than what it was that makes it a trauma (117) • Defined by how secretive people it ends up being (125) • Trauma as level of distress (145) • Defined how isolated people feel (125) 	<ul style="list-style-type: none"> • Not easy to recognise symptoms unless told (130, 147) • Acting unpredictable (131) • Sudden distress or upset (132) • Panicky (135) • Avoidance (135) • Not being able to move on from it (140) • Being in the past (140) • Fixated (140) • Keep bringing it up (141)

Appendix G- Emerging Superordinate Theme 1

SUPERORDINATE THEME 1: VARIABLES TO DISCLOSURE

SUBORDINATE THEMES	PARTICIPANT	EXAMPLE	LINES
<u>UNCERTAINTY OF DISCLOSING</u>	1	'the anxiety, the worry about how it will be received'	327
	2	'Worry about compromising professional respect' 'Saying too much' 'Seen as a bit of a weakness'	121,124 96 131
	3	'If it wasn't taken you know, you would put your barriers up and I think then it would totally change that relationship'	147-148
	6	'might they judge them afterwards as being (pause) not fit to practise...really anxiety for some...might make a judgement, a negative judgment about them (pause) yeah' 'Concern about other people's judgements...how they might see you, it might change' 'well what am I going to say to people, what, what, how, what will people think...they were panicking a bit about that'	256-259 264 329-330

	7	'They feel disclosure may effect their self-esteem, or be worried that it would' 'might be concerned it may change the way people might view them...how capable people think they are...feel more vulnerable...more emotional'	160-161 145-147
	8	'I suppose people may worry it's going to to have a negative response but it isn't, I can't think of any times it has...yeah'	189-190
	<u>PERCEPTION OF SELF</u>	3	'I think that is more my insecurity'
	4	'Struggling makes you feel vulnerable'	216
	7	'Sexual related crimes...unfortunately there is more shame than perhaps a car accident...even if that is not true, the person who has the trauma might feel those judgements' 'More the victim's perception' 'I think it was more my own thoughts I put on to it'	154-157 163 223

8	'Feel guilty or ashamed about what happened...worry people would think they are terrible...it's the same with clients, they often expect that you are going to judge them badly'	226-228
1	'Judgements that are formed, psychologists are stuffy...non-inclusive...actually people need to see the person, the human side' 'We ask young people to talk about stuff all the time that I don't think we are prepared to talk about ourselves or that we find incredibly difficult to talk about'	60-63 310-311
2	'trauma a...again when we talk about childhood experiences it's more common that we think I can imagine'	271-272
3	'assistant psychologist or psychologists and you put a hat on, that is your role, are we meant to have not experienced any of our own'	298-299
6	'I suppose almost as a psychologist you could feel you are not allowed, you are not allowed to have been through a traumatic event...you have got to portray this person that is squeaky clean'	259-261

Appendix H- Experience of dealing with trauma disclosure from a colleague

Participant 5

EXPERIENCE	EMOTIONS	SHATTERED ASSUMPTIONS	LACK OF CONTROL	EMPATHY	EXPERIENCE AS INFORMATIVE	EXPERIENCE AS CONSTRUCTIVE
	Incredibly upsetting (254, 260)	Hit home (267)	Hadn't been recognised and validated in a way I would have wanted it to have been (256)	Connected with her live fear (504)	Informative experience for what you have at a practical level (260)	Positive in terms of being able to act and make a conscious move (264)
	Most difficult for feelings it brought up for me (262)	Shone a light for me how little we know what we are doing, what we are dealing with (270)	Have opportunity to be nurturing for those you supervise (370)	Thinking what the experience of sharing must have been like (261) – 'brave' (285, 515)	Brought up lots of things for me about dignity, respect, how as we wouldn't as a team respond (273)	Use upsetting energy (262)
	Unsettling (266)	Response by others as shocking (332, 327) – 'pulled the rug from under me' (335, 336)	'Didn't want to be associated with dismissive response, so freaking out on a number of levels' (490)	Want her to know I hear her story and think it is serious (313, 345)	Didn't do a good job as a team, raised that for me (275)	Driven by experience to make changes (310)
	Angry and upset people didn't act (287)	Floored me what happened had happened anyway (487, 488, 503)		Right to be scared (357, 364), Risk of re-traumatisation (346)	Realisation that the psychological care for colleagues is often not good enough (309)	Won't do the same again
	Reactions of others as really upsetting (289, 281, 278)			Could have been a source of great shame (513)	Long way to go in terms of how we treat colleagues (323)	
	Horrified (340)	'Nuts and bolts of the area you work in and didn't get that validation, care and support you deserve' (492)		Torture as ongoing as we didn't manage it better (506, 503, 507)	If client wouldn't have responded that way (277, 364, 520)	
	Process of sharing brings back original feelings (380)				Way it was managed colleague put at new risk (366)	
					Recognition of the importance of caring for colleagues (367)	