“You’re firefighting”: The experience of vicarious trauma and vicarious post-traumatic growth in psychological professionals

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Overview

This thesis portfolio comprises three parts: a systematic literature review, an empirical paper, and appendices.

Part One: Systematic Literature Review

The systematic literature review explored the vicarious trauma coping facilitators of psychological professionals. This exploration mapped across psychological, behavioural, organisational, and social coping facilitators. Thirteen studies met the inclusion criteria following a systematic literature search. Narrative synthesis enabled integration of findings from both qualitative and quantitative research. A bespoke quality assessment checklist, designed by the researcher, was utilised to appropriately assess quality. Two main themes emerged: 'individual coping facilitators', exploring psychological and behavioural facilitators, and 'systemic coping facilitators', capturing organisational and social facilitators. Interactions emerged across the themes, with considerations to how the systems around psychological professionals may mediate coping facilitators. Clinical implications and areas for future research are discussed.

Part Two: Empirical Paper

The empirical paper explored clinical psychologists' (CPs) experiences of vicarious post-traumatic growth (VPTG) within a National Health Service (NHS) context. It also explored VPTG facilitators and barriers. Seven qualified CPs, currently working in the NHS, completed semi-structured interviews. Interpretative Phenomenological Analysis (IPA) was utilised to analyse the qualitative data. Four overarching themes emerged: 'naming VPTG', 'CPs' VPTG experiences', 'a system that enables growth', and 'feeling understood'. CPs' VPTG emerged as 'development of insight', a 'shift in priorities', and 'personal meaning'. Various VPTG mediators were also identified. CPs found a shared understanding, team support, and processing spaces essential in facilitating VPTG. Barriers included perceived systemic threat, consequences, and NHS disconnect. Clinical implications and recommendations for further research are discussed.

Part Three comprises the Appendices

The appendices contain additional information to support both the systematic literature review and empirical paper. This includes the researcher's reflective statement and epistemological position.

Total word count (excluding appendices): 22246

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Part One – Coping facilitators for vicarious trauma in psychological professionals: A systematic review

This paper is written in the format ready for submission to the International Journal of Wellbeing. Please see Appendix A for the Guidelines for Authors.

Word count: 8240

Abstract

Background: Working with trauma presentations can have a significant impact on psychological professionals' (PPs) wellbeing, levels of stress, and sick leave. Vicarious Trauma (VT) conceptualises the personal effect and change resulting from indirect trauma through empathetic engagement. The review aimed to explore PPs' VT coping facilitators across psychological, behavioural, organisational, and social domains.

Method: Thirteen qualitative and quantitative studies were included within the review. A bespoke quality assessment tool was utilised to assess methodological quality. A narrative synthesis approach enabled integration of findings to create an overall picture of the VT coping facilitators utilised by PPs.

Results: Two main themes emerged: 'individual coping facilitators', exploring psychological and behavioural facilitators, and 'systemic coping facilitators', capturing organisational and social facilitators. Interactions across the themes also emerged, with considerations to how the systems around the individual may mediate individual coping facilitators. When supporting VT experiences, a culture of safety and looking beyond the workplace environment may promote staff wellbeing.

Keywords

Vicarious Trauma, coping facilitators, narrative synthesis, psychological professionals, staff wellbeing

Introduction

The wellbeing of mental health professionals has had increased focus within the UK National Health Service (NHS). Since the outbreak of COVID-19 (Agpalza & Cegelka, 2023) staff wellbeing hubs, guidance, and policies have emphasised the importance of keeping staff safe. Reports underline the increase in clinician sick leave and staff turnover associated with experiences of stress, strain, and burnout (The Kings Fund, 2019). The British Psychological Society (BPS) estimated 23% of NHS staff sickness between November 2021 and October 2022 was linked to mental health experiences (BPS, 2023). Ensuring clinicians' psychological safety and wellbeing seems paramount to meet service demand and maintain quality of care. This may be supported by continuing to understand clinicians' experiences and how to best protect and offer intervention to those working to support others. This review draws attention to the mental health and wellbeing of PPs.

Hearing the traumatic experiences of clients, on a frequent basis, can have significant effects on PPs' wellbeing. VT, coined by Pearlman and Saakvitne (1995), captures the experience of personal effect and change resulting from experiencing trauma indirectly through empathetic engagement (McCann & Pearlman, 1990). Experiences of VT include changes in personal identity, views in the world, mood, management of emotions, and desire to engage with others (Iqbal, 2015). This is associated with cognitive disruptions in ideas of safety, power, self-esteem, dependency, trust, and intimacy (McNeillie & Rose, 2021).

The onset, experience, symptoms and long-term effects of VT differ from other psychological consequences of working within a mental health profession (Jimenez et al., 2021). VT has been referred to interchangeably with other similar but different phenomenon such as Compassion Fatigue (CF) and Secondary Traumatic Stress (STS) (Sutton et al., 2022). CF (Figley,1995) captures the experience of emotional and physical effects of empathetic engagement with a reduced capacity to empathise or support clients (Stoewen, 2020). STS (Figley, 1999) is an experience that mirrors symptomatically to that of Post-Traumatic Stress Disorder due to exposure to indirect trauma (Finklestein et al., 2015). Conceptually, VT differs to STS and CF due to its emphasis on internal, cognitive changes on a schematic level (Sutton et al., 2022). In the literature, these differences are often hazy with much overlap (Branson, 2019).

PPs may be vulnerable to experiencing VT due to the nature of their work (Barre et al., 2023) and frequent exposure to details of clients' trauma (Buchanan et al., 2006). VT can occur despite professional role when exposed to traumatic themes (Jimenez et al., 2021). It is thought that personal mental health history (Leung et al., 2023), age (Way et al., 2007), styles of coping (Lerias & Byrne, 2003), and job satisfaction (Ogińska-Bulik et al., 2021) mediate experiences of VT.

VT can often go undetected, particularly since PPs are not directly involved in the traumatic event and therefore may not identify with the experience as a trauma response (Lerias & Byrne, 2003). Research indicates PPs experience barriers to seeking support, including colleague perception, potential negative consequences, and wanting to manage independently (Edwards & Crisp, 2017). VT has been linked to loss of service treatment efficiency, decrease in job satisfaction (Sui & Padmanabhanunni, 2016), and increase in sick leave (Sutton et al., 2022).

Increased interest in PPs' wellbeing may derive from a systemic focus on staff-wellbeing and trauma-informed care (TIC). TIC is a framework that acknowledges how individuals' previous experiences or trauma may present within their 'whole story' (Grossman et al., 2021). The approach has been influential in policies and practice, particularly within healthcare, for both those who access and deliver service care. Interest in TIC has influenced growing focus on how frequent trauma-focused work impacts clinicians (Branson, 2019). Similarly, the BPS recommended creating a culture of normalisation and empowerment for discussing clinician mental health experiences. This aims to reduce barriers and stigma for PPs seeking support (BPS, 2020). Although, this does not seem to be supported by the recent closure of many NHS staff Mental Health and Wellbeing hubs (BPS, 2023). Understanding the coping facilitators for VT to inform policies and service support seems paramount in preventing or managing VT experiences or crisis. This may be aided by findings from a systematic literature review.

Literature surrounding coping facilitators for VT identified preventive factors across an individuals' wider system; including self-care, therapeutic self-awareness, supervision, caseload management, spiritual beliefs, and maintaining empathetic 'distance' from clients (Aldwin, 2009; Bober & Regehr, 2006; Gerding, 2012; Pross, 2006). This suggests that a systematic literature review of coping strategies would benefit from following this holistic view to identify the variability in sources of support. Despite this, it was common for the literature reviewed to group coping strategies for VT with other concepts such as burnout (Freudenberger, 1974) or CF (Newell & MacNeil, 2010). Since these are considered distinct concepts, understanding the efficacy of these coping strategies for VT alone was limited.

Previous reviews of VT looking at coping facilitators appeared to separate domains of coping. Sutton et al.'s (2022) review focused on PPs' organisational coping facilitators however, personal support and individual coping strategies are important in managing VT (Pross, 2006). There is likely overlap in VT coping facilitators, indicating VT coping should be explored both inside and outside of the working environment. Although, Bercier and Maynard's (2015) review of VT interventions for PPs identified no suitable papers. Therefore, there appears to be a gap in the literature reviewing PPs VT coping facilitators holistically.

Aims

The proposed review aims to synthesise VT literature surrounding psychological, organisational, behavioural, and social factors that may work as both preventative and intervention strategies for PPs. This would inform future steps to supporting PPs' wellbeing in a proactive and reactive manner. Findings may also influence VT preventative curricula, such as professional training (Newell et al., 2010). The review may also support staff wellbeing, reduce staff sick leave, and aid staff retention as in line with the NHS Long-Term Plan of improving staff wellbeing (NHS, 2019).

Review questions.

1. What are the coping facilitators for VT experiences in PPs?
    a. How do PPs' organisations support VT management?
    b. What social factors support VT?
    c. What are the psychological coping facilitators for VT?
    d. What are the behavioural coping facilitators for VT?

Method

This systematic literature review was registered via the International Prospective Register of Systematic Reviews (PROSPERO) on the 29th of November 2023. The search was completed in February 2024.

Search Protocol

Relevant healthcare databases accessed from EBSCOhost included CINAHL complete, Academic Search Premier, APA PsycArticles, MEDLINE, and APA PsycInfo. Search terms were developed through reviewing existing literature titles, previously used search terms, and an online thesaurus. Search terms were devised and categorised using relevant aspects of the PICOS tool (Amir-Behghadami & Janati, 2020):

Population/patient/problem (P), Intervention (I), Comparator (C), Outcome (O), and Study Design/Characteristics (S) (see Table 1). Limiters were applied to retrieve peer reviewed and full articles that were written in English to support researcher access. The research supervisor and research librarian, with experience conducting systematic literature reviews, reviewed the search terms.

Table 1.

Search terms utilised from relevant PICOS factors (Amir-Behghadami & Janati, 2020)

PICOS				
P		**I**		**O**
“Clinical psychologist*" OR Psychologist* OR Counsellor* OR "Mental health professional*" OR therapist*OR psychiatrist* OR "Mental health practitioner*"	AND	cope* OR coping OR resilien* OR intervent* OR prevent* OR protect* OR support* OR manag*	AND	(vicarious* OR secondary*) AND (trauma* OR stress*)

OR "Mental health person*" OR “mental health worker*” OR clinician*

Inclusion and Exclusion Criteria

Table 2 and Table 3 show review inclusion and exclusion criteria with rationale.

Table 2.

Inclusion criteria with rationale

Inclusion criteria	**Rationale**
Peer reviewed	To support papers included of being high quality which in turn provides weight to conclusions drawn (Kelly et al., 2014).
Studies that use the term ‘secondary trauma’ as an alternative to Vicarious Trauma.	The terms secondary trauma or STS are often used inter-changeably with vicarious trauma (Sutton et al., 2022). Therefore, to ensure all relevant literature is included, research that explores secondary trauma or STS will be included.

Studies of vicarious trauma with professionals working in mental health.	This is the primary focus of the review, with the aim of understanding the coping facilitators in relation to PPs.
Both qualitative and quantitative or mixed-methods research.	SLR aims and research questions will be supported by literature findings across all methods (Gough, 2015).
Published in English language.	To support understanding and analysis by researcher.

Table 3.

Exclusion criteria with rationale

Exclusion criteria	Rationale
Case studies	Case studies will be excluded due to not being able to generalise findings (Evers & Wu, 2006).
Studies that have a mix of PPs and non-psychological professionals where it is not possible to distinguish findings that pertain to which group.	It is important that the findings can be attributed to PPs, as in line with the review aims and research questions.
Literature reviews/discussion papers	Literatures reviews or other reviews to be excluded as the present paper aims to review original research findings.

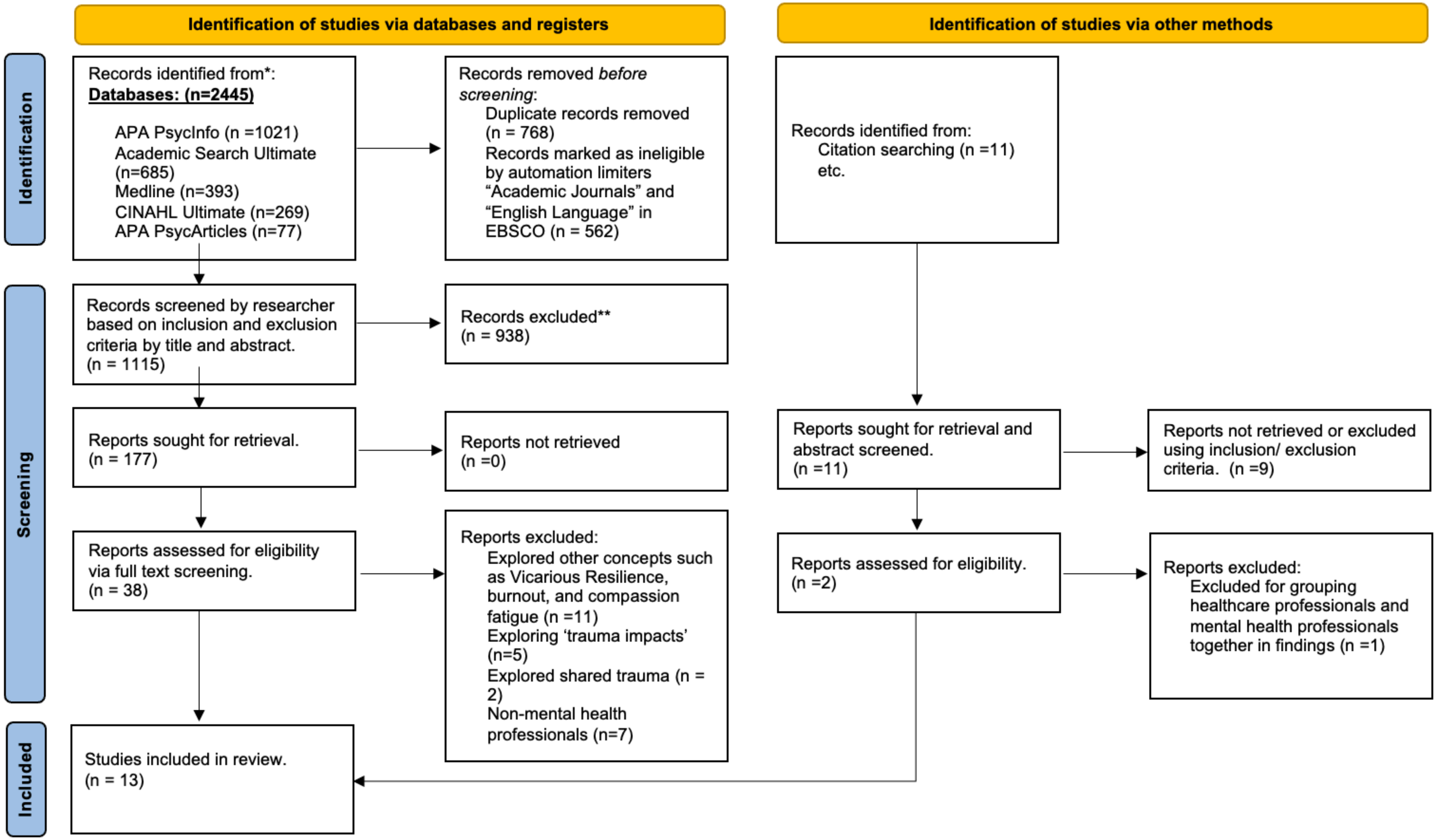
Studies that look at CF.	CF is believed to be influenced by vicarious trauma and conceptualised as a different (Figley, 1995). CF captures the psychological and physical effects or exhaustion of working with others and feeling unable to 'regenerate'. This is different from the psychological effects of VT which depicts a shift in world view or experiences (Pearlman & Saakvitne, 1995).
Studies that look at burnout.	Burnout is characterised as the experience of emotional and physical exhaustion, different in nature from VT (Freudenberger, 1974).
Studies that look at vicarious resilience.	Vicarious Resilience is the phenomenon of effect resulting from hearing about clients' resilience following trauma (Hernández et al., 2007), a different concept from VT.
Studies that solely explore the experiences of or predictors of VT	Understanding causes/predictors is not the aim of the current review.

Article Selection

The journal articles were screening by title and abstract following the removal of duplicates. Articles were excluded if they did not meet the inclusion criteria or met one or more of the exclusion criteria. Reference lists of articles identified were manually searched to explore additional papers. A total of 13 articles were included in the review. Figure 1 demonstrates the process of article selection.

Figure 1.

Article selection summary using Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) flow diagram (Page et al., 2021)



Records identified from*:
Databases: (n=2445)
APA PsycInfo (n =1021)
Academic Search Ultimate (n=685)
Medline (n=393)
CINAHL Ultimate (n=269)
APA PsycArticles (n=77)

Records removed *before screening*:
Duplicate records removed (n = 768)
Records marked as ineligible by automation limiters "Academic Journals" and "English Language" in EBSCO (n = 562)

Records identified from:
Citation searching (n =11)
etc.

Records screened by researcher based on inclusion and exclusion criteria by title and abstract. (n = 1115)

Records excluded** (n = 938)

Reports sought for retrieval. (n = 177)

Reports not retrieved (n =0)

Reports sought for retrieval and abstract screened. (n =11)

Reports not retrieved or excluded using inclusion/ exclusion criteria. (n =9)

Reports assessed for eligibility via full text screening. (n = 38)

Reports excluded:
Explored other concepts such as Vicarious Resilience, burnout, and compassion fatigue (n =11)
Exploring 'trauma impacts' (n=5)
Explored shared trauma (n = 2)
Non-mental health professionals (n=7)

Reports assessed for eligibility. (n =2)

Reports excluded:
Excluded for grouping healthcare professionals and mental health professionals together in findings (n =1)

Studies included in review. (n = 13)

Data Extraction

To effectively extract the relevant data from each article, a table was designed to capture and summarise key points (see Appendix B). This bespoke table was developed through considering the key information relevant to answering the research questions. This included authors, year of publication, aims, design and method of analysis, population and sampling, VT coping facilitator explored, and summary of findings for each study.

Quality Assessment

A bespoke Quality Assessment tool was developed by the researcher to appropriately assess the qualitative and quantitative studies included in the review (see Appendix C). This checklist utilised items from the NICE quality appraisal tool (National Institute for Health and Care Excellence, 2012), the Downs and Black checklist (Downs & Black, 1998), the Mixed Methods Assessment Tool (MMAT) (Pluye et al., 2009), and the Critical Appraisal Skills Programme (CASP) checklist for qualitative research (Critical Appraisal Skills Programme, 2018). Quality was assessed across six domains: theoretical approach, study design, data collection, validity/reliability, analysis, and ethics. By bringing together various quality items, appropriate quality assessments were conducted for each study while accounting for variability in their methodology. The bespoke assessment tool explored factors such as research relationship, biases, and analysis reliability which were deemed of particular importance for 'trustworthiness' during synthesis. Questions were scored either 'n/a', '0', '1', or '2'. Scores were converted into percentages, with 0% being the lowest and 100% being the highest. A second reviewer, separate from the research, also scored the articles using the bespoke quality assessment tool. Discrepancies were discussed during until a final rating was agreed.

Data Synthesis

Narrative Synthesis was utilised to analyse the results of the studies following the framework of Popay et al., (2006). Due to the studies' heterogeneity of aims, context of settings, and conceptualisations, narrative synthesis was deemed appropriate. Narrative synthesis supported the integration of research findings, from qualitative and quantitative research combined, to develop a preliminary synthesis relevant to clinical practice.

The following steps were taken to carry out the Narrative Synthesis (Popay et al., 2006) and create an overall picture of the present knowledge:

- Developing a theory-based understanding of coping facilitators of VT for PPs.
- Constructing a preliminary synthesis of the findings.
    - This included descriptive summaries followed by groupings. Tabulation was also used to identify patterns.
- Exploring the relationships within the data
    - Exploration of similarities or contradictions across the studies relating to the review questions.
- Assessing the robustness of the synthesis.
    - This included utilising the quality assessment checklist, engaging in supervision reflections, and linking back to the existing literature of VT.

Researcher position

The first author acknowledges their own narratives and understanding of VT due to the nature of their current professional position. The researcher identifies as a white, British, cis female working within the NHS as a third-year trainee CP. Due to two years clinical experience, perspectives of potential coping facilitators for VT have begun to develop. To ensure these narratives were held in mind, the researcher maintained a reflective journal and engaged in regular supervision. While this aimed to support transparency and rigour of the analysis through reflexivity (Berger, 2015), it is also acknowledged that these narratives will likely have continued to hold influence.

Results

Descriptive overview of the studies included.

The initial search identified 1115 articles for screening. Following the exclusion criterion, 13 articles were deemed suitable (see Figure 1). Studies were published between 1998 and 2022: four from Australia, three from Canada, six from USA, and one from Iran (see Table 4).

Of the 13 studies, eight used a qualitative methodology, and five used quantitative. Across these studies, 1145 PPs were included, varying from 2–518 participants. These PPs ranged from counsellors (n=117), psychologists (n=81), trauma therapists (n=17), mental health social workers (n=285), child and welfare professionals (n=237), clinicians and supervisors (n=115), and PPs grouped as ‘mental health professionals’ (n=289). To ensure the heterogeneity of the varying professions were fully captured, the term ‘psychological professionals’ has been used throughout the results analysis. Of the demographics disclosed, 699 PPs were female (83%) and 147 were male (17%), with two studies not providing these figures. Length of time working, age ranges, and race were not consistently reported across the studies.

Purposive sampling was the predominant recruitment strategy, with snowball sampling (Bell, 2003; Roberts et al., 2022), convenience sampling (Beckerman & Wozniak, 2018), and cluster sampling (Ting et al., 2008) also being utilised. Coping strategies or styles were the primary focus of 10 studies, with one exploration targeting support available across systems (Strolin-Goltzman et al., 2020). For quantitative studies, outcome measures of stress, coping, and impact of event scales were utilised. Qualitative studies predominantly opted for semi-structured interviews, with one study following a narrative approach. There was a variety of quantitative analysis techniques, mostly focusing on correlation or regression analysis. Qualitative analysis techniques included Thematic Content Analysis, Thematic Analysis, Grounded Theory, and Phenomenological Research Method (Moustakas, 1994).

Some studies explored coping strategies more broadly than others, meaning their findings contributed across differing themes more than other studies (Harrison & Westwood, 2009; Hunter & Schofield, 2006; Roberts et al., 2022; Ting et al., 2008). Other studies explored coping strategies of specific domains, which tended to use quantitative methodologies measuring strategy effect (Deblinger et al., 2020; Diehm et al., 2019; Strolin-Goltzman et al., 2020).

Table 4.

Overview of the included studies

Authors, Year, Country	Research Aims	Research Design	Population and sampling	Intervention	Summary of findings relating to coping facilitators	Quality Rating
Steed and Downing (1998) **Australia**	To investigate the VT effects for female therapists working with sexual abuse or assault survivors and coping strategies.	Qualitative Semi-structured interviews Thematic content analysis	Purposeful sample 12 female therapists 4 counsellors 8 psychologists	Coping strategies for VT	Maintaining professional boundaries, debriefing, ongoing development, and supervision. Preventative strategies including creating work life balance, compartmentalising work from home, and self-awareness of own vulnerabilities which in turn helped seek support from supervision. Importance of training and education around VT for confidence and validation of VT experiences.	47%
Ting et al. (2008)	To explore types of support,	Quantitative	Cluster sampling.	Coping behaviour Support available	Predictors of positive coping: family and friends, group therapy, religious	75%

USA	perceived effectiveness of support, and coping strategies with Mental Health social workers who have experienced fatal and non-fatal client suicidal behaviour.	The Secondary Traumatic Stress Scale Coping and available support measured through questions developed. One time point. Hierarchical multiple regression analysis	285 mental health social workers. 217 females 68 males		beliefs (prayer), supervision, exercise, meditation and help seeking. Inferred quality of supervision is important. Inferred family and friends' ability to empathise, being a burden. Peer supervision less available but deemed most effective, suggestion of empathy and understanding.	
Naghavi and Samlimi (2018) **Iran**	To explain the experiences of VT and consequences for rehabilitation counsellors.	Qualitative Collaborative autoethnographic approach. Thematic analysis	2 counsellors 2 Female	Coping strategies.	Journal writing, mental health support, peer support, yoga, meditation, and understanding supporting managing VT experiences and promoted growth.	78%
Deblinger et al. (2020) **USA**	A preliminary examination of levels of STS before and after TF-CBT engagement.	Quantitative Pre-to-post training (TF-CBT) analysis Comparison of pre-to post-training stress, behaviours, and activities means.	Purposive sampling 115 clinicians and supervisors 103 females 12 males	Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) with a 'PRACTICE what you preach' focus.	TF-CBT linked to a decrease in STS experiences and increase in use of coping skills included in the TF-CBT framework. Social support, active coping, humour, and restraint. Included in TF-CBT:	89%

		Repeated MANOVA's			Physical activity, social activity, mindfulness, gratitude, reflective listening, focused breathing, cognitive coping, writing activity, PRACTICE skills.	
Hunter and Schofield (2006) **Australia**	Explore how counsellors coped with the impact of traumatic clients' experiences and what helped develop these strategies.	Qualitative Open-ended interviews Grounding theory	Purposive sampling 8 Counsellors 1 male 7 females	Resources/coping strategies. -personal -professional -organisational	Professional and personal life balance was one of the most important factors identified. All counsellors discussed taking responsibility for their own self-care as a prevention for VT. Belief that physical activity was a great stress reliever, independent on how much they engaged. Use of In-session strategies, breathing, imagery. Supervision, looking for someone who can trust and feel safe with, with knowledge to advise. Valuable role for informal debriefing that does not take a psychological/therapeutic position and peer support, with team confidentiality.	64%

Strolin-Goltzman et al. (2020) **USA**	To explore the macro- or mezzo-environmental levels effects on STS experiences within child welfare and mental health populations.	Quantitative Structural equation modelling. Community assessment tool Bivariate correlations and multiple mediator model for analysis.	Purposive sampling 237 Child welfare and 281 mental health professionals. 195 females 41 males	Strategies to prevent and intervention for STS.	Coping strategies split into Micro-(individual factors), mezzo- (organisational factors), and macrolevel factors (community factors). Transformative leadership= prepares for positive growth and change Interprofessional collaboration= trust, understand roles and sharing information. Competency, collaboration, and leadership were found to be protective factors for STS. Micro= feelings of mastery and competency as a preventative factor for STS. Mezzo= positive relationship between work time pressures and STS experiences.	81%
Harrison and Westwood (2009)	To identify protective practices for VT experiences	Qualitative Narrative method of exploration.	Purposive sampling 6 trauma therapists.	Protective practices for VT.	Twelve themes: Countering isolation to restore balance, self-awareness, professional development, openness to	97%

Canada	among trauma therapists.	Thematic content analysis.	Female and male		unknown, holistic self-care, hope, optimism, problem solving, boundaries, use of imagery and metaphors, empathy, professional satisfaction, mindfulness, and meaning making. Finding of empathy being a protective factor challenges previous literature that suggests empathy in therapy increases risk of VT.	
Diehm et al. (2019) **Australia**	To explore the experience of VT and contributing factors, and to examine whether social support acts as a moderating factor.	Quantitative Secondary Traumatic Stress Scale Social support Questionnaire. Correlation, regression, and moderation analyses	Purposive sampling 77 psychologists 63 females 14 males	Social support as a moderating factor.	Social support was found linked to STS experiences and a third-party moderator between clinical contact hours and STS experiences. Social support moderating the hours of clinical contact and STS, therefore a mediator. Low levels of social support increased levels of STS	61%
Bell (2003) **USA**	To explore a strengths-based approach as a framework for understanding	Qualitative Semi-structured interviewing	Snowball recruitment 30 counsellors working with female	Strengths based approach to coping with STS experiences	Have a sense of competence about coping and it being ‘successful’ outweighed the type of coping strategy used.	75%

	STS with counsellors.	2 interviews, nearly 1 year apart. Grounded theory method- data collection.	domestic violence victims 29 females 1 male		Maintaining an objective motivation, such as personal experiences and/or academic interest. Resolving personal traumas was found to prevent VT. Drawing on positive models of coping Having buffering personal beliefs.	
Baker (2012) **USA**	To understand graduate-level trauma therapists' experiences of VT and their effective coping.	Qualitative 2 semi-structured interviews across a 15-month period. Phenomenological Research Method, (Moustakas, 1994)	Purposive sampling 11 masters-level trauma therapists who were also on a doctoral programme. 'Almost all female'	Effective coping strategies to manage VT.	Coping intellectually/professionally, spiritually, and physically with VT experiences. - Talking with colleagues/supervisors. - Religion (meditation, prayer, trust in God). This was discussed as both a VPTG concept, such as a deeper sense of connection, and a strategy. - Physical exercise.	78%
Dunkley and Whelan (2006)	To explore telephone counsellors' experiences of	Quantitative	Purposive sampling	Influence of coping styles and supervision on VT measures.	'Dealing with the problem' was the most frequently used coping strategy.	78%

Australia	VT, investigating both intrinsic and external influences of coping.	Coping Scale for adults (short form) – Supervisory Working Alliance Inventory (supervisee scale) The Trauma Attachment and Belief Scale The Impact of Event Scale-Revised. One-way ANOVA Pearson's correlation Standard multiple regression	62 telephone counsellors of a pool of 137 from trauma services. 54 females 8 males		Strong supervisor relationships were associated with lower levels of cognitive beliefs disruptions. Strong supervisory working alliances was 'partially' associated with lower VT experiences.	
Roberts et al. (2022) **Canada**	To examine the influencing factors of VT experiences on fly-in and fly-out mental health service providers.	Qualitative Semi-structured interviews Thematic analysis	Snowball sampling 8 'fly-in fly-out' mental health service providers. 6 females 2 males	Factors that influence experiences of VT, mitigation strategies.	Organisational strategies support the reduction in VT experiences and reduce its risk. - Self-care, exercising, supportive network. - Debriefing, colleagues, and supervisor. - Mental health support	92%

Beckerman and Wozniak (2018) **USA**	To identify the range of experiences of STS and related psychosocial factors with domestic violence counsellors.	Qualitative Pre-set code for analysis based on existing literature themes and emerging themes.	Convenience sample 11 domestic violence shelter counsellors 11 females	Experiences of STS, including methods of coping.	Self-care, finding a comforting balance against the nature of the work, exercise, and meditation. Socialising with colleagues after work to 'blow off steam'. Culture, community, religion, and family indicated as both sources of support and stressors. Mentally separating client experiences from their own.	89%

Methodological quality assessment

Quality assessment scores are included in Table 4. For a full break down of assessment, see Appendix D.

All studies were rated above 60%, except Steed and Downing (1998) which received a rating of 47%. This was due to the lack of richness of information the authors attributed to their write up. Despite this, there was rationale to include this study as most quality criterion were rated ‘partially’ (1) meaning the information was present but lacked depth. The highest rating was 97% to which captured the detail of Harrison and Westwood's (2009) exploration.

A key strength was the detail of theoretical approach and study design, providing clarity of the purpose and aims which were in-line with the research methods. All quantitative papers had full ratings (2) on ‘Analysis’ checklist items, whereas there was more variability of analysis reporting in qualitative studies. This seemed attributable to the lack of information outlining qualitative analysis procedures. All qualitative studies did support reliability through utilising multiple coders or participant feedback. All studies’ findings were deemed relevant to their aims, strengthening the rationale for including these studies within the current review.

The checklist items attracting the lowest ratings were for ‘ethical considerations’. There was a lack of detail surrounding researchers’ positioning and reflexivity of their role or biases. Only 3 of the 13 studies detailed the researchers’ positioning (Baker, 2012; Harrison & Westwood, 2009; Roberts et al., 2022). Majority of the studies reported ethical approval, although there were frequently gaps of detail regarding their ethical considerations (Baker, 2012; Dunkley & Whelan, 2006; Roberts et al., 2022; Strolin-Goltzman et al., 2020).

Narrative Synthesis of findings

Coping facilitators were organised into psychological, social, organisational, and behavioural domains, in line with the research questions. Throughout these domains, coping facilitators were interpreted to fall within two overarching themes: 1. ‘Individual coping facilitators’ and 2. ‘Systemic coping facilitators’.

‘What are the coping facilitators of VT experiences in psychological professionals?’

1. Individual coping facilitators

Individual coping facilitators captures components that were interpreted to be internal processes. These were deemed to be within the realm of the individual and mediated by the individuals’ engagements/actions. Individual coping facilitators were split into psychological and behavioural themes.

1.1 Psychological

A component identified as an individual coping facilitator for VT was psychological experiences. This factor captures the mental state and internal mechanisms or processes described by PPs. This was often discussed in abstract concepts such as an underlying ‘sense’ or perception.

Creating Psychological Safety

Creating a sense of psychological safety was prominently discussed as a preventative coping facilitator for VT. Protective personal beliefs were perceived to be central to this. These personal beliefs were a source of strength, with the function rather than content mediating VT (Baker, 2012; Bell, 2003). PPs’ appraisal of difficult experiences and whether their beliefs had a protective effect influenced how the beliefs impacted.

Beliefs of PPs' own limits and realm of competency to influence or change alleviated internal expectations and pressures (Beckerman & Wozniak, 2018). Maintaining their own beliefs of the world, rather than adopting those of their clients, seemed essential in PPs' psychological protection and safety (Beckerman & Wozniak, 2018).

Compartmentalising experiences was also linked to developing psychological safety through having awareness of psychological boundaries and avoiding emotional fusion (Beckerman & Wozniak, 2018). To avoid emotional fusion would indicate that PPs maintained their own emotions without 'taking on' or adopting their clients' emotions and experiences. Actively attempting to avoid picturing the client and their experiences supported compartmentalisation (Steed & Downing, 1998). Thus, compartmentalising may be facilitated by creating a psychological boundary between professionals and clients' experiences to buffer against VT.

Understanding Self

Self-awareness of own vulnerabilities, including for VT experiences, acts as a catalyst for seeking support from others (Harrison & Westwood, 2009; Steed & Downing, 1998). Without an understanding of the PPs' own experiences, they may not recognise the need for support. Self-awareness may encompass understanding stress reactions, responses, and potential vulnerabilities (Steed & Downing, 1998). It is likely that these reactions and vulnerabilities may link to PPs' personal history, particularly personal traumas. PPs who feel they have resolved personal trauma's report lower levels of stress (Bell, 2003).

Linking to this, resolving personal traumas protects against VT through understanding the processes in their clients' healing (Bell, 2003). This may be associated with PPs having their own lens of the personal meaning created from processing trauma, to which develops self-awareness and a sense of competence (Bell, 2007; Harrison &

Westwood, 2009). This understanding of self also supports monitoring personal reactions during sessions. In turn, this enables acknowledgement of when additional support or adjustments to caseload are necessary (Steed & Downing, 1998). These factors themselves are identified as coping facilitators of VT, indicating that PPs' understanding of themselves precipitates and facilitates other VT coping strategies.

Outlook and Feelings

PPs' outlook and feelings towards their work and experiences may mediate VT. Experiencing optimism and hope influences outlook on trauma work and managing VT experiences (Bell, 2003; Harrison & Westwood, 2009; Hunter & Schofield, 2006). Holding a hopeful and optimistic outlook that clients can heal from trauma mediated secondary impacts of the work (Harrison & Westwood, 2009) . This may be associated with maintaining a positive outlook in the processes of trauma therapy and understanding the complexities in trauma interventions. Despite this, Dunkley and Whelan (2006) reported no link between optimism and levels of VT. Therefore, this may be a strategy that encompasses other mediating factors, such as the resources available or system pressures.

Having a sense of competency for managing VT experiences was linked to a reduction in VT (Strolin-Goltzman et al., 2020). This encompasses feeling confident and successful in VT responses and implementation of coping strategies (Bell, 2003; Hunter & Schofield, 2006). This was regardless of the strategy employed (Bell, 2003). This suggests that confidence in coping ability is positively linked to appraisal of VT coping. However, it is unclear whether this comes from previously utilising VT strategies but did appear to be mediated by interprofessional collaboration (Strolin-Goltzman et al., 2020) such as feeling supported by colleagues.

Psychological Approach and views of VT.

Finally, conceptualisation of VT experiences influences PPs' approach and behaviour. Some studies suggested VT as a 'problem' that needed to be managed (Dunkley & Whelan, 2006; Harrison & Westwood, 2009). Being able to self-advocate and be proactive in 'taking care' supported experiences of disruptions in cognitive beliefs seen in VT (Deblinger et al., 2020; Dunkley & Whelan, 2006). Acknowledging the presence of VT and taking responsibility for acting upon this was a preventative strategy (Hunter & Schofield, 2006). This connects to the previous subtheme of 'understanding self' in noticing the effects of trauma work and consciously attending to how these experiences can be managed (Harrison & Westwood, 2009). This then enables PPs to seek support or implement strategies (Dunkley & Whelan, 2006; Harrison & Westwood, 2009; Hunter & Schofield, 2006). Although, views of this 'responsibility' varied across the PPs, colleagues, and supervisors (Dunkley & Whelan, 2006; Harrison & Westwood, 2009; Hunter & Schofield, 2006; Strolin-Goltzman et al., 2020).

To conclude, there are psychological coping facilitators for VT. These encompass PPs' sense of psychological safety, understanding of themselves, outlook or feelings, and approach to VT management. It appears that many of the psychological coping facilitators mediate or influence each other.

1.2 Behaviours

The second component identified as an individual coping facilitator for VT was 'behaviours'. Behavioural facilitators encompassed activities and actions within the realm of the individual. Self-care was a key aspect within this component, with an interpreted goal of finding a comforting balance to the nature of trauma work. Self-care was discussed within 11 of the 13 studies, often referenced as a routine to be developed (Baker, 2012; Beckerman & Wozniak, 2018; Deblinger et al., 2020; Dunkley & Whelan, 2006; Harrison &

Westwood, 2009; Hunter & Schofield, 2006; Naghavi & Salimi, 2018; Roberts et al., 2022; Steed & Downing, 1998; Strolin-Goltzman et al., 2020; Ting et al., 2008). There was a level of importance placed on developing self-care routines prior to training to protect against VT (Harrison & Westwood, 2009) before starting clinical work.

Physical activity

Seven of the 13 studies acknowledged physical activity as a coping facilitator for VT and a key component of self-care (Deblinger et al., 2020; Naghavi & Salimi, 2018; Roberts et al., 2022; Steed & Downing, 1998). Physical exercise was described as action orientated coping (Ting et al., 2008), spanning across going to the gym, walking, dance, swimming, or playing sports (Hunter & Schofield, 2006). Exercise, meditation, and breathing exercises were noted to intentionally reduce stress as a prevention and intervention strategy (Baker, 2012; Beckerman & Wozniak, 2018; Deblinger et al., 2020; Hunter & Schofield, 2006). Meditation and yoga were also linked to spiritual components (Baker, 2012; Naghavi & Salimi, 2018; Roberts et al., 2022), with yoga being named to create a mind-body connection.

Physical activity was linked to feelings of relief following the emotional demands of trauma work (Hunter & Schofield, 2006). Further, as a method to create quiet time (Roberts et al., 2022) and separate work from home (Hunter & Schofield, 2006). This suggests that physical activity creates pauses in PPs’ lives and is a way to decompress or process experiences. It also links to compartmentalisation and creating psychological safety. The positive impact of physical activity on VT was independent to frequency or intensity of engagement (Hunter & Schofield, 2006).

Reflection

Some strategies identified were interpreted as behaviours that create space for reflection. This could link to a previous idea of creating self-awareness. Journal writing and 'writing activities' were described as self-care that encouraged reflection and supported VT experiences (Deblinger et al., 2020; Naghavi & Salimi, 2018). Prayer created space for introspection (Baker, 2012) and positive coping (Ting et al., 2008), and was described as tool to connect to God in times where guidance was needed (Baker, 2012). This indicates a desire for connection, spiritual guidance, or support. Mindfulness was considered a technique in compassionately developing awareness of PPs' experiences working with trauma presentations (Deblinger et al., 2020; Harrison & Westwood, 2009). Therefore, these techniques enable PPs to manage their own experiences before, during, and after sessions, to consistently arm against difficult experiences and stress.

Outsourcing

Seeking external support, typically within PPs' personal realms, was conceptualised as outsourcing. This encompassed seeking external support outside of the organisation as a personal responsibility, either regularly or occasionally (Diehm et al., 2019; Hunter & Schofield, 2006).

Mental health support, such as therapy, was considered a form of self-care and a positive coping behaviour for VT (Naghavi & Salimi, 2018; Ting et al., 2008). This also included engaging in therapeutic interventions and strategies that are used with clients (Deblinger et al., 2020). Group therapy and individual therapy were also considered methods of help-seeking (Hunter & Schofield, 2006; Naghavi & Salimi, 2018; Roberts et al., 2022; Ting et al., 2008). In turn, help-seeking was mediated by experiences of VT responses and self-awareness (Steed & Downing, 1998; Ting et al., 2008). Further, personal therapy was sourced either through PPs' organisations or externally, with the view that organisations should provide internal mental health support (Hunter & Schofield, 2006; Roberts et al., 2022). This suggests that some organisations may not provide mental health support. This is likely a barrier for VT coping due to PPs' perception of how much their service values and invests in staff support. However, some PPs did prefer to seek private counselling due to knowing many counsellors through their profession (Hunter & Schofield, 2006). Engaging in mental health support gave insight into client experiences and increased empathy (Hunter & Schofield, 2006) through being an expert by experience. Therefore, not only does outsourcing support VT experiences but may also have therapeutic benefits.

Boundary setting

Considering the strategies within this review, many VT coping facilitators had a commonality in creating a work-life balance. The aim of which was to implement strategies to counterbalance difficult experiences, or to mark the end of the working day. This encompassed balancing the nature of trauma work through action and creating physical or psychological comfort (Beckerman & Wozniak, 2018; Steed & Downing, 1998). Self-care strategies could then be implemented to create personal and professional boundaries (Steed & Downing, 1998). Practically, this included not answering emails/calls after work, annual leave, and scheduled holidays (Hunter & Schofield, 2006). Further, to independently pursue activities outside of work (Steed & Downing, 1998). How work-life balance was created was interpreted as individual and less important to ensuring its presence (Beckerman & Wozniak, 2018; Hunter & Schofield, 2006; Steed & Downing, 1998).

Some PPs found it important to implement set routines, or rituals, pre and post client contact to reduce experiences of stress and prepare, focus, and defuse (Hunter & Schofield, 2006). They were also used to mark the start or end of client contact, which may support processing of therapeutic experiences. This further develops the idea of creating a distinction between client and professional experiences, linking to subthemes of psychological safety and the concept of compartmentalising.

To conclude, the theme of behavioural coping facilitators explores action orientated strategies to manage VT. These strategies focus on individual implementation and have an underlining idea of creating personal time for the PP. Self-care was a running theme across this component, with many aspects of subthemes being part of a self-care routine.

2. Systemic Coping Facilitators

Systemic coping facilitators encompassed components that appeared to be linked to external processing. These factors were mediated by the system around the individual, such as the organisation or individuals within their network. Further, how the individual is held by their system. Systemic coping factors were thought to be influenced by something other than the individual themselves to cope with VT.

2.1 Organisational

The third theme identified as a coping facilitator for VT was 'organisational'. This factor captures the role of PPs' organisation in managing VT through their approach, opportunities, processing spaces, and environment.

Processing spaces

Creating organisational spaces to process trauma work, such as supervision and debrief meetings, positively influenced VT coping. These spaces acted as both a prevention and intervention strategy, as well as a method to increase self-awareness.

Ongoing supervision was a key processing space that mitigated risks of VT (Harrison & Westwood, 2009; Steed & Downing, 1998; Ting et al., 2008), particularly for less experienced PPs (Naghavi & Salimi, 2018). Clinical and professional supervision was associated with continuous ‘check-ins’, processing, and a way to maintain balance (Harrison & Westwood, 2009; Roberts et al., 2022). Evidence suggested the presence of supervision alone was obsolete without a strong supervisory relationship (Dunkley & Whelan, 2006). Trusting the supervisor, feeling safe, reassured, not being shamed or blamed were highlighted as key in supervisor alliances (Harrison & Westwood, 2009; Hunter & Schofield, 2006). It was also important that supervisors were able to offer knowledge and expertise in advising a plan moving forward (Hunter & Schofield, 2006). Strong supervisory relationships were also found to reduce cognitive belief disruptions (Dunkley & Whelan, 2006). Alternatively, supervision that focused on interprofessional collaboration rather than self-care was deemed most effective for managing VT (Strolin-Goltzman et al., 2020). Although discussions of wellbeing were also important (Roberts et al., 2022). This creates the idea that the content and approach of supervision mediates whether the presence of supervision is effective.

Despite this, from the view of some PPs, group and peer supervision were considered more effective than individual supervision (Ting et al., 2008). Being able to collaborate with other professionals in sharing information protected against VT experiences and countered isolation (Harrison & Westwood, 2009; Strolin-Goltzman et al., 2020). Through engaging in peer/group supervision, VT strategies can be shared and self-awareness is thought to develop (Harrison & Westwood, 2009). It is also likely that peer platforms develop a sense of shared understanding (Diehm et al., 2019) and normalisation, without dominant power imbalances.

Debriefing was also considered an important processing space to manage VT experiences (Steed & Downing, 1998). Formal and informal debriefing with colleagues provided a space for open and honest dialogue away from a therapeutic position (Hunter & Schofield, 2006; Roberts et al., 2022; Strolin-Goltzman et al., 2020). This was further linked with empathy, understanding, and normalisation from colleagues (Roberts et al., 2022; Ting et al., 2008). Processing experiences through collaborative healing and group discussions were underlined as essential in buffering VT (Baker, 2012; Harrison & Westwood, 2009; Roberts et al., 2022).

Creating safety

When working with trauma presentations, creating a safe organisational environment is essential. In doing so, PPs are more likely to explore VT experiences and reach out for support in managing the effects.

Organisations acknowledging and discussing VT mediates VT experiences and develops a culture of understanding (Naghavi & Salimi, 2018; Steed & Downing, 1998). PPs voiced training, including psychoeducation and coping strategies, as fundamental to normalising and identifying when VT arises (Baker, 2012; Naghavi & Salimi, 2018; Steed & Downing, 1998). VT training was linked to the development of self-care strategies, increased VT awareness, and clarification of experiences (Baker, 2012; Harrison & Westwood, 2009; Naghavi & Salimi, 2018; Steed & Downing, 1998). Therefore, understanding VT may guard against the experience due to being able to notice and act against early warning signs.

Training may also come from specific programmes that enable PPs to tap into client therapeutic experiences. It is also possible that PPs experience therapeutic benefits themselves from facilitating interventions with clients. Deblinger et al.'s (2020) evaluated the effects of facilitating Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) with encouragement for the PPs to use the coping skills drawn upon. These skills included physical activity, social activity, mindfulness, expressing gratitude, reflective listening, focused breathing exercises and writing activities (such as thought journals). The findings suggested that through promoting and supporting PPs to engage in the TF-CBT skills, VT reduced. This indicated that encouragement to utilise the TF-CBT skills enabled PPs to engage in the skills they likely use every day. Therefore, organisations could also promote and underline the benefits of using intervention skills to manage VT.

Creating safety was also linked to developing an organisational culture of maintaining professional boundaries and encouragement to self-care. This was particularly through ensuring to take leave and feeling safe to do so as seen in the previous theme of ‘boundary setting’ (Hunter & Schofield, 2006; Steed & Downing, 1998; Strolin-Goltzman et al., 2020). It was important that organisations foster empathy and move away from stigma that may be attached to feelings of VT. Further, that employers and supervisors support PPs to monitor caseloads and balance trauma presentations (Harrison & Westwood, 2009; Hunter & Schofield, 2006). A workforce that fosters trust and a shared understanding of roles may also facilitate VT coping (Strolin-Goltzman et al., 2020). This seems to develop a sense of being understood and appreciated by the organisation and colleagues. This likely creates a sense of belonging (Diehm et al., 2019)and therefore safe space to share VT experiences.

Creating change

Finally, organisations that promote and facilitate change is a coping facilitator for VT. Feeling supported to grow and ongoing professional development underpins preventing VT experiences. This is further facilitated by adopting a transformative leadership approach which was outlined as leaders influencing and preparing for positive growth through the facilitation (Strolin-Goltzman et al., 2020). This links to creating space and opportunities for clinical professional development to which increases feelings of competence (Steed & Downing, 1998). It is likely that transformative leadership has this effect due to its link with a reduced feeling of time pressures, which thereby enables space for ongoing professional development. Even so, an approach of transformative leadership reduces VT experiences (Strolin-Goltzman et al., 2020). Similarly, professional development alone was discussed as an intervention for VT experiences, and a way to anchor PPs to the clinical community (Harrison & Westwood, 2009). Therefore, professional development appears to enable PPs to maintain a sense of connection to their work and other colleagues. Overall, it feels unlikely that professional development can be undertaken if the system and leadership approach does not facilitate or promote this.

To conclude, organisational factors support VT coping. These facilitators are external to the individual and fall within the responsibility of the organisation to foster. Through creating processing spaces, a sense of safety, and opportunities for change, PPs may feel valued and heard within their service. In doing so, wellbeing and VT experiences can be prioritised.

2.2 Social

Social coping facilitators were discussed within 11 of the 13 studies. This explores the idea of having others to rely on and talk to in times of distress or VT (Diehm et al., 2019). Underlying emotional aspects of social relationships were also identified by PPs.

Connection

Several studies captured positive effects of being connected to others in coping with VT. Having a supportive network that included both connections within PPs' personal and working life were highlighted (Roberts et al., 2022). This social support was found to mediate the existing relationship between hours of clinical contact and levels of VT (Diehm et al., 2019). This indicates that the presence of social support can reduce VT and buffer against other work-related factors (Harrison & Westwood, 2009; Steed & Downing, 1998).

While Diehm et al. (2019) looked at overall social support, other studies identified family, friends, peers and colleagues, culture, community, and clergy/religion as predictors of positive coping (Baker, 2012; Beckerman & Wozniak, 2018; Deblinger et al., 2020; Hunter & Schofield, 2006; Ting et al., 2008). For some PPs, talking to colleagues and supervisors was deemed the most effective in managing VT (Baker, 2012) and as a way to unwind (Hunter & Schofield, 2006). However this form of connection was not always available (Dunkley & Whelan, 2006; Ting et al., 2008), indicating some PPs did not have social support available. Despite this, socialising with colleagues away from the working environment was deemed a way to 'blow off steam' through informal interactions such as humour (Beckerman & Wozniak, 2018; Deblinger et al., 2020). This implies feeling connected to colleagues and being able to defuse with them outside of the working environment.

Additionally, being connected to family and friends was found to be one of the most available sources of social support (Ting et al., 2008). Although, culture, community, religion, and family were also indicated as potential stressors (Beckerman & Wozniak, 2018). This may suggest that PPs are reluctant to seek support from these sources due to risk of increased distress. Further, being connected to family members enabled some PPs to draw upon positive family role models to manage VT (Bell, 2003).

Perceived emotional support

'Perceived emotional support' interprets emotional aspects of social support that may impact feeling connected. Simply having connections may not be enough. Empathy, understanding, and not feeling a burden were underlying aspects of effective support from family, friends, and peers (Ting et al., 2008). Importantly, having a personal network with reciprocity and mutual caring is also essential (Harrison & Westwood, 2009). This would suggest that for connections to be meaningful, PPs must feel emotionally supported within these relationships. This emotional aspect appears to mediate the effectiveness of social connections.

The theme of ‘social’ coping facilitators captures the idea that being connected and close to other individuals supports coping with VT. Through having meaningful connections with perceived emotional support, PPs can develop a social network inside and outside of their professional role. However, social support was not available for all participants.

Discussion

Overview of findings

This review explored PPs’ VT coping facilitators, emerging across themes of ‘psychological’, ‘behavioural’, ‘organisational’, and ‘social’. These were identified as ‘individual’ or ‘systemic’ coping facilitators and were synthesised holistically with their wider contexts considered. This supports literature of varying coping facilitators and sources of support across systems (Aldwin, 2009; Bober & Regehr, 2006; Gerding, 2012; Pross, 2006). The current findings build upon previous literature in discussing the relationships across the coping facilitators’ themes rather than focusing on identifying their presence.

Overall, PPs who experienced VT use a wide range of prevention and intervention coping strategies to manage VT. Many of the subthemes influenced other subthemes making it difficult to consider these in isolation. This is line Pross’ (2006) stance that coping strategies overlap. Feedback loops linked many subthemes since similar concepts were identified throughout. Feedback loops are referred to with the idea that subthemes were promoted and facilitated by other subthemes, acting as reinforcers (Adams, 1968). ‘Creating psychological safety’ is an example of a perceived feedback loop whereby compartmentalisation was a key aspect of VT prevention and intervention (Steed & Downing, 1998).

Compartmentalisation was also indicated when PPs engaged in physical activity and aimed to create boundaries between work and home (Beckerman & Wozniak, 2018; Hunter & Schofield, 2006; Roberts et al., 2022; Steed & Downing, 1998). Avoiding emotional fusion linked to this in distinguishing client experiences from PPs (Beckerman & Wozniak, 2018). It is likely that through boundary setting and avoiding emotional fusion, psychological safety can be created which in turn may strengthen the boundaries in place. While these strategies emerged across the themes, it appeared that they promoted psychological safety through their facilitation and therefore guarded against VT. Although, it was unclear whether one strategy precipitates the others. It is also likely that psychological safety is promoted by PPs' organisations developing a culture of maintaining professional boundaries. Encouragement and support in managing caseloads, taking annual leave, and engaging in self-care appear to contribute to psychological safety within the workplace (Harrison & Westwood, 2009; Hunter & Schofield, 2006; Steed & Downing, 1998). Alternatively, through fostering empathy, challenging stigma surrounding VT experiences, and having a shared understanding for roles, PPs may feel safer to raise their VT experiences (Harrison & Westwood, 2009; Hunter & Schofield, 2006; Strolin-Goltzman et al., 2020). Therefore, the culture and approach of organisations may mediate the psychological safety developed from behavioural and psychological VT coping facilitators.

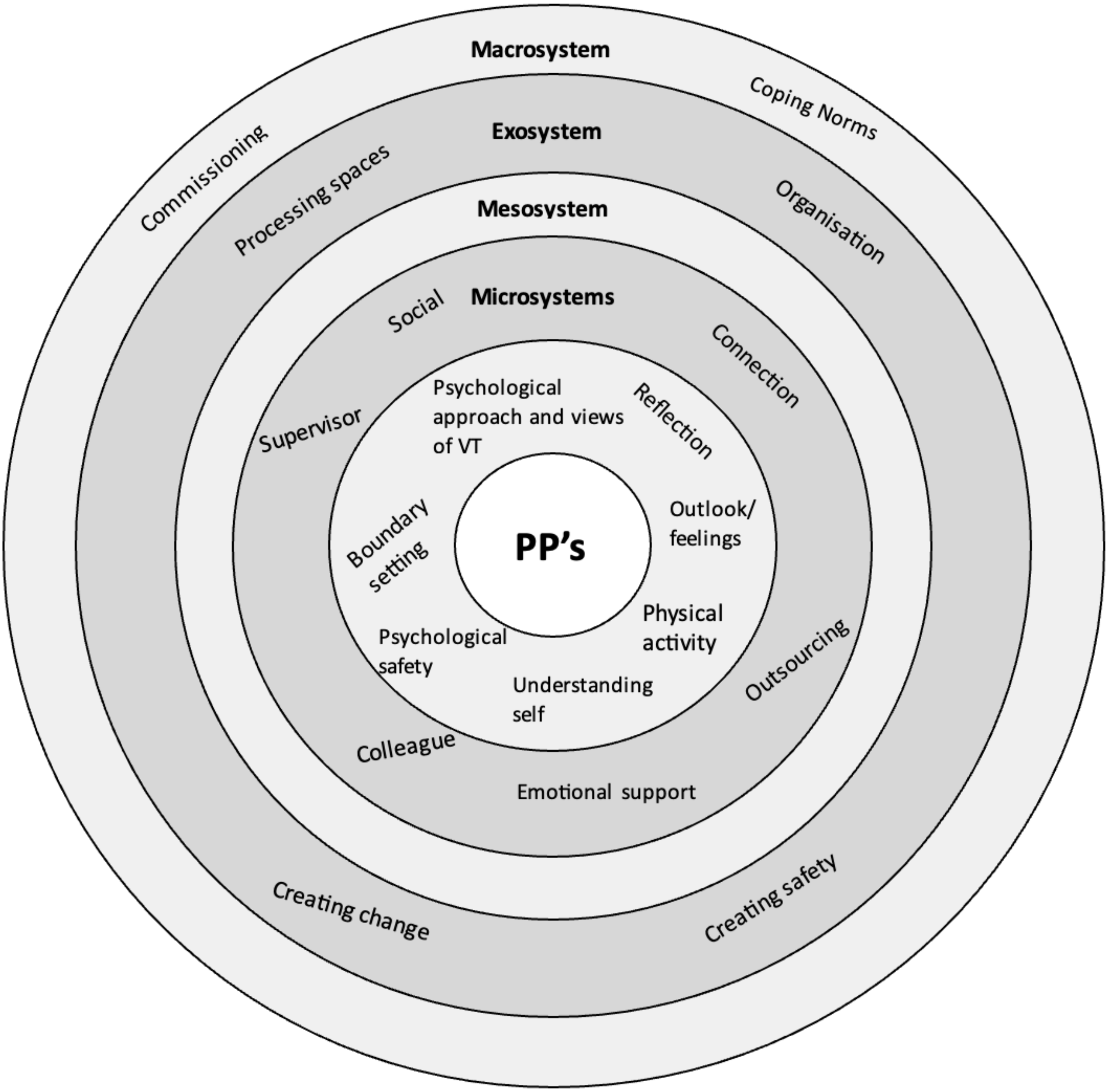
The theme 'understanding self' was also perceived to relate to many of the VT coping facilitators discussed within this review. Developing an understanding of PPs' own reactions and responses may be supported by strategies of reflection, such as journal writing, and outsourcing to mental health support (Bell, 2003; Deblinger et al., 2020; Naghavi & Salimi, 2018). Likewise, recognising the need for these strategies may be elicited from self-awareness (Harrison & Westwood, 2009; Steed & Downing, 1998). Organisations also have a role in facilitating reflective and processing spaces, such as supervision and debriefing, to which further supports self-awareness (Baker, 2012; Dunkley & Whelan, 2006; Harrison & Westwood, 2009; Hunter & Schofield, 2006; Roberts et al., 2022; Strolin-Goltzman et al., 2020; Ting et al., 2008). These coping facilitators created a picture of holistically managing VT experiences.

These feedback loop examples emphasise the influence of systemic approaches on individual action or experience. This likely mediates psychological and behavioural VT coping. This interaction mirrored the concept of Bronfenbrenner's Ecological Systems Theory (Bronfenbrenner, 2000) whereby the immediate and wider environment interact and impact the PP. See Figure 2.

Following Bronfenbrenner's theory, PPs may have individual coping facilitators in place but their systemic environment mediates their efficacy. This suggests PPs' experiences of managing VT is dependent on both systems offering coping resources. This could be associated with an overarching sense of psychological safety across the systems. Likewise, organisational coping facilitators may be influenced by macrosystem factors such as funding for processing spaces or caseload pressures. Family and friends' impact on VT coping may also be influenced by their own Ecological Systems.

Figure 2.

Coping facilitators displayed using Bronfenbrenner's Ecological Systems Theory



There was also consideration to how systemic coping facilitators may create an environment of compassion, furthering the sense of safety. This mirrors the three flows of compassion conceptualised by Gilbert (2014) to which identifies compassion for others, from others, and to ourselves. It also links back to the concept of feedback loops (Adams, 1968). Through organisations creating a culture of compassion for VT experiences, coping facilitators such as processing spaces and creation of safety can be better implemented (Baker, 2012; Hunter & Schofield, 2006; Naghavi & Salimi, 2018; Roberts et al., 2022; Steed & Downing, 1998; Ting et al., 2008). Compassion received from social connection and perceptions of emotional support can further aid this (Beckerman & Wozniak, 2018; Bell, 2003; Deblinger et al., 2020; Diehm et al., 2019; Harrison & Westwood, 2009; Steed & Downing, 1998; Ting et al., 2008). In doing so, this flow of compassion can continue to the PPs' view of themselves and VT experiences. This has a positive impact on the psychological outlook and approach or views of their VT experiences (Bell, 2003; Dunkley & Whelan, 2006, 2006; Harrison & Westwood, 2009; Hunter & Schofield, 2006; Strolin-Goltzman et al., 2020). This likely impacts PPs' perceptions of prioritising self-care and focusing on behavioural coping facilitators. These feedback loops demonstrate the importance of systemic and individual coping facilitators for VT.

Strengths and limitations

Based on the gaps identified in the literature, this is the first review to synthesise both prevention and intervention VT coping facilitators for PPs. Coping facilitators across psychological, behavioural, social, and organisational factors were identified. This enabled relationships between coping facilitators to be explored to create a picture of a flexible systemic approach to managing VT. This mirrors a ‘whole story’ as seen in TIC (Grossman et al., 2021).

The review follows previous literature of identifying those who work with mental health as vulnerable for VT experiences (Barre et al., 2023; Buchanan et al., 2006; Jimenez et al., 2021). In opening the inclusion criteria to all PPs the findings may be used across mental health services. It also contributes to the growing interest in staff-wellbeing and drive to create a culture of normalisation and empowerment (BPS, 2020; Branson, 2019). Despite this, only 13 studies met the inclusion criteria. Other elements of the inclusion and exclusion criteria may have created rigidity, such as those that also explored CF (Figley, 1995) or burnout (Freudenberger, 1974). It is possible that these experiences are studied together due to how the terms are often referred to interchangeably (Sutton et al., 2022). Although, since these experiences are conceptualised and defined to be distinct, understanding coping facilitators specific to VT was key to the review’s rationale.

Across the 13 studies, the demographics reported varied which impacted the participant information that could be reported within this review. It was noted that around 83% were female, creating a skew in the overall data findings of coping facilitators. All but one of the studies were conducted in western countries (Naghavi & Salimi, 2018), meaning the findings may also be skewed to western culture. This raises questions of inclusivity and diversity of the findings. This is furthered by the lack of culture and race demographics reported by the studies.

A further limitation is that some studies did not detail the nature of coping strategies identified, meaning the richness of data was limited (Naghavi & Salimi, 2018; Steed & Downing, 1998). This meant that some studies’ findings were discussed in more depth than others to support the narrative synthesis. For some papers this was reflected within their quality assessment scores (see Appendix D), such as Harrison and Westwood (2009) (97%), and Roberts et al. (2022) (92%) compared to Steed and Downing (47%). For others, the weight to which they contributed to the review did not appear to be mediated by their quality assessment rating. Although, studies that explored coping strategies broadly were weighted more (Harrison & Westwood, 2009; Hunter & Schofield, 2006; Roberts et al., 2022; Ting et al., 2008) than those that were specific in their coping exploration (Deblinger et al., 2020; Diehm et al., 2019; Strolin-Goltzman et al., 2020). This was linked to the diversity of data available.

A final limitation is that most studies did not consider the researcher position. This means that their relationship with the participants and lens or biases could not be fully evaluated. How their positioning impacted their interpretation of the findings remains unclear. Likewise, the depth and detail to which ethical considerations were reported was limited, impacting interpretations of process transparency.

Clinical implications and future research

This review synthesises VT coping facilitators utilised for prevention and intervention across psychological professions. While many coping strategies emerged within the realm of the individual, such as ‘psychological’ and ‘behavioural’, a relationship also emerged within the wider system. Creating psychological safety appeared to be key in managing VT experiences, which was mediated by social support and organisational approaches. While the responsibility of utilising and deploying strategies may be held by the PP, an environment where PPs feel understood and validated seems vital in managing VT (Harrison & Westwood, 2009; Ting et al., 2008). Organisations hold a responsibility to foster a supportive and safe environment where VT experiences can be discussed (Baker, 2012; Harrison & Westwood, 2009; Hunter & Schofield, 2006). Challenging stigma of ‘needing to cope’ also plays a role in enabling PPs to reach out for the support they need (Steed & Downing, 1998). This provides direction for the BPS’s aim of creating a culture of normalisation and understanding (BPS, 2020), shedding light on how organisations can facilitate a safe and empathetic space (Hunter & Schofield, 2006). It’s also in-line the Psychological Professions Network’s (PPN) vision of creating a supportive community for staff wellbeing (PPN, 2021). This may include facilitating and promoting shared time for processing spaces, such as meetings for reflection, clinical supervision, or debriefing (Dunkley & Whelan, 2006; Harrison & Westwood, 2009; Hunter & Schofield, 2006; Naghavi & Salimi, 2018; Roberts et al., 2022; Steed & Downing, 1998; Strolin-Goltzman et al., 2020; Ting et al., 2008).

Additionally, initiatives that aim to mediate sick leave, staff turnover, and promote staff-wellbeing, such as the NHS Long Term Plan (NHS, 2019), may also benefit from considering staff-wellbeing outside of the working environment. Further, to create change in how organisation’s view ‘staff-wellbeing’ and how these touch upon the promotion of boundaries and reduction of pressures. Understanding PPs’ experiences and resources outside of the organisation may shed light to how they can support wellbeing holistically or mediate gaps in support.

Research indicated that PPs may experiences barriers to seeking support due to colleague perceptions and potential negative consequences (Edwards & Crisp, 2017). It also indicates that personal mental health may mediate VT experiences (Leung et al., 2023). Despite this, engaging in mental health support, such as therapy, emerged as a mediator for VT (Steed & Downing, 1998; Ting et al., 2008). This was linked to sharing experiences of stress, resolving personal traumas, and developing self-awareness (Bell, 2003; Harrison & Westwood, 2009; Naghavi & Salimi, 2018; Roberts et al., 2022). Therefore, to create a culture of normalisation and understanding (BPS, 2020), concerns for stigma and consequences may need to be expunged so PPs feels safe to access support. This may be supported by internally provided mental health support or through promoting PPs to utilise modelled therapeutic strategies themselves (Deblinger et al., 2020; Hunter & Schofield, 2006; Roberts et al., 2022).

Conclusion

This review explored PPs' coping facilitators for VT. These facilitators emerged across psychological, behavioural, organisational, and social domains of coping. The VT 'individual' and 'systemic' coping facilitators held a mediating and influencing relationship. Organisations have a key responsibility in supporting individuals to manage VT. A key concept identified was creating a sense of safety, both psychologically, socially, and within the organisation. Overall, if service drivers, such as the BPS, PPN, or NHS long term plan aim to support staff retention, sick leave and wellbeing, PPs need to be viewed holistically. This is both inside and outside of the working environment. In doing so, VT may be better prevented and managed.

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Part Two – The experiences of vicarious post-traumatic growth for clinical psychologists

This paper is written in the format ready for submission to the Journal of the International Journal of Wellbeing. Please see Appendix A for the Guideline for Authors.

Word count: 8059

Abstract

Vicarious Post-traumatic Growth (VPTG) is a phenomenon that captures positive psychological growth resulting from trauma experienced indirectly, or vicariously. VPTG is linked to new internal and external understanding which is stable over time. Existing research explores VPTG and clinicians, however there is limited research focusing on VPTG and Clinical Psychologists (CPs). CPs' various roles, workload and contact with complex trauma presentations should be considered. Further, there is a current National Health Service (NHS) focus on CPs drawing upon lived experiences to normalise and value mental health. On the other hand, there is a reluctance to seek support due to shame and stigma. CP's have been noted to leave the NHS for private services or the profession entirely due to mental health. This study aims to understand the experience of VPTG with CPs. Additionally, to explore VPTG facilitators and barriers. Seven qualified CPs, working in the NHS, took part in semi-structured interviews. Interpretative Phenomenological Analysis (IPA) was utilised to analyse CPs' experiences. Four overarching themes emerged: 'naming VPTG', 'CPs' VPTG experiences', 'a system that enables growth', and 'feeling understood'. CPs' VPTG emerged as 'development of insight', a 'shift in priorities', and 'personal meaning'. In the current NHS context, shared understanding, team support, and processing spaces were facilitators of VPTG. Barriers identified were predominantly within the NHS system. The findings indicated the importance of a culture of compassion, normalisation, and shared understanding to support VPTG.

Keywords

Vicarious Post-traumatic Growth, clinical psychologists, NHS, staff wellbeing, IPA, qualitative

Introduction

1. Vicarious Post-traumatic Growth

Defining Vicarious Trauma

Traumatic stress is recognised as a dynamic psychological reaction to abnormal or unexpected events whereby changes in anxiety or mood are experienced (Gerhart et al., 2015). Traumatic stress reactions can be present when trauma is experienced indirectly or vicariously (Finklestein et al., 2015). Vicarious Trauma (VT) is linked to personal effect and change from empathetic engagement with trauma presentations (Pearlman & Saakvitne, 1995). VT captures changes in personal identity, mood, emotional regulation, beliefs in the world and others, and relationships (Jimenez et al., 2021; Marriage & Marriage, 2005). Psychological professionals (PPs) may experience changes in mental health and job satisfaction (Kounenou et al., 2023). Workload and working exclusively with trauma is thought to link to VT experiences (Board of Professional Affairs' Advisory Committee, 2008).

Despite this, Positive Psychology research suggests positive psychological changes, such as Post-traumatic Growth (PTG) (Tedeschi & Calhoun, 1996) can also occur following experiencing traumatic stress or events (Joseph & Linley, 2008). This is including VT experiences, to which the phenomenon is known as Vicarious Post-traumatic Growth (VPTG) (Arnold et al., 2005).

Defining Post-traumatic Growth

PTG, coined by Tedeschi and Calhoun (1996), captures personal growth after psychological struggle and new internal and external understanding which is stable over time (Powell et al., 2012). The phenomena underlines the psychological shifts in thinking and perception of the world and self (Tedeschi & Calhoun, 2004). PTG manifests across experiences, including positive and meaningful relationships with others, newfound appreciation for life, spiritual change, the finding of new possibilities in life, personal strengths, and feelings of accomplishment (Tedeschi & Calhoun, 1996). Theoretical models often characterise PTG as an outcome of coping with traumatic experiences; transformational functioning (Aldwin, 2009), where the growth leads to either higher or lower levels of functioning, or homeostatic (O'Leary & Ickovics, 1995), where levels of stress return to baseline. Alternatively, PTG is often viewed as a coping strategy to create meaning from traumatic events (Davis et al., 1998; Park & Folkman, 1997).

VPTG, coined by Arnold et al. (2005), expands upon Tedeschi and Calhoun's (1996) theory in that PTG can also be experienced when the trauma is vicarious. Importantly, research has highlighted that the domains of change in VPTG hold few differences to those of PTG (Manning et al., 2015). Other research suggests that VPTG is experienced regardless of the type of trauma related role (Beck et al., 2016; Bybee, 2018; Cosden et al., 2016).

2. Psychological professionals' experience of VPTG

In line with PTG and VPTG theories, PPs' experiences of VPTG indicate positive changes across their lives. This includes interpersonal relationships, new found appreciation for their lives, connection and spiritual changes, feelings of strength and competence, and views of themselves and others (Arnold et al., 2005). VPTG is believed to be fostered by self-care, social support, and PPs viewing their work as inspiring (Ball et al., 2022). Deriving a positive meaning from VT and privileging a shared journey with clients were found to be mediators of VPTG (Michalchuk & Martin, 2019). Workplace support systems and supervision are key facilitating factors for VPTG and PPs' wellbeing (Tsirimokou et al., 2023). Supervisors that monitor supervisee stress, focus on self-care and promote growth from VT enable a space whereby VPTG can be fostered (Long, 2020). Although research indicated that some PPs may be hesitant to engage openly within supervision due to the dynamics of the relationship (Long, 2020). Therefore, PPs often seek external support.

While research suggests that VPTG can be experienced despite the nature of trauma PPs are exposed to (Beck et al., 2016; Bybee, 2018; Cosden et al., 2016), further research does highlight differences in level of growth. Although VPTG is experienced across professional roles, the type and range of trauma presentations mediates the level of VPTG experienced (Ben-Porat, 2015; Weiss-Dagan et al., 2022). Therefore, additional support and attention may be needed within psychological professions that are in contact with high levels of trauma. Exploring VT and VPTG in training may act as a buffer for negative impacts and distress (Adams & Riggs, 2008; Michalchuk & Martin, 2019).

3. Limitations of the literature

In the literature, there is has been a shift away from concepts such as ‘burnout’ (Freudenberger, 1974) and onto Positive Psychology phenomena such as VTPG (Becker & Marecek., 2008). Despite this, existing literature predominantly focuses on the clinician experiences and protective factors for VT but not for the experience of VPTG.

There is a research gap that explores VTPG with CPs specifically. CPs take on multiple roles in varying trauma settings that have a high likelihood of VT being experienced, including education, supervision, research, and psychotherapy (American Psychological Association [APA], 2022). While some research has explored CP students’ experiences, such as master’s students (Ball et al., 2022), the experiences of a trainee on a master’s programme are different to that of a qualified CP (Health & Care Professions Council [HCPC], 2018). This is significant when considering CPs professional expectations, responsibilities, service development involvement, and increased complexity of client trauma presentations (APA, 2022).

Research that has included qualified CPs within the participant pool ‘clinicians’ seemed to group profession findings (Dar et al., 2023; Jimenez et al., 2021), meaning distinction of experience is uncertain. This means that there is little evidence understanding the effects of VPTG for qualified CPs specifically. There is also a gap in exploration of wider context factors, such as workplace environment and social support networks, that may have influenced VPTG. Since these factors are thought to mediate growth (Chang & Busser, 2019), examining these systems may identify a gap within CPs’ resources. Finally, findings from VPTG literature utilising quantitative tools, such as the Post-traumatic Growth Inventory (PTGI) (Tedeschi & Calhoun, 1996), may be limited in identifying the rich experiences of VPTG. Unique appraisals and coping strategies may be missed when using quantitative methods. Therefore, a qualitative approach may be more appropriate for exploring VPTG through semi-structured interviews (Barrington & Shakespeare-Finch, 2013; Melaki & Stavrou, 2022; Splevins et al., 2010).

4. Rationale and Clinical Implications

There is a current focus on creating a culture of compassion around mental health by normalising and utilising CPs’ lived experiences within the workplace (The British Psychological Society [BPS], 2020). Therefore, exploring VPTG with CPs enables positive contributions, such as normalising VT, highlighting gaps in support, and underlining how CPs experience VPTG. It may also follow a Trauma Informed Approach (TIC) in valuing and voicing CPs’ experiences (Kings Fund, 2020). This is important as CPs may be reluctant to seek mental health support from colleagues/friends due to perceived shame and stigma (Grice et al., 2018; Zaninotto et al., 2018).

Additionally, the NHS Long Term Plan aims to support and invest in staff wellbeing and to boost mental health provision by expanding psychological therapies and CP roles (National Health Service [NHS], 2019). The plan aims to boost staff retention (NHS, 2019);

however, evidence estimates 15-16% of CPs are moving jobs, leaving the NHS for private services, or the profession entirely (Longwill, 2015). Despite these findings, NHS staff mental health and wellbeing hubs are closing (BPS, 2023).

VT is believed to be associated with decreased quality of service, increased sick leave and difficulties with productivity (Sutton et al., 2022). Therefore, the feasibility of the NHS Long-Term Plan may be questioned and understanding how to support CPs' VPTG seems vital. Research findings may be helpful in equipping against VT to reduce its impacts within the workplace. This exploration may highlight whether VPTG is useful for staff retainment and reducing staff sick leave. Additionally, to underline what is currently working within the NHS and develop this further.

5. Research aims and research question

This research aims to understand the experience of VPTG for CPs and the surrounding experiences that facilitate or are barriers for growth. This may include where support is accessed, gaps in service provisions, and necessary adaptations. Further, whether workload and contact with trauma presentations interacts with CPs wellbeing through exploring the working environment.

> The research question is "What is the experience of VPTG for CPs working in an NHS context?"

Method

Design

This qualitative study utilised semi-structured interviews and Interpretive Phenomenological Analysis (IPA) (Smith et al., 2009) to explore and understand CPs' experiences of VPTG.

Sample

Purposive sampling identified seven qualified CPs currently working in the NHS (Purna singh et al., 2023). This was in line with Smith et al.'s (2009) guidance for between 6 and 10 interviews for IPA studies and previous similar IPA research (Hyatt-Burkhart, 2014; Michalchuk & Martin, 2019; Splevins et al., 2010). CPs were recruited via social media, including CP Facebook groups, LinkedIn, and researcher connections. Inclusion and exclusion criterion (see Tables 1 and 2) were applied to support homogeneity in gathering VPTG experiences from similar groups of individuals.

Table 1.

Inclusion criterion with rationale

Inclusion Criteria	Rationale
CPs working within the NHS	The aim of the study is to explore the experience of VPTG within the NHS context.
Qualified CPs currently practising	This will enable a current perspective of the NHS with up-to-date information around what is in place now.
CPs working with any type of trauma presentations.	In line with IPA (Smith et al., 2009), the research proposes to explore VPTG experiences and is not looking for differences across trauma presentations.
CPs who identify with the experience of VT	The research aims to explore VPTG, to which experiencing VT precipitates (Arnold et al., 2005).

Table 2.

Exclusion criterion with rationale

Exclusion Criteria	Rationale
CPs that are known to the researcher	Individuals personally known to the researcher will not be included due to potential effects on VPTG disclosure and concerns with stigma (Grice et al., 2018).
Trainee CPs	Trainee's will not be included within the study as research around the experience of VPTG has previously been covered (Ball et al., 2022).
CPs who have not worked with trauma presentations	The concept of VT is related to secondary exposure to an individual's direct traumatic experience and the impact this has (Pearlman & Saakvitine, 1995).

Ethical considerations

Ethical approval was obtained via the Faculty of Health Sciences Research Ethics Committee at the University of Hull (see Appendix E). All participants received a copy of the information sheet (Appendix F) and signed a consent form (Appendix G) prior to their engagement. 'Sources of Support' resources were provided to each participant prior to their interview engagement (see Appendix H). Information and participant experiences gathered was handled in accordance with the General Data Protection Regulations and Ethical guidelines, with confidentiality maintained. Confidentiality was ensured through using pseudonyms which were assigned by the researcher, presenting demographic information collectively.

Procedure

Within the study's advertisement (see appendix I), CPs were asked to contact the researcher via email if they were interested in partaking and met the inclusion criteria. The researcher provided an information sheet and consent form, along with the opportunity for CPs to ask further questions. CPs who wished to take part returned their electronically completed consent form via email. A mutually convenient time was then agreed, with all participants choosing to conduct the interviews remotely via MS Teams. A calendar invitation for the interview was then sent to the CPs via email using MS Teams. Verbal consent was obtained at the start of the interviews with all interview's audio recorded. An NHS encrypted laptop was used to record the interviews, which was only accessible to the researcher. Each interview lasted between 45 and 60 minutes and followed an interview schedule (see Appendix J). CPs were sign-posted to the sources of support sheet sent via email prior to their engagement. Audio recordings were transcribed in verbatim.

Data collection

During the initial stages of the interviews, CPs' age, gender, and length of time working as a qualified CP in the NHS were collected (see Table 3). An Interview Schedule was utilised during the interviews as guidance and to ensure key elements or questions were covered. This interview schedule was developed by the researcher and supervisor. Questions comprised of descriptive and narrative questions to aid expansive exploration of experiences. These questions were developed with acknowledgement to Smith's et al.'s

(2009) interview scheduling guidance and the present study's overarching research question. Interviews began with a general exploration of VT experiences, progressing to focus on VPTG, facilitators and gaps or barriers. Later questions targeted experiences of VPTG support within the NHS.

Data analysis

IPA was utilised to analyse the data from the semi-structured interviews. This followed the guidance of Smith et al. (2009). IPA was chosen as the research aimed to understand the participants' *experience and meaning* of VPTG (Demuth & Mey, 2015). IPA is suitable for understanding meanings when individuals share an experience, such as VPTG (Smith et al., 2009).

The four key steps of the analysis:

Step 1: In the initial stages of analysis, transcripts were considered individually with the researcher immersing themselves in the original data and recordings. Following reading a transcript multiple times, initial thoughts, reflections, and reactions were noted.

Step 2: Descriptive codes were noted line-by-line in the margins for each transcript. These codes were semantic, latent, or in Vivo in nature and were analysed in-depth. This enabled the basis of an initial interpretation of the data.

Step 3: Within each transcript, analysis of descriptive and interpretative codes supported the emergence of themes.

Step 4: These themes were compared within each transcript, before being compared across all transcripts to identify connections and patterns. Clustering similar themes enabled final themes to be developed. See Appendix K for a transcript excerpt. Once initial themes were developed, transcripts and themes were shared with the researcher's supervisor.

Through line-by-line transcription coding, the researcher was able to establish whether findings were associated with a theme or a particular question that created an answer. A reflective journal was utilised throughout the research process to support reflections and consider researcher biases or experiences. Reflection was also aided through regular supervision.

Researcher Position

The researcher is a trainee CP who has been working clinically for over two years. Therefore, the researcher brought their own understanding of VT and VPTG to the research. They also brought their own assumptions and experiences working within an NHS context, and acknowledgment of some of the current challenges that CPs may be experiencing. The researcher adopted a critical realist epistemology to explore the topic (Bhaskar, 2020). IPA is thought to be complimented by a critical realist position when seeking to understand experiences (Hood, 2016). Through adopting an IPA methodology (Smith et al., 2009), biases and assumptions were considered inevitable and double hermeneutics were considered. In doing so, CPs' and researchers' interpretations were acknowledged to shape the research, with reflection and supervision utilised to maintain awareness. See appendix L and M for researchers' epistemological position and reflective statement.

Results

Table 3 summarises CPs' demographics, with consideration to homogeneity and noted number of female CPs compared to male.

Table 3.

Participants' demographics

Demographic	Number of participants *(n=7)*
Age (years)	25-34 (*n*=3), 35- 44 (*n*=2), 45-54 (*n*=2)
Gender identity	Female *(n=5)* Male *(n=2)*
Years qualified as CP	Range: 3- 24 years Mean: 12 years

From the interview data and IPA analysis four overarching themes emerged: 'Naming VPTG, 'CPs' VPTG experiences', 'A system that enables growth', and 'Feeling understood'. From this, 10 subthemes emerged, see Table 4.

Table 4.

Overview of themes and subthemes

Themes	Subthemes
Naming VPTG	
CPs' VPTG experiences	- Development of insight - Shift in priorities - Personal Meaning

A system that enables growth	- Threat
	- NHS priorities
	- Processing spaces
	- Discussions of VT
Feeling understood	- NHS disconnect
	- Shared Understanding
	- Supervision

1. Naming VPTG

All CPs referenced or named VPTG experiences that align with the literature and mapped onto personal and professional development. For Jack and Henry, naming VPTG felt difficult due to being uncertain whether growth came from VT experiences, clinical experience, or the *"aging process"* (Henry). Views of VPTG was often linked to new, *"thought provoking"* (Sally) reflections elicited prior to or during the interview space. Mable shared:

"My immediate reaction was that I didn't grow from that because it made me quit my job, it made me go off sick (..), and it was a horrendous time. But now I, I'm able to reflect a bit more on it, I do think I do identify with that, I do identify with that"

Despite identifying with VPTG, Mary and Jack shared that they were unsure whether their experiences 'qualify' as VT. Jack explained:

"I've had very intense reactions to some of the experiences people have had, but whether I would call that vicarious trauma or not, I'm not quite sure".

However, since all CPs discussed experiences that aligned with VT literature, and Mary and Jack both identified with VPTG, all interviews were included in the overall findings. Therefore, any uncertainty of naming VT and VPTG was deemed to link to wider factors. This included narratives of CPs being able to manage distressing experiences and individual identity. Mary outlines:

“I think there's still a stigma in the NHS for health care professionals to acknowledge the impact that the work has on them”.

2. CPs’ VPTG experiences

2.1 Development of insight

From their experience of VPTG, CPs described developments in their insight and perspectives around client and colleague experiences. This increased connection enabled CPs to draw upon their VT experiences within their practice. Firstly, to have further insight into client experiences and the *“range of human experiences”* (Henry). Secondly, to be more attuned and aware of the risk of VT for colleagues working with trauma.

While CPs acknowledged that experiences of VT do not completely align with their clients’ trauma, it did enable a ‘peek behind the curtain’. While experiencing VT was distressing, Rose shared that the act of ‘hearing’ client experiences enabled a *“wider lens of the world”* which was helpful in practice. CPs positively appraised the development of insight for shedding light on trauma experiences, enabling meaningful understanding that could be drawn upon in the therapeutic space. Anne explained:

“I can ask them about flashbacks in a way that they might be able to understand because I have some lived experience of that, you know, erm it it. Yeah, I feel like I needed to do that, that made me a better psychologist.”

This conceptualisation of being a better CP from VPTG was interpreted as an increase in competence in managing trauma presentations. Mable discussed feeling "*more confidence to go in and just call the space a space".* The insight gained created a sense of being able to connect and work with trauma presentations. This was deemed beneficial when building therapeutic rapport and having *"capacity to stay with somebody through the trauma's"* (Mary). This decreases CPs' concern or anxieties when clients disclose distressing experiences.

Through experiencing VT, CPs wanted to create safe spaces for colleagues to share their difficult experiences and create awareness for VT. This insight elicited a sense of urgency and importance in prioritising and protecting colleagues, particularly for CPs who were in leadership roles. Sally outlined:

> *"[I] really try and create a safe space that in the same way that has been created for me so that I feel like my trainee can like bring struggles or things like that and they don't feel scared of me"*

2.2 Shift in priorities

Another component of VPTG was a shift in priorities and outlook for CPs' own wellbeing. CPs gained insight into themselves and their reactions, developing self-awareness of how historical personal experiences may become present in the therapeutic space. Mable felt *"I think I've learnt a lot more of how to recognise that and deal with that because of this experience".* CPs experienced a shift in focus onto ensuring their psychological safety and development of coping strategies. Sally captured *"I think they've helped me to learn how to look after myself better"*.

For some, VPTG supported naming their own experiences and sitting with the idea that their work impacts their wellbeing and the importance of developing self-awareness. Jack described:

“Different challenging experiences has helped me erm, become a little bit more comfortable with just kind of owning my anxieties or owning my vulnerabilities”

CPs’ increased self-awareness was also present when prioritising boundaries and work-life balance. This VPTG was elicited from recognising factors that influenced the experience of VT, and therefore a drive to prevent this in the future. A key underlying factor was monitoring self-care. Mary said, *“[I] tried to look at how I manage my time outside of work to recharge and I pledge myself”.* This ‘pledge’ was shared by many CPs who were now prioritising their wellbeing and self-care wherever possible. Ensuring both physical and psychological separation appeared to come from CPs’ new perspectives of their own limits and needs to re-charge. Henry described the importance of *“having the ability to kind of switch on and switch off”* from work. Rose felt:

“Whether it's that car journey or it's that bit of time just to go for a coffee, have a walk in your day I think it's just really important in that where you can find that time”.

The development of self-awareness for the impact of trauma contact also held weight for ensuring longevity of CPs careers, with Mary sharing *“it’s not a sprint”.* This implied that through VT experiences, *“lessons were learnt”* (Anne) and CPs were able to re-frame their working approach to be more sustainable.

2.3 Personal meaning

Through VPTG, CPs found personal meaning of VT experiences that continue to drive their appraisal of working with trauma presentations. This development was interpreted as a strengthening of existing views.

CPs named their passion for working with trauma as an important mechanism in managing difficult experiences, such as VT. This passion increased following VT due to a strengthening in CPs' appraisal of the importance of trauma interventions. CPs shared a desire to continue development of their trauma knowledge, particularly through training. Further, that witnessing positive changes in client presentations and managing VT reinforced CPs meaning of their roles and *"incredibly privileged position" (Anne).* Jack described:

> *"As much as they are like challenging experiences or challenging times, they kind of reinforce the idea that I'm in the right job as well, you know erm, and I do I do kind of think my job is being like quite privileged"*

CPs shared the increased drive to stay connected to clients as an outcome of VPTG. The importance of managing the impacts of the work while staying grounded and not desensitising was considered challenging but important. Despite this, CPs recognised there may be an underlying desire to desensitise to self-protect. Henry viewed this as a *"trap"* that he'd *"seen many other people fall into where they, where they 'other' the people that we care for".* VPTG elicited meaning for staying connected, feeling *"more compassionate, more worldly, more mindful"* of client experiences (Rose).

CPs shared an increased sense of gratitude for their own lives and wellbeing, and how this may differ from client experiences. While CPs had experienced VT, this trauma was a result of hearing or "*to bear witness"* (Sally) to 'someone else's' trauma. This created a feeling of gratitude for CPs' own experiences and a shift in perspective of what was important for them. This was also seen when considering life's fragility and that changes can occur without warning. Mary discussed:

"I know that things can change in people's lives really quickly, so I think that I have a different appreciation, and more gratitude for for what I do have".

To summarise, VPTG created changes in CPs' views and understanding of the world and themselves. CPs felt VPTG enabled deeper connection and understanding to their clients' experiences. CPs shared a development of self-awareness and coping strategies to manage the impact of their work. A key theme in this was a shift in priorities onto their own wellbeing.

3 Systems that enable VPTG

CPs experiences of VPTG appear to be entrenched in the system around them, and how this facilitates or enables individuals to take time out to process their VT. CPs felt unsafe within their wider systems and the NHS. This constricted their ability to reach out for support or prioritise their own well-being.

3.1 Threat

CPs felt that a key barrier of VPTG was the wider working system and NHS environment. CPs voiced a current culture of blame which promoted fear of consequences from VT experiences. Further, that VT elicited questions of competence or, as Mable shared, it's *"implied that there is a lack of experience".* There was concern for being watched and feeling on edge within practice which created a sense of those in 'power' holding CPs' vulnerability. Jack explained that there's "*a culture where people are so* *scared to make a mistake".* Sally described "*I think the growth comes from the safety to be fallible"*, highlighting the importance of a safe working environment to promote VPTG.

Narratives seemed to perpetuate this culture of blame and fear for consequences, with most CPs feeling that the NHS and wider system assumed their wellbeing. Mary felt this stigma effects when CPs are able to *"acknowledge the impact that the work has on them".* CPs felt that they were expected to manage trauma impacts, and that ethos' such as trauma informed care (TIC) were not aimed at CPs. Anne explained:

> *"[There's] this idea that we need to just cope and if you don't cope, there's something wrong with you".*

CPs felt pressure to be 'okay' to prevent consequences, such as questioning competence or feeling unsafe in their role. Rose wanted to share "*we're human and of course, we feel things".* A perceived safe environment appeared to promote VPTG in being able to take time out to understand their experiences.

3.2 NHS priorities

Through the narrative CPs created from their experiences, there was a consensus that the NHS has become more business led as time has progressed. CPs shared beliefs that the NHS's priority is numbers, targets, and waiting lists rather than patient or staff wellbeing. This in turn appeared to increase the pressures of caseloads for CPs and a feeling of *"firefighting*" (Sally). As Rose noted the "*pressure of 'you need to see more clients'*" perpetuated VT experiences in increasing stress, which became a barrier for VPTG. These pressures limited CPs capacity to engage in VPTG supportive events/resources. Jack shared the difficulty in focusing on VPTG due to *"other demands* *that are way more pressing"* and that opportunities *"become neglected".* Anne felt a shift away from this was detrimental for "clinicians to not be off sick".

CPs who were able to access additional training were able to develop an understanding of their own VT experiences and foster strategies that protected against future VT. Attending training supported the sense of professional development and growth outlined in the VPTG literature. Mable shared:

> *"The further training in trauma has helped, doing EMDR and the other trauma training directly after that incident happened in the team, which is about dealing with multiple traumas, that was good".*

3.3 Processing spaces

CPs suggested a mixed availability of whether their service and NHS facilitated spaces for processing, reflection, and clinical separation. CPs shared the perspective that when available, these spaces were invaluable for their general wellbeing and facilitating VPTG. Some CPs felt that these spaces were important to reinforce as otherwise, VT and VPTG may not be considered. Rose described *"you just don't really sit down and think about the impacts it has".* Henry discussed the *"privilege that psychologists do have space to reflect and think"*. This implied the benefits professionally and personally of organisational processing spaces. Anne felt that it was important that these spaces were "*protected time*" while Mable shared that these spaces may be under threat:

> *"If you have leadership in certain teams that doesn't support things like reflective practice, then you're also screwed".*

Creating physical separation from the work entirely was also key in facilitating VPTG. Mary discussed how "*having a little bit of time to get out of the building and process stuff*" was key to managing wellbeing. CPs voiced taking annual or sick leave for VT promoted VPTG. While the purpose of sick leave and annual leave is intended to be different, it appeared that most CPs used annual leave to manage and process the impacts of VT. For others, simply ensuring to take time out of their working day for a walk or coffee was beneficial in refocusing, refuelling, or to "*let everything kind of sink in"* (Sally). This mirrors the previously discussed idea of CPs' shift in wellbeing priorities.

Despite this, recent COVID-19 effects appeared to have jeopardised previously established routines whereby separation and physical distance were created. While the NHS appears to have resumed most functioning, some changes, such as online meetings or home working have continued. CPs voiced this as a barrier for VPTG and a point of additional strain. Henry outlined:

> *"So I think I think one of the ways in which people used to to deal with things is having that kind of processing time. And I think that erm, kind of meeting Tetris with people's diaries now and erm, and teams just doesn't, just doesn't allow for that as well".*

3.4 Discussions of VT

A further facilitator of VPTG was whether discussions surrounding VT took place within services or the wider system. Mable shared there's *"a lack of understanding about things like vicarious trauma in teams".* CPs felt that VT was not acknowledged within the NHS and that it was dependent on the service whether these experiences were raised. Sally described the importance of "*every single member of the service being aware that like this is a thing"*. When CPs were able to discuss VT, normalisation and validation facilitated VPTG. Some CPs did not have knowledge of VT during their experiences, which increased uncertainty and distress. Mary shared:

“I think it was a relief when I first read, started reading about vicarious trauma and compassion fatigue, I think it was a relief of actually what I'm experiencing other people have experienced”.

Discussions of VT promoted processing and reflections which lead to VPTG. Shared language enabled CPs to acknowledge VPTG can occur following VT. Rose explained *“it never really occurred to me about growth from Vicarious Trauma, which is just sad”*. For some CPs, taking part in the interviews were some of the few times they had discussed their VT experiences. This enabled reflections whereby VPTG was identified and built upon. Jack discussed:

“I think I've kind of vocalised some things that I've never really explicitly been aware of before. So, in terms of my own kind of building up my sense of self, it's been helpful”.

To conclude, the system around CPs appears to hold unhelpful narratives and uncertainty which promotes a feeling of threat and unsafety. While this is a barrier for VPTG, having spaces to safely process and reflect facilitated VPTG. CPs felt that a cultural shift towards prioritising staff-wellbeing would enable a system that supports VPTG.

4 Feeling understood

Throughout the interviews, CPs shared the importance of feeling understood in facilitating VPTG. While how this was discussed varied, themes of validation and normalisation were identified. Feeling understood appeared to spread across both professional and personal aspects, with a seeming desire for CPs to be seen as human.

4.1 NHS Disconnect

CPs perceived a gap in understanding for VT and VPTG experiences within the NHS. CPs shared that the NHS as an organisation did not understand the reality of their work or experiences. This meant the system itself was not promoting of VPTG and therefore CPs had to find safety and support within their teams or personal lives. CPs voiced a disconnect from the NHS, with Jack describing "*the NHS is so big that I don't identify with it".* CPs perceived the NHS as 'them and us' and a hierarchy that was 'out of touch'. Henry shared:

> *"Now I say like 'they are the TRUST' 'the trust did this', like 'the TRUST' has become a person, that's a a negative person in my life".*

This disconnect acted as a barrier for CPs to feel understood by the NHS, and for VT to be missed. This continued for CPs when considering initiatives such as staff wellbeing or TIC and feeling forgotten. Anne shared *"we need to have trauma informed care for ourselves",* indicating that initiatives need to be implemented from within to promote VPTG. CPs felt undervalued and there was an assumption that they could manage. Mary explained the importance of *"awareness and acknowledgement and checking in on staff"* and how this can be a *"vehicle"* for CPs to seek VPTG support.

There was also acknowledgement that the support in place by the NHS ‘misses the mark’ of the reality of VT and *“depth of struggle that can come”* (Sally). Despite CPs indicating NHS support is available, there was a narrative that this was not helpful. Mable felt that staff wellbeing support *“doesn’t really touch the surface”* due to its commissioning limitations and how the wider system mediates VT experiences. CPs suggested that NHS support could also lean towards being patronising *or “token gestures”* (Rose). Therefore, CPs avoided seeking VT and VPTG support from the NHS due to doubts that this would be meaningful. This linked back to feeling forgotten and undervalued by the NHS, with a perception for some CPs of being a number and replaceable. Anne stated, *“I could die at my desk, and no one would give a shit”.* This outlines that the support facilitated by the NHS is falling short and failing to promote the idea that staff wellbeing is a priority.

4.2 Shared Understanding

Team support was discussed highly and interpreted as a key factor in facilitating VPTG. So much so, some CPs found it important to point out that their VPTG was solely linked to their teams and not to the wider system or NHS. Sally voiced that her growth was likely associated with support from her team and “*not necessarily because the NHS has like got this right”.*

This value in VPTG facilitation appeared to be promoted by a shared understanding from CPs’ colleagues. CPs felt safe and valued by their team which promoted them to discuss their VT experiences. This created spaces to process and grow from these experiences, feeling psychologically safe to be vulnerable without consequences or judgement. Mary captured:

"I think it's been really important to have a safe space to talk through the impact, erm and have a good team around where we've got a language where we can support each other and where it's okay to say that you're affected by that work".

This shared understanding was facilitated by having the same frame of reference for the nature of working with trauma presentations. For some CPs, profession was not important, but shared understanding of the work enabled validation and normalisation. Jack explained *"I think like my anxieties felt quite held within the team".* This team safety promoted CPs to voice their VT experiences and hold discussions where VPTG could be fostered. This created a sense of community whereby colleagues supported each other's wellbeing. For Anne, the team *"caught me when I fell"* which enabled *"really open conversations*". Henry shared the value of *"coming back after a difficult session, sitting down and sharing that it was tough"* with the team.

Despite this, CPs voiced that those within the immediate hierarchy, such as managers, did not share the same frame of reference or understanding of trauma presentations. Mable felt as banding increases "*the less confident people are with trauma".* This acts as a barrier for VPTG in not being able to access support within the wider system. It also reinforces the perception of 'them and us' and NHS disconnect. It suggests an avoidance to seek support from the system at a managerial level due to concerns of a lack of understanding and that the support managers could offer would be limited. This creates an uncertain and vulnerable working environment and may mean CPs are not accessing the support needed.

4.3 Supervision

CPs found that a beneficial facilitator for VPTG was supervision and being able to *"talk it through"* (Mary). This also appeared to be underlined by a shared understanding and validation for the nature of working with trauma presentations. Rose shared that having supervision from individuals who "*do similar types of work can be really helpful"*. This suggested that through having a similar working experience or background, CPs could access support directly without having to provide context. By doing so, there was certainty in being understood and that the extent of how trauma presentation can impact CPs are valued rather than considered 'abnormal'. Jack shared the importance of having *"a supervisor that can help you make sense of that [VT]"* in a safe way to promote VPTG. This psychological safety was also identified when supervisors are acknowledging of CPs' wellbeing and responsive when difficulties arise. Mable captured:

> *"I had a supervisor at the time that was clocked onto like, the fact that I was like, vicariously traumatised and helped me basically".*

Having this rapport and support appeared to be promoted when supervisors were perceived to be engaged in the CPs' experiences. Sally shared *"my supervisor is empathetic and very present in the moment of supervision"* to which was valuable in promoting VPTG. This allows CPs to be trusting and vulnerable with their supervisors, which supports re-focusing of their clinical work and management of VT.

For some CPs, there was concern that supervision may not be as safe for others within the wider services and that it may be the 'luck of the draw'. It also became clear that supervision may not be as readily available for those within leadership roles. This raises concerns as to whether a valuable facilitator of VPTG is being missed for some CPs. Anne described:

> *"As a consultant psychologist, supervision is shit man, it's it's a month, once a month it's group supervision".*

To conclude, CPs shared the importance of feeling understood by their teams, wider systems and the NHS. There appears to be a disconnect from the NHS and CPs' work with trauma presentations. CPs shared the validation, normalisation, and safety that comes from their teams and how this facilitated VPTG.

Discussion

This study aimed to explore the experiences of VPTG with qualified CPs working in the NHS. An understanding of VPTG, its facilitators and barriers could be developed within the context of the seven NHS CPs. Four overarching themes emerged; 'naming VPTG', 'CPs' VPTG experiences', 'systems that enable VPTG', and 'feeling understood'. CPs' VPTG emerged within three themes: 'development of insight', 'prioritising self', and 'personal meaning'. These themes link to VPTG literature of new internal and external understanding, newfound appreciation of life, and personal strengths (Powell et al., 2012; Tedeschi & Calhoun, 1996). In the current context, experiences of VPTG appear to be mediated by the NHS system, approach to staff wellbeing, and team. CPs found teams and colleagues important in promoting VPTG due to their shared understanding, sense of community, and acknowledgement of the importance of processing distressing experiences.

Making meaning from VPTG

CPs voiced VPTG in developing meaningful insight into client experiences, such as PTSD reactions (O'Donnell et al., 2014; Pai et al., 2017). This supported their connection within the therapeutic space. It also promoted feelings of competency in managing trauma presentations. CPs shared a new found appreciation for their own lives and insight into its fragility (Tedeschi & Calhoun, 1996). Alongside this, CPs experienced a shift in priorities towards their own wellbeing through developing self-care strategies, creating boundaries, and acknowledging vulnerabilities. This mirrors VPTG literature of a psychological shift in thinking or views of the self and world that creates change (Arnold et al., 2005). It also supports previous indications that PPs derive positive meanings and develop insight from VT experiences (Michalchuk & Martin, 2019). Despite this, barriers to VPTG appeared linked to threat and a perceived pressured system. This system may not facilitate work-life boundaries, prioritise wellbeing, or attendance at organisational wellbeing events. Many CPs voiced that the NHS feels increasingly business focused, particularly in having caseload pressures and unmanageable targets. Some CPs felt watched by those in power and indicated concerns for consequences or stigma (Grice et al., 2018; Zaninotto et al., 2018). As the literature suggested, being able to access processing spaces, such as supervision, reflective spaces, or debriefing meetings with colleagues, was a key facilitator for VPTG (Ball et al., 2022). This was particularly when other colleagues were aware of CPs' wellbeing, creating a sense of community (Chang & Busser, 2019). CPs discussed taking sick leave or annual leave due to VT and limited support (Sutton et al., 2022). This may provide insight for concerns of staff retention and why statistics indicate CPs are leaving the NHS for private services (Longwill, 2015).

Feeling understood

A key facilitator for VPTG was that CPs' experiences of VT and distress were understood by their organisation and team. Further, the nature of their work and contact with trauma presentations were acknowledged. CPs being recognised for their profession and competence, and feeling validated was essential in processing VT and deriving positive VPTG meaning (Chang & Busser, 2019). Shared understanding also created a safe space for CPs to disclose experiences to access support and promote VPTG. This mirrors the literature for VPTG being promoted by social support and organisational resources (Arnold et al., 2005; Ball et al., 2022). As Long (2020) suggested, VPTG appeared to be supported by supervisors who were engaged and ‘clocked on’ to CPs’ wellbeing. Although, supervision was recognised as a ‘luck of the draw’ which indicates that supervision may not be as beneficial for others who experience VT.

Organisational safety

While all seven CPs discussed VT experiences in line with the literature, two CPs were unsure whether their experiences qualified as VT. Despite this, both CPs chose to participate in the interview following acknowledging the inclusion criteria surrounding VT experiences. Therefore, their uncertainty during the interviews could be attributed to wider factors. It is likely that narratives held within the NHS of CPs being able to manage distressing experiences mediates whether CPs feel safe naming VT. These narratives may be perpetuated by the lack of discussions, normalisation and acknowledgement of VT and VPTG. This links to literature suggesting CPs are reluctant to seek mental health support due to shame and stigma (Grice et al., 2018; Zaninotto et al., 2018). Further, to the perceived culture of blame and consequences within the NHS. This goes against the BPS’s aim of creating a culture of compassion through normalising adverse experiences (BPS, 2020). Compassionate leadership literature suggests the importance of seeking to understand staff challenges in an empathetic and inclusive environment (Kings Fund, 2022). Therefore, VPTG barriers may be mediated by CPs’ perceived relationship with leaders and lack of shared understanding or language used to create a safe climate (West & Bailey, 2023). This also creates a disconnect between CPs and the NHS whereby VPTG support is perceived to ‘miss the mark’ despite there being an increased focus on staff-wellbeing (NHS, 2019). This indicates that CPs may feel that the NHS is unable to support VPTG, furthering any concerns to speak out.

Clinical Implications

Overall, while the NHS is aiming to support and invest in staff wellbeing through expanding psychological therapies and CP roles (NHS, 2019), CPs may continue to request sick leave or leave the profession if the systemic pressures are maintained (Longwill, 2015). While VT may not directly link to staff retention statistics, CPs made it clear that caseload, targets, and the perceived NHS business focus were barriers for VPTG. Additionally, while the NHS Long Term Plan (NHS, 2019) may be driving staff support initiatives, this appears to be disconnected from CPs' experiences. Therefore, for initiatives such as the NHS Long Term Plan (NHS, 2019) to reach its aim, systemic changes are required.

CPs experienced VPTG that impacted their personal and professional lives. VPTG facilitators were underpinned by a shared understanding and feeling safe to share their experiences. Processing spaces, such as reflections or debriefing, were key in promoting VPTG. Likewise, not having time to unwind or process sessions was conceptualised as a barrier for VPTG. Therefore, while organisations aim to promote staff wellbeing, this may be mediated by the systemic pressure that drives the service. Balancing these pressures with protected processing spaces could ensure CPs feel supported to manage distressing experiences and able to take time out without consequences. Organisations may wish to enhance team connections through events or acknowledge the value of informal debriefing with colleagues. This also seems to be mediated by the systemic pressures placed on CPs, particularly when providing accounts of their working day.

Organisational cultures were referenced across CPs, with many naming the NHS a culture of blame. CPs believed that a cultural shift would promote VPTG, and that creating a culture of safety is paramount for staff-wellbeing. Discussions and normalisation of clinical impacts, such as VT, were considered vital to develop a shared understanding and manage uncertainty. Since this mirrors the BPS' aim of creating a culture of compassion

(BPS, 2020), it creates a picture that the aim is not yet reaching the organisation. A top-down approach may be key to creating a safe and compassionate environment. Through compassionate leadership (West & Bailey, 2023), NHS senior and managerial professionals may influence services' acknowledgement and promotion of VPTG. This would also promote a TIC approach spreading beyond client care and onto the NHS workforce to acknowledge challenges, clinical impacts, and VT experiences (Kings Fund, 2020). This may be aided by VT and VPTG training to account for the potential negative impacts of working with trauma presentations (Adams & Riggs, 2008; Michalchuk & Martin, 2019). Including this training during master's or doctoral training curricula could be essential in intwining trauma informed language early into CPs' careers (Ball et al., 2022).

Limitations and future research

Throughout CPs' discussions, COVID-19 was often referenced as a cause of organisational change. Since COVID-19, demand for mental health services has increased (Mukadam et al., 2021; Murch et al., 2021), which may be linked to the CPs' experiences of increased service pressures and decrease processing time. Additionally, COVID-19 is considered a shared trauma in itself (Hutto et al., 2024). The impact of COVID-19 only became apparent as CPs' interviews progressed, therefore exploring how COVID-19 mediated VPTG is a gap for future research. It may also be interesting to compare CPs' accounts of VPTG before and after COVID-19 to understanding changes to VPTG facilitators and barriers.

The study included CPs with a broad range of years clinical experiences (3-24 years) which enabled VPTG exploration across CPs' careers. While this initial exploration of VPTG and CPs' warranted this inclusion criteria, it is likely that clinical experience mediated VT and VPTG (Finklestein et al., 2015). Those who were newly qualified experienced different stressors to those who had established themselves within the clinical field. This may elicit variance in feelings of competence which the current study found was a buffer for future VT (Clance & Imes, 1978). Future research could draw comparisons of VPTG across clinical experience, or isolate exploration to newly qualified CPs. Findings could acknowledge how to protect newly qualified CPs from VT alongside the additional mediators of joining the profession.

It is a strength that the seven CPs worked across NHS services and client populations to ensure the participant pool accounted for the variance in NHS mental health services. CPs who had been qualified for some time also held experiences in various NHS services, furthering their insight into how NHS supports VPTG. Despite this, some CPs worked in trauma specific services while others did not, affecting the homogeneity of the sample. It also indicates that some CPs would have been working predominantly with trauma presentations, while others' caseloads may be varied (Jimenez et al., 2021; Weiss-Dagan et al., 2022). Trauma specific services may also have more awareness of VT and VPTG, suggesting possible differences in VPTG promotion or facilitation. As the literatures understanding of CPs and VPTG expands, exploring how trauma specific services manage VT and VPTG may offer beneficial contributions.

Conclusion

This study underlined CPs' experiences of VPTG in the NHS' current context. CPs experienced a shift in views of themselves and the world, their priorities for staff-wellbeing, and gained insight into client experiences. CPs positively appraised their experiences of VPTG, predominantly attributing their growth to their team. Processing spaces, a shared understanding, and validation were key facilitators for VPTG. Barriers for VPTG included perceived systemic threat, consequences, disconnect, and NHS pressures. To support staff wellbeing, further research is needed to understand how COVID-19 impacted VPTG facilitators and how newly qualified CPs experience VT and VPTG.

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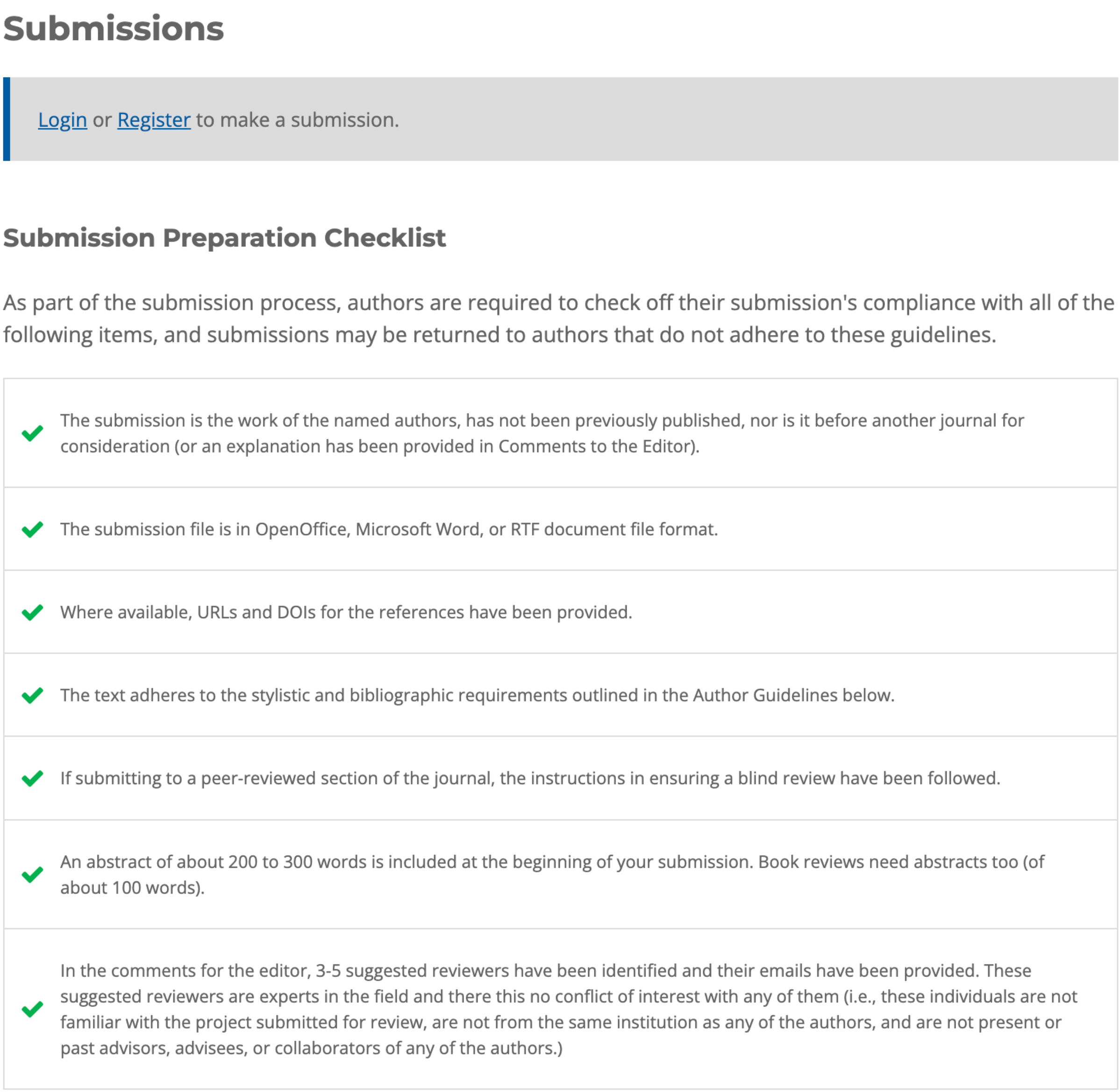
Part Three - Appendices

Appendix A: Guideline for submission to the International Journal of Wellbeing for the systematic literature review



Submissions

Login or Register to make a submission.

Submission Preparation Checklist

As part of the submission process, authors are required to check off their submission's compliance with all of the following items, and submissions may be returned to authors that do not adhere to these guidelines.

- ✓ The submission is the work of the named authors, has not been previously published, nor is it before another journal for consideration (or an explanation has been provided in Comments to the Editor).
- ✓ The submission file is in OpenOffice, Microsoft Word, or RTF document file format.
- ✓ Where available, URLs and DOIs for the references have been provided.
- ✓ The text adheres to the stylistic and bibliographic requirements outlined in the Author Guidelines below.
- ✓ If submitting to a peer-reviewed section of the journal, the instructions in ensuring a blind review have been followed.
- ✓ An abstract of about 200 to 300 words is included at the beginning of your submission. Book reviews need abstracts too (of about 100 words).
- ✓ In the comments for the editor, 3-5 suggested reviewers have been identified and their emails have been provided. These suggested reviewers are experts in the field and there this no conflict of interest with any of them (i.e., these individuals are not familiar with the project submitted for review, are not from the same institution as any of the authors, and are not present or past advisors, advisees, or collaborators of any of the authors.)

Author Guidelines

All articles will preferably be up to 8,000 words, but longer articles will be considered if written concisely. The text should be double-spaced; use an easy-reading 12-point font (such as Times New Roman); sparingly employ *italics*, rather than underlining for emphasis (except with URL addresses); and all illustrations, figures, and tables should be placed within the text at the appropriate points, rather than at the end. If your article is accepted for review, you may be asked to layout the article in the IJW format.

Please note the policy in 'About the Journal' about the types of articles that the IJW is looking to publish.

All articles should use internally consistent spelling, grammar, and language (American and British English will both be accepted). Please also restrict the use of Latin phrases, long sentences, and overly-technical writing as much as possible.

Referencing should follow any one of the major referencing formats (APA, Chicago author-date or footnote, etc.). Please see existing articles for examples. If using APA, please refer to the latest Publication Manual of the American Psychological Association. Basic and comprehensive guides to APA style and referencing are available here.

To ensure a blind review, identifying information such as author names should be removed from the manuscript. Self-citations should be in third person.

Authors of accepted articles are encouraged to create a Video Abstract (see guidelines here) to accompany their article. The video abstract will be posted on the article page as well as on the *International Journal of Wellbeing* YouTube channel.

The journal will consider for peer-review articles previously available as preprints. Authors may deposit any version of the paper in a preprint server, repository, or archive (e.g., PsyArXiv, OSF). A note on the title page must explicitly state the date and version of the draft deposited (e.g., version submitted for peer review, version accepted for publication). Authors may post a link to the published articles on a personal or institutional or scientific network website (e.g., ResearchGate). Once the paper is published, authors are requested to update any pre-publication versions with a link to the final published article.

If you are having trouble with the submission process or have any questions, please email the editor at intnljournalofwellbeing@gmail.com and let us know the precise issue.

Appendix B: Data extraction table

Author Year County	***Research Aims***	***Research Design***	***Population and Sample***	***Intervention***	***Summary of findings***

Appendix C: Methodological quality assessment checklist for qualitative and quantitative studies (CASP, 2018; Downs & Black, 1998; Pluye et al., 2009; NICE, 2012)

Study identification	
Criteria **Scoring system: 2= Yes, 1= Partially, 0= No/Not reported, N/A if not applicable.**	**Score**
Section 1: Theoretical Approach 1.1: Is the study clear in what it seeks to do? • Is the purpose of the study discussed- aims/objectives/research question/s? • Is there adequate/appropriate reference to the literature? • Are underpinning values/assumptions/theory discussed? 1.2: Are the main outcomes to be measured clearly described in the introduction or methods section?	
Section 2: Study design 2.1: Was the research design appropriate to address the aims of the research? • Justified the research design: how and why they decided which method to use. 2.2: Are there clear accounts of the rationale/justification for the sampling, data collection and data analysis techniques used?	
Section 3: Data collection 3.1: Was the recruitment strategy appropriate to the aims of the research? 3.2: How well was the data collection carried out? • Are the data collection methods clearly described? 3.3: Are the characteristics of the participants included in the study clearly described? 3.4: **(Quantitative only)** Are measurements appropriate (clear original, or validity known, or standard instrument?) 3.5: **(Quantitative)** Is there an acceptable response rate (60% or above)?	
Section 4: Validity/reliability 4.1: Is the sample representative of the population under study? • Describe how participants were selected? 4.2: Were those subjects who were prepared to participate representative of the entire population from which they were recruited? • Number of participants who were asked and agreed should be stated, demonstrating that confounding variables were the same in the study sample and the source population. 4.3: **(Qualitative only)** Were the methods reliable? • Was data collected by more than 1 method? • Do the methods investigate what they claim to?	
Section 5: Analysis 5.1: **(Quantitative only)** Are the main findings of the study clearly described? • Simple outcome data should be reported for all major findings so that the reader can check the major analyses and conclusions.	

5.2: **(Quantitative only)** Were the statistical tests used to assess the main outcomes appropriate? • Statistical techniques used appropriate to the data? • Non-parametric methods used for small sample sizes? • Distribution of the data (normal or not) described? 5.3: **(Qualitative only)** Is the data analysis sufficiently rigorous? • Is the procedure explicit? • How systematic is the analysis, the procedure reliable and dependable? • Is it clear how the themes and concepts were derived from the data? 5.4: **(Qualitative only)** Are the findings convincing? • Are the findings clearly presented? • Are the findings internally coherent? • Are the extracts from the original data included? • Are the data appropriately referenced? • Is the reporting clear and coherent? 5.5: (**Qualitative only)** Is the analysis reliable? • Did more than one researcher theme and code the transcripts/data? If so, how were their differences resolved? • Did participants feedback on the transcripts/data if possible and relevant? 5.6: Are the findings relevant to the aims of the study? 5.7: Conclusions • How clear are the links between data, interpretation, and conclusions? • Are the conclusions plausible and coherent? • Have alternative explanations been explored and discounted? • Does this enhance understanding of the research topic? • Are the implications of the research clearly defined?	
<u>Section 6: Ethics</u> 6.1: Have ethical issues been taken into consideration? • Issues raised by the study been discussed? 6.2: Has the relationship between the researcher and participants been adequately considered? • Researcher critically examined their own role, potential bias, and influence during been considered? 6.3: How clear and coherent is the reporting of ethics? • Have ethical issues been taken into consideration? • Are they adequately discussed e.g. do they address consent and anonymity? • Have the consequences of the research been considered i.e. raising expectations, changing behaviour? • Was the study approved by an ethics committee?	

Appendix D: Quality assessment summary table for studies reviewed

Study author	Checklist Item																						
	1.1	1.2	2.1	2.2	3.1	3.2	3.3	3.4	3.5	4.1	4.2	4.3	5.1	5.2	5.3	5.4	5.5	5.6	5.7	6.1	6.2	6.3	Total
Steed and Downing (1998)	1	1	1	0	2	1	2	n/a	n/a	1	1	1	n/a	n/a	1	1	1	2	1	0	0	0	**47%**
Naghavi and Samlimi (2017)	2	1	2	2	2	2	1	n/a	n/a	1	1	2	n/a	n/a	1	2	2	2	1	2	0	2	**78%**
Deblinger et al. (2020)	2	2	1	2	2	2	2	2	2	2	2	n/a	2	2	n/a	n/a	n/a	2	2	2	0	2	**92%**
Hunter and Schofield (2006)	2	2	2	2	1	2	2	n/a	n/a	1	1	1	n/a	n/a	1	2	0	2	2	0	0	0	**64%**
Harrison (2007)	2	2	2	2	2	2	2	n/a	n/a	2	1	2	n/a	n/a	2	2	2	2	2	2	2	2	**97%**
Diehm et al. (2018)	2	2	2	1	0	1	1	2	1	1	1	n/a	2	2	n/a	n/a	n/a	2	2	0	0	0	**61%**
Bell (2003)	2	1	2	2	2	2	2	n/a	n/a	2	2	2	n/a	n/a	1	1	2	2	2	0	0	0	**75%**
Baker (2012	1	2	2	2	1	2	2	n/a	n/a	1	1	2	n/a	n/a	2	2	2	2	1	0	2	1	**78%**
Dunkley and Whelan (2007)	2	2	2	1	2	1	2	2	0	2	2	n/a	2	2	n/a	n/a	n/a	2	2	0	0	2	**78%**
Roberts et al. (2022)	2	2	2	2	2	2	2	n/a	n/a	2	1	2	n/a	n/a	2	2	2	2	2	0	2	2	**92%**

Berckerman and Wozniak (2018)	2	1	2	1	2	2	2	n/a	n/a	2	2	2	n/a	n/a	2	2	2	2	2	2	0	2	**89%**
Ting et al. (2008)	2	1	2	1	2	2	2	2	1	2	2	n/a	2	2	n/a	n/a	n/a	2	2	0	0	0	**75%**
Strolin-Goltzman et al. (2020)	2	2	1	2	2	2	2	2	2	2	1	n/a	2	2	n/a	n/a	n/a	2	2	0	0	1	**81%**

Those coded in red indicating quantitative only

Those coded in blue indicating qualitative only

Appendix E: Ethical Approval

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T: +44 (0)1482 463336 | **E:**
Maureen.Twiddy@hyms.ac.uk
w: www.hull.ac.uk

PRIVATE AND CONFIDENTIAL
Bethany West
Faculty of Health Sciences
University of Hull
Via email

Wednesday 05th July 2023

Dear Bethany,

FHS 22-23.76 – The experience of Vicarious Post-Traumatic Growth for Clinical Psychologists.

Thank you for your responses to the points raised by the Faculty of Health Sciences Research Ethics Committee.

Given the information you have provided I confirm approval by Chair's action.

Please refer to the Research Ethics Committee web page for reporting requirements in the event of any amendments to your study.

Should an Adverse Event need to be reported, please complete the Adverse Event Form and send it to the Research Ethics Committee FHS-ethicssubmissions@hull.ac.uk within 15 days of the Chief Investigator becoming aware of the event.

I wish you every success with your study.

Yours sincerely

Maureen Twiddy

Dr Maureen Twiddy
Chair, FHS Research Ethics Committee

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Appendix F: Information sheet

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Version 2: 22/06/23

INFORMATION SHEET FOR PARTICIPANTS

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

Title of study: The experience of Vicarious Post-Traumatic Growth for Clinical Psychologists

I, Bethany West, would like to invite you to participate in a research project which forms part of my Clinical Psychology Doctorate thesis research. The sponsor for this research is University of Hull. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask me if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

Through working with others, there may be times that you have heard traumatic experiences and been personally affected in some way from this empathetic engagement. This may be linked to a phenomenon known as Vicarious Post-traumatic Growth (VPTG), whereby there is positive psychological growth as a result of trauma experienced indirectly. The purpose of the study is to gain an understanding into the experience of Vicarious Post-traumatic Growth (VPTG) for Clinical Psychologists.

Why is this important?

There is a gap in the literature that explores the experience of VPTG with Clinical Psychologists. Other literature either groups ‘clinicians’ together in the findings or looks at another profession within mental health. There is a current focus on creating a culture of compassion around mental health by normalising and utilising Clinical Psychologists’ lived experiences within the workplace (The British Psychological Society [BPS], 2020). However, CPs may be reluctant to seek mental health support from colleagues/friends due to shame and stigma (Grice et al., 2018; Zaninotto et al., 2018). Therefore, exploring VPTG with Clinical Psychologists would enable positive contributions, such as normalising and reducing stigma surrounding the experience of indirect trauma, highlighting gaps in support. Further, to underline how Clinical Psychologists experience VPTG to act as a guide for others. Alongside this, the NHS Long Term Plan aims to support and invest in staff wellbeing and to boost mental health provision by expanding psychological therapies and CP roles (National Health Service [NHS], 2019). However, evidence estimates 15-16% of CPs are moving jobs, leaving the NHS for private services, or the profession entirely (Longwill, 2015). Therefore, research findings may highlight whether VPTG is useful for staff retainment and reducing sick leave, as well as identifying solutions to support CPs’ wellbeing.

Why have I been invited to take part?

You are being invited to participate in this study because you are a qualified Clinical Psychologist currently practising within the NHS and have worked with trauma presentations.

Due to the nature of the research, it is important that you identify with the experience of indirect trauma/ vicarious trauma. This is important so the experiences associated with VPTG can be articulated and explored.

What will happen if I take part?

If you choose to take part in the study, you will be invited to take part in a 60-minute interview, where a variety of questions about your experiences of VPTG will be asked. For example, ‘could you tell me about any positive impacts this experience had on your life’. You will also be asked to provide some information about who you are, such as age, gender, job role and years working with trauma presentations in the NHS.

You will be asked for consent for the interviews to take place either online or in-person and this will be organised via email. The options for location of face-to-face meetings are either within your place of work, with others present in the building, or within a booked room at the University of Hull. However, the distance from the researcher’s base will be restrictive to the Humberside area.

Do I have to take part?

Participation is completely voluntary. You should only take part if you want to and choosing not to take part will not disadvantage you in any way. Once you have read the information sheet, please contact me if you have any questions that will help you make a decision about taking part. If you decide to take part, we will ask you to sign a consent form and you will be given a copy of this to keep.

What are the possible risks of taking part?

During the interviews, the experiences discussed may elicit levels of distress that you may need further support with. Before the interview begins, the potential for distress due to discussing your experiences will be highlighted, and a verbal care plan can be discussed, such as taking pauses/time out when needed and what I can do to support you as a facilitator. Key contact information will be provided, such as local mental health crisis numbers and Improving Access to Psychological Therapies (IAPT) numbers. There will also be recommendations to contact these services, and/or your GP, if you experience significant distress following your participation. Additionally, it is also recommended that you contact your line manager or occupational health department for support.

What are the possible benefits of taking part?

Exploring your experience of Vicarious Post-Traumatic Growth could enable positive contributions, such as normalising and reducing stigma surrounding the experience of Vicarious Trauma. There will also be exploration of your experiences of support which will highlight any gaps. Findings may underline how Clinical Psychologists experience Vicarious Post-traumatic Growth to act as a guide for others. The findings may also highlight whether growth after vicarious trauma is useful for staff retainment.

How will we use information about you?

We will need to use information from you for this research project. Your data will be processed in accordance with the UK-GDPR and the Data Protection Act 2018. Audio recordings of interviews will take place on an NHS encrypted and password protected laptop. Transcribed recordings will be kept anonymous, referred to with a pseudonym, and stored separately to your personal data. Once recordings have been transcribed, they will be deleted. However, if you reveal current risk of harm to yourself or others, including dangerous practice, the researcher may need to breach confidentiality to contact the services relevant to these issues, for example police, local authorities or crisis team, and their research supervisor. Risk disclosure will be supported through following the usual risk procedures, such as assessing risk, signposting and/or contacting relevant services necessary. The purpose of this is to ensure the safety of you and others, and risk management will be approached in the most collaborative way possible with you. If you decide that you wish to conduct the interviews face-to-face and at your place of work, no information about the address provided will be paired with your data/interviews and will be deleted immediately following the interview has concluded. The email address that you provide will be deleted upon completion of your interview. If you wish to have updates on the research, you can contact the researcher again at any point before September 2024. If participants do contact the research team for research updates, your email address will be once again deleted upon conclusion of contact (updated provided). Data that is collected, i.e. interview transcripts, age, gender, job role and years working with trauma presentations will be processed anonymously and stored as research data for 10 years by the long-term custodian, research supervisor Dr Claudia Myler. Data will only be accessed by the me, the researcher, and my research supervisor. We will write our reports in a way that no-one can work out that you took part in the study.

What are your choices about how your information is used?

You are free withdraw at any point of the study, without having to give a reason but we will keep information about you that we already have.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained up to the point of data analysis. After this time, it will not be possible to withdraw your information. To safeguard your rights, we will use the minimum personally identifiable information possible.

Where can you find out more about how your information is used?

You can find out more about how we use your information:

- By asking one of the research team
- By contacting the University of Hull Data Protection Officer by emailing dataprotection@hull.ac.uk or by calling 01482 466594 or by writing to the Data Protection Officer at University of Hull, Cottingham Road, Hull, HU6 7RX
- By reviewing the University of Hull Research Participant privacy notice: https://www.hull.ac.uk/choose-hull/university-and-region/key-documents/docs/quality/research-participant-privacy-notice.pdf

Data Protection Statement

The data controller for this project will be the University of Hull. The University will process your personal data for the purpose of the research outlined above. The legal basis for processing your personal data for research purposes under GDPR is a 'task in the public interest'.

If you are not happy with the sponsor's response or believe the sponsor processing your data in a way that is not right or lawful, you can complain to the Information Commissioner's Office (ICO) (www.ico.org.uk or 0303 123 1113).

What will happen to the results of the study?

The results of the study will be summarised in the researcher’s thesis write up. This is a thesis for their Clinical Psychology Doctorate. It is aimed that the research will be published within a peer reviewed journal and may be presented at research conferences.

If you would like to have updates on the research, you can contact the researcher again at any point before September 2024. You are also welcome to obtain a copy of the published research by contacted the researcher by email.

Who has reviewed this study?

Research studies are reviewed by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and been given a favourable opinion by the Faculty of Health Sciences Ethics Committee, University of Hull.

Who should I contact for further information?

If you have any questions or require more information about this study, please contact me using the following contact details:
Email: B.WEST-2018@hull.ac.uk

What if I have further questions, or if something goes wrong?

If you wish to make a complaint about the conduct of the study, you can contact the University of Hull using the details below for further advice and information:
Dr Claudia Myler, c.myler@hull.ac.uk

Thank you for reading this information sheet and for considering taking part in this research

Appendix G: Consent form

Version 3: 04/07/23

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CONSENT FORM

Title of study: The experience of Vicarious Post-Traumatic Growth for Clinical Psychologists

Name of Researcher: Bethany West

Please initial box

1. I confirm that I have read the information sheet dated 2 version 22/06/23 for the above study. I have had the opportunity to consider the information, ask questions and have had any questions answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, up until the point of data analysis. ☐
3. I understand that the research interview will be audio recorded and that my anonymised verbatim quotes may be used in research reports and conference presentations. ☐
4. I understand that the research data, which will be anonymised (not linked to me) will be retained by the researchers and may be shared with others and publicly disseminated to support other researchers in the future. ☐
5. I understand that my personal data will be kept securely in accordance with data protection guidelines and will only be available to the immediate research team. ☐
6. I give permission for the collection and use of my data to answer the research question in this study. ☐
7. I give permission to be contacted by the researcher via the email provided for the ☐

purpose of organising a research interview

8. I agree to take part in the above study and participate in a 60-minute interview vi ☐ video call or if preferred, face-to-face.

Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature

Appendix H: Sources of support handout

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Version number 2: 4/7/23

SOURCES OF SUPPORT

Where can you find support?

During the interviews, the experiences discussed may elicit levels of distress that you may need further support with. If this happens, please reach out for support.

◆

Some suggested services:

Your line manager or Occupational Health department.

Your local mental health crisis team

Local Improving Access to Psychological Therapies (IAPT)

Your GP

Local staff wellbeing hub

Mind information line: 0300 123 3393

SHOUT text support: 85258

Samaritans: 116 113

Appendix I: Research recruitment advertisement

PARTICIPANTS NEEDED

ARE YOU A CLINICAL PSYCHOLOGIST WORKING IN THE NHS?

My name is Beth and I am looking for **qualified Clinical Psychologists** working within the NHS to take part in my Clinical Doctorate thesis.

This research is focused on the experience of growth after experiencing Vicarious Trauma, or indirect trauma. You may have experienced this during your work when working with trauma presentations and learning about their experiences. This is especially on a repetitive basis.

The experience of Vicarious Trauma can often be linked to feelings of growth, which is the primary focus of this research: The Experience of Vicarious Post Traumatic Growth in Clinical Psychologists.

Your participation would involve 60-minute interviews to discuss your experiences.

If you feel that you identify with the experience of Vicarious Trauma and would like to find out more about the study, please contact me at B.WEST-2018@hull.ac.uk.

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Appendix J: Interview schedule

Version number 3: 15/8/23

Semi Structured Interview Topics and Questions Outline

Anticipated time of interview: 60-minutes

Introduction outline:

Thank you for agreeing to take part in the interview and research. Let me know if at any point you would like a break, and of course we can conclude the interview at any time. A rough plan is to start with taking a few demographics, then beginning to explore your work and the impacts of your work, onto VPTG. Do you have any questions before we begin?

Verbal consent to audio record.

Example responses

Thank you for sharing that.
Can you tell me more about that?

Demographics- age, gender, how long have you been qualified as a Clinical Psychologist?

Interviews starting with gaining an understanding of the CPs job role:

- Could you please tell me a little about your role?
- What does a typical day look like for you?

Moving onto briefly understanding their clinical contact with trauma presentations:

- Within your typical case load, what types of trauma presentations do you work with?

Impacts of working with trauma presentations and vicarious trauma:

- How did this work impact you? Your work? Your mental health?
- How do you identify with the concept of VT?
- Have you ever taken time out/sick leave for these experiences?
- How did your service support you?

VPTG experiences:

- How do you feel now looking back at that/those experiences?
- Could you tell me about any positive impacts this had within your life?
- Could you tell me about any positive impact this had within your work?
- How do you identify with the concept of growing from this experience?
- What factors supported this experience of growth?

Facilitators and barriers

- How do you feel the NHS supported your mental wellbeing?
- How do you feel the NHS supported your VPTG
- What helped?
- Where there any barriers of support or growth?
- Are there areas where more support was needed?

Conclusion

- Is there anything else you would like to share surrounding your VPTG experiences?
- How are you feeling?
- Any questions for me?
- Signposting to the support handout sent via email
- Thank you for taking part and taking time out of your day to meet with me.

Appendix K: Example interview analysis

Transcript	Descriptive codes	Interpretative codes
R: How do you feel when you look back at those difficult experiences you've had?		
P: how do I feel? Erm, I feel like, I don't wanna say, write a passage cause that's not right, but I feel like if I hadn't had them again, I wouldn't be the psychologist that I am, and maybe I wouldn't protect my trainees in the way I protect my trainees. And maybe my 8A psychologists wouldn't get as much supervision as she gets, you know, maybe I wouldn't have had, you know, wouldn't, ohh, I definitely wouldn't know I had a limit on what I could do, I wouldn't have set up the	Having experiences shaped CP in role. Becoming protective of trainees Increased 8A supervision due to valuing own supervision from experience?	Influenced practise Growth effected views of support and wellbeing

team CBT peer support you know, and now that's something anyone in XXXX can access. So, I feel like I needed that to go through them to truly know and to truly understand that also, you know, it's really hard to understand flashbacks if you've never had had that experience of washing your hair and going ‘ohh there, that's nice, brilliant, good, I've got that image in my head now, that's crap, wonderful’. You know, unless you've been there, you know, and you can talk about that with kids. You know, obviously it's not the same and obviously I wouldn't tell them I've been, you know had that experience, but I can ask them about flashbacks in a way that they might be able to	Aware of own limits and self-awareness. Mindful of self Influenced implementation of support and provisions. Focus on this being available for all. A needed experience? Developed understanding and perspective of client experiences. Understanding of daily intrusions First hand insight Can show shared und. Feeling connected to clients? Feels private?	Self-awareness and own wellbeing Change of views and priorities? Insight Shared understanding with clients Useful insight experience Lived experience

understand because I have some lived experience of that, you know, erm it it. Yeah, I feel like I needed to that, that made me a better psychologist.	Can tailor questions from experiences Gained insight and perspective which feels useful	Shaped therapeutic approach Overall, feeling more competent? Or insightful?
R: Umm yeah, you've mentioned quite a few different bits there and you also mentioned as well before that the peer supervision came out of it as well.	Experiences supported professional growth	Increased sense of competence
P: I feel like, personally, I think it comes back to kind of that bit about the matrix and like you know, you're taking the pill, you know, erm I mean again, that's it for better and for worse thing, isn't it, you know? I meet somebody or my my husband describes somebody at work that that's acting out and I'm like, 'sound		

like a trauma kid.' They're 35, but it sounds like a trauma kid, be nice. You know that like, you know it's for better and for worse, it gives you insight into why people might be behaving the way that behaving, and again, that's for better and for worse. Sometimes it would be nice to just think someone was an arsehole, but you know that's less likely to to happen. Erm, so I think that that probably helps erm, I think it also gives you insight into, and I don't know whether this is trauma specifically or it's just being a psychologist or a mental health professional, but you have, you well, you wouldn't be a very good one if you never looked at yourself. And I feel like working with trauma in particular exposes every	Taking the 'pill of knowledge' and can't unknow. Irreversible Taking a trauma informed perspective outside of work. Mixed views of 'pill of knowledge' Trauma informed to others, engrained Insight into adults' behaviour Good and bad Always seeking understand or take a different perspective	Changes to views of the world Insight and perspective of others' experiences. Increased awareness Increased awareness Broadened perspective of those around Following a trauma informed approach in personal life Insight

little sore maladaptive, coping strategy that you have, it exposes it you know any little bit of disruption from your own childhood, any little bit of your own personality, it's gonna come out, you know, and our kids, because of the nature of them, will find them and you need to you need to be able to own those things and and sometimes do something about them, you know, so maybe in that way also makes you a better person, more self-aware person and you know, doing this kind of work and again for better and for worse. Sometimes it would be nice to be live in ignorance, wouldn't it? And just think I am a good person all the time, I am wonderful, there is nothing wrong with me, you know but	Self-reflection is important to the profession Trauma work exposes personal experiences Personal experiences being exposed Vulnerability in client work Taking ownership of experiences Important to act upon them Better person?	Self-awareness Understanding own experiences impacts Risks and vulnerabilities Need for acknowledging these experiences Need for strategies Acknowledging a how experiences shape you

maybe it makes me more self-aware person.	Increased understanding of self and personal history Ignorance feels safe? To have a positive perspective of self Creates self-awareness	Changes on views as of self from VPTG Self-awareness Desire for safety and to be sheltered Understanding self and reflections from VT enable self-awareness Feels positive

Appendix L: Epistemological statement

This statement outlines and explores the epistemological and ontological stances of the researcher and considers the underpinning assumptions that may have influenced the research development.

Ontology refers to the study of being, the nature and structure of reality or existence (Rawnsley, 1998). Two main ontology positions are realism and relativism (Gupta, 2023). Realism holds the view that there is, in some way, an observable reality independent of the researchers' perceptions or beliefs (Ylönen & Aven, 2023). Relativism assumes the position that reality is not independent to the researcher and that there is no objective truth but only varying interpretations (Hugly & Sayward, 1987). Trauma is considered a subjective experience that holds objective variables that can be measured through existing understanding of characteristics (Weinberg & Gil, 2016), such as for clinical diagnostic measures (Boals, 2018). Trauma informed approaches value the subjective experiences of trauma, such as internal processes and individual perceptions of events (Center for Substance Abuse Treatment (US), 2014). Within psychology research of trauma, a realist approach is thought to hold weight due to the nature of critical enquiry associated with exploring science and practice (Maree, 2015). I hold the view that existing understanding of VT and VPTG influences assumptions during research. Further, that there may be a thread of 'realism' across VPTG experiences. Despite this, I also view VPTG as a subjective and relative experience, and that I as a researcher impact interpretations (Levers, 2013).

Epistemology refers to the study of knowledge, how knowledge of the world is produced and how we can understand reality (Sol & Heng, 2022). It considers how the researchers epistemological position may influence their methodological decisions and interpretations (Chamberlain, 2014). When conducting qualitative or quantitative research, epistemology underpins the assumptions and processes. Qualitative research is linked to constructivism, an approach of subjective experience and interpretation mediated by the researcher (Yilmaz, 2013). This stems from a relativist ontological position (Bahari, 2010; Hartas, 2010). Quantitative research assumes a positivist epistemology that considers research objective and scientific (Bryman, 1984). Positivism views researchers as external to the exploration, stemming from a realist ontology (Slevitch, 2011). Despite this, I held the position that both qualitative and quantitative literature could provide rich data for understanding VPTG and VT. Therefore, holding the position of positivism or constructivism did not align with the my assumptions.

The epistemological position of this research was a critical realist approach (Bhaskar, 2020). As its name suggests, critical realism captures the position that is ‘critical’ of realism, and views knowledge as fallible and theory dependant (Poucher et al., 2020). In arguing the presence of the natural world outside of knowledge, it enables an ongoing process of exploration and development of understanding (McCormack, 2010). Previous VPTG literature holds a critical realist position to focus on the subjective interpretation of phenomena and individual experiences shared during interviews (McCormack, 2010). The position enabled qualitative and quantitative research methods to be combined (Cohen et al., 2017).

Critical realist takes an inductive focus rather than deductive or cause and effect like positivism. The position draws conclusions through retroductive reasoning, or the logic of developing inferences (Downward & Mearman, 2007). In doing so, inferences are developed through considering the mechanisms associated with producing them (Sayer, 1992). Exploring experiences, events, and causal mechanisms are key to a critical realist approach, to which combines ‘what’ the data is or how it can be observed with ‘what this means’ (Mukumbang, 2023). Therefore, this research assumed that VT and VPTG experiences are socially constructed and influenced by psychological professionals’ wider system, such as organisations. These influences were considered as real and mediated by relationships within the system (Mukumbang, 2023; Sayer, 1992). How CPs made sense of their VPTG experiences were considered in relation to the resources available, their internal understanding of VPTG, and experiences within their organisation. This fits with my views that mental health experiences are mediated by the resources available at an individual and systemic level. As a trainee clinical psychologist working in the NHS, I also hold the view that our experiences within the workplace likely mediate our existing mental health experiences. This critical realist approach elicited the aim of exploring the VPTG phenomena in relation to CPs' social world through investigating relationships between social structures and individual agents (Archer et al., 1999; Stutchbury, 2022).

The systemic literature review within this portfolio utilised both qualitative and quantitative papers. Critical realist principles underpin this methodology in acknowledging that valuable information and interpretations could be sought from both qualitative and quantitative papers (Tsirimokou et al., 2022). Additionally, for the quantitative papers to measure a reduction in VT, their independent variable was the implementation of VT coping strategy. Since the reviews focus was of identifying coping strategies, this methodology continued to provide interpretable findings. For critical realism, language is believed to reflect experience (Bhaskar, 2020) to which compliments the nature of 'story telling' in narrative synthesis (Popay et al., 2006). This is particularly in bringing experiences and events together to understand relationships or influences of causal mechanisms (Popay et al., 2006).

For the empirical paper, several qualitative methodologies were considered: including Narrative analysis (Crossley, 2000; Lyons & Coyle, 2007) or Grounded Theory (Corbin & Strauss, 1990). Interpretative Phenomenological Analysis (IPA) (Smith et al., 2009) was utilised due to the nature of the research question in exploring CPs' experiences and meaning of VPTG. IPA is grounded in Phenomenology, hermeneutics, and ideography, which underpinned the empirical research. Phenomenology aims to describe and understand experiences such as VPTG (Jen, 2016). This is thought to be complimented by a critical realist epistemological position in seeking to understand experiences, events, and causal mechanisms (Hood, 2016). IPA allowed for CPs' experiences of VPTG to be explored in depth where there was limited previous literature. It also enabled CPs' differing perspectives of VPTG to be valued through examining their detailed experiences independently before exploring across participants (Smith & Osborn, 2015). If 'Factors that influence' or 'How do people describe the experience of' was the primary basis of the research question then alternative approaches, such as Grounded Theory (Corbin & Strauss, 1990) or a Narrative analysis (Crossley, 2000), may have been more suitable. As such, with the aim of understanding CPs' VPTG experiences, IPA was considered most appropriate.

Double hermeneutics is also fundamental in IPA in recognising the role of the researcher and participant in interpreting VPTG experiences (Smith et al., 2009). This was considered essential to the empirical process in recognising my current position as a trainee clinical psychologist working in the NHS, while also exploring CPs' experiences of VPTG in the NHS. My assumptions of VPTG and perceptions of the NHS were recognised through early reflections, with great thought to how I would ensure to remain as unbiased as possible during the interviews. It was important that the interview schedule questions did not label or assume the presence of VT or VPTG but instead explored CPs' appraisal and relationship with the concepts. Supervision and reflective journaling supported this process, as well as the process of analysis in relation to recognising pre-existing theoretical understanding of VPTG. It was important that my prior knowledge of VPTG was 'bracketed' during the analysis to focus on CPs' experiences and meaning making (Tufford & Newman, 2012). Despite this, from a critical realist position I acknowledge the inevitable role of the researcher and their biases within interpretation (Bhaskar, 2020).

Based on this acknowledgement, reflecting on the assumptions and biases that may influence the research is essential (Halquist & Musanti, 2010). A key assumption was that social support would be essential in facilitating VPTG. This was based on my own clinical experience with clients and the literature that underlines the importance of social networks, support and friendships for mental health (Brummett et al., 2005; Cleary et al., 2018). I also held the assumption that reflection would be an important part of CPs' experiences, both within the interviews and as a facilitator for VPTG. This was based on my doctoral training and clinical experience to which reflection is a key focus, and reflective practice groups are highly valued (Carmichael et al., 2020; Fisher et al., 2015). During the interview process, I ensured to manage these assumptions by adhering to the interview schedule. Throughout analysis, I utilised a reflective journal to thoughtfully engage with how CPs' experiences aligned or differed from my perspective (Jamieson et al., 2023). This tool also supported consideration to my dual role as researcher and fellow NHS employee within the CP field. Further, as a researcher who holds strong personal values of organisations supporting staff-wellbeing.

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Appendix M: Reflective statement

I first started thinking about research of VT and VPTG when I was reflecting on comments from fellow trainees and CPs about how many psychological professionals have had personal experiences or exposure to mental health. I was curious how CPs managed their mental health in the workplace and the effects of working with trauma presentations. There seemed to be a movement towards positive psychology concepts rather than ‘problem saturated’ concepts, leading me to explore experiences of thriving, flourishing, and later VPTG. COVID-19 seemed to increase this focus on staff-wellbeing, which was mirrored by the upcoming service drivers such as the NHS long-term plan (NHS, 2019). It felt natural for me to explore VPTG as it aligned with my curiosities about what support was available for PPs to manage the impacts of their work. This interest was driven by my position as a trainee CP who has had their own mental health experiences, and perspective that these experiences have a place in my role as a professional. I am passionate about normalising mental health experiences within the clinical psychology profession and personally understand the stigma that may be associated with disclosing mental health experiences. I am also passionate about organisations moving away from this stigma through validation and creating a safe environment, valuing the idea that CPs do not have to be ‘perfect’.

My initial searches into VPTG led me to ask, “have I experienced VT before?”. While I felt that I had not, I recognised the risks and therefore the importance of PPs developing protective and management strategies. I was curious about “how do PPs keep themselves psychologically safe?” and “what support is available for those that do experience VT?”. I acknowledged the importance of growing from VT, and that positive experiences may come from VT that impact both professionally and personally. This created a sense of hope and value in identifying the facilitators of VPTG, leading me to query “how to people grow from VPTG?”, “why do some people not grow from VT?”, and “how does the NHS make room for prioritising growth from VT?”. Researching some more, I noticed and felt shocked by the gap in literature for VT and VPTG in CPs. Particularly when reflecting on CPs’ contact with trauma presentations. This propelled the development of my research question and aim of exploring CPs experiences of VPTG. I believed that this would be supported through a qualitative approach, conducting one-to-one interviews whereby rich experiences could be captured.

Methods and Approach

When considering methodology for the study, I was naturally drawn to IPA (Smith et al., 2009) due to its value in exploration of experiences and meaning making. With my trainee position and personal experiences in mind, I was interested in the double hermeneutics principle within IPA. While I perceived my passion for staff-wellbeing as valuable in the research process, I was also mindful of managing my pre-existing assumptions and perceptions. Double hermeneutics acknowledged how I would be interpreting CPs’ own interpretations of their experiences (Giddens, 1982) and the value of utilising a reflective journal to enhance methodological rigour (Smith, 1999). These fundamentals within IPA underlined how I as a researcher would influence the research and provided a framework to aim to manage these effects. Narrative analysis was also considered, with interest to how lived experience can be analysed from embedded narratives of experiences (Seale, 2012). Despite this, due to the nature of enquiry, ‘experiences of VPTG’, I was interested in the experience of and meaning made from VPTG rather than a chain of experience that form a narrative (Weatherhead, 2011). Grounded theory would have also been suitable if the aim was to develop an understanding of ‘how’ CPs experience VPTG to inform theory or understanding (Chun Tie et al., 2019). With this in mind, I felt that IPA was most suitable with the research aims and questions.

Ethics Process and Recruitment

The process of developing an ethical application was helpful in solidifying the planned research processes and putting myself in the position of CPs who wished to take part. It provided a space to reflect on the potential impacts of taking part in the research and how this experience may feel for CPs sharing their personal experiences of VT and VPTG. It became a key focus to ensure the interview space felt safe and that CPs had the resources to manage their wellbeing during and following the interviews. I was also mindful of ensuring the interviews were more than ‘information seeking’, and reflected on how I would mitigate this. For example, making space for lighter dialogue and taking a conversational approach. Through considering ethics in this way, I received ethical approval without much difficulty. I applied and received ethical approval from the Faculty of Health Sciences’ Research Ethics Committee, deciding not to apply for NHS Ethical Approval alongside this. The basis of this decision focused on being able to recruit CPs from outside of their NHS organisation, with the aim that this would provide safety in CPs not being linked to their working environment. I perceived that this would promote CPs to feel more comfortable engaging in the interviews and sharing their views on the NHS’ support openly.

The recruitment process was a space for reflection and questioning of my recruitment method and previous decision to not apply for NHS ethics. Over time I was concerned with whether this decision had created some barriers to recruitment than I had initially expected. This was due to the recruitment process taking longer than anticipated, with few CPs coming forward with interest to partake. CPs from trauma specific services asked whether I wished to advertise within their service, which initially felt like a missed opportunity. However, by advertising through social media groups dedicated to supporting CPs or PPs’ mental health, I was able to advertise to my target audience effectively.

Further, when reflecting on my acknowledged anxieties, I felt this was associated with feelings of uncertainty and “what if I don’t recruit enough participants?”. Using my reflective journal, I was able to re-visit my initial decisions and value my previous reasoning for seeking ethical approval outside of the NHS committee. When finishing recruitment, all CPs included in the study were currently working in the NHS, indicating that my concerns were more likely linked to underestimation of the lengthy recruitment process.

During the recruitment process, I also became curious as to my decision to have an exclusion criterion of CPs ‘not known to me personally’. I questioned whether this was the right decision and wondered if I had not included this exclusion criteria, would I have been able to recruit participants with ease? This was based off CPs who I was personally linked to sharing interest in partaking in my research. Despite this, later reflections and discussions with my research supervisor re-aligned this decision to the original rationale; if participants were known personally to the researcher, would they feel comfortable disclosing their experiences? Looking back, I believe that if the CPs had been known to me personally, it may have affected the interview process. The dynamics in the space would have been vastly different and I wonder whether it would have felt more of a favour than desire to independently take part in the research. Additionally, through recruiting from social media community groups, those that did take part presented with either an interest in the topic or desire to contribute to the literature surrounding the mental health experiences of their profession.

Relationship with participants

As a trainee CP, it was noted through early reflections that I related to the participants in that they are the ‘future me’. Additionally, my role as both an ‘insider’ and ‘outsider’. During the interviews, I noted a sense of awe in that they presumably have more clinical experience and often felt absorbed by their experiences discussed. At times, this elicited feelings of being an imposter and ‘less than’ compared to the qualified CPs I was engaging with. There were times when I also experienced anxiety in hearing about the vast responsibilities and pressures the CPs managed, and questioned whether I would be able to manage in the future. I was also aware that the CPs would likely have completed their own research, creating a sense of pressure to ‘do well’ and ‘interview correctly’. Although, I also recognised an unspoken understanding from the CPs as to the value and pressures of completing a thesis portfolio. This provided comfort and eased my nerves, supporting me to be present with the CP and their experiences. Despite this, I related to the CPs in that I also work in the NHS and its current system, strain, and service drivers. I noted that this, as well as professional discussions, may have pre-empted by expectations of what the participants would disclose in terms of feeling supported. This was impacted by my research and understanding of the current NHS context. This had particular focus on staff wellbeing community hubs closing and my positioning of this being counterintuitive when discussing normalising and focusing on professional mental health experiences. Therefore, I found it vital to manage these beliefs and my perceived relationship with the CPs taking part in the research. During the analysis phase, I valued the use of a reflective journal and cognitively tracing my thoughts to either existing assumptions or new findings. This was also supported by using mind maps to visualise the data or emerging themes.

Interviews

During the first few interviews, I recall feeling nervous and conscious of my responses and uncertainty as to whether I was following the ‘correct’ procedure. I found it challenging to not respond as I would in my clinical role and to not to fall into clinical ‘assessment’ mode, such as normalising and summarising. I was concerned that despite my initial reflections during the ethical approval stage, I was being ‘cold’ by not engaging the same as I would during client interactions. I found research supervision incredibly helpful for this and spent time reflecting on interviews processes and language, particularly the during the initial stages. As time progressed, I felt more comfortable with the interview process. This was supported by CPs' feedback towards the end of the interviews, verbalising that they found the space enjoyable and conversational.

Despite this, I was also mindful of CPs' experiences of participating in the research project. I was conscious of how re-living trauma-based experiences may be difficult and continued to feel passionate about creating a safe space for the CPs. I was also aware of the dynamic within the room, of which I as a researcher was trying to gain data and understanding that serves a purpose. Throughout interviews I often felt an overwhelming sense of gratitude that the participants were willing to take time out of their day and be vulnerable in their disclosures. Although, I became curious whether this perception was an assumption based on how I believed I may feel if taking part in such a study and interview. This came to light with participants who discussed the interview being a reflective space and identifying with growth because of the space. This provided me with an alternative, positive perspective in the experience of engaging in the research. Looking back, I wonder whether the assumption of engagement being difficult is linked to the ethical approval process and thinking about 'the risks involved in taking part in the research'. While this consideration was important, and may speak to some participant research, I appreciated the alternative, positive perspective to which will be insightful for future research.

Context around the study

During the period of developing my research and conducting the interviews, I noticed the increased in focus on staff-wellbeing the literature had indicated. COVID-19 had created admiration for NHS staff and nurses, although societal discourses appeared to shift when nurses raised issues of pay and working environment conditions (Kalocsanyiova et al., 2023). I wondered of the effects the media coverage and perceptions of nurses speaking out had on the culture of voicing distress and advocating for wellbeing. Alongside this, campaigns were growing for the protection of staff-wellbeing hubs, with much discussion of why these hubs are essential for mental health (BPS, 2024). The funding cuts created uncertainty as to the support available for staff wellbeing, despite the NHS voicing their focus on promoting staff-wellbeing through services drivers (Ravalier, 2022). Acknowledging the disparity in service aims and cuts, I feel that this impacted CPs’ views of how the NHS supported mental health experiences such as VT and VPTG. Although, I also wonder whether this makes the current research more authentic to the current NHS context.

Trauma informed care was also continuing to gain momentum as a key service driver, shaping healthcare services’ contact with those accessing the services. This was also mapping onto the experiences of NHS staff, and I was part of many placement discussions of how staff could benefit from this driver. This linked back to the aim of creating a culture whereby staff felt safe discussion their own mental health experiences. Looking back, I am curious as to how the trauma informed model maps onto VPTG experiences. In future research, I would consider incorporating the trauma informed principles into the interview schedule to explore whether this creates a model of facilitators or gaps.

Data analysis

When initially exploring the interview transcriptions, I felt a pull to include all the data and found it overwhelming to consider how a handful of themes would emerge. The language used by many CPs were impactful, which highlighted the effects of dialogue and I felt pressure to effectively capture all the experiences discussed. I managed this by having my research question and aims visible throughout the analysis and write up process. Further, through sharing the emerging themes with my supervisor, using reflection to ensure the research direction retained its direction. I also found talking to my fellow trainees essential in developing connections/ relationships across themes, and often found general conversations of placement sparked an ‘ah ha’ moment. Through looking at the data beyond its text form, I was able to interpret the meaning in relation to its human and lived experience. I found that much of what the CPs discussed aligned with many of my views and beliefs surrounding the NHS system. Therefore, it was important I remained mindful of potential biases and ensured I focused on the interviews as a whole, not just the elements that ‘attracted’ my attention. My reflective diary was essential in monitoring my assumptions and considering why particular CP experiences stood out for me. Looking back at earlier reflections of why I chose this research topic, I linked these stand out experiences to the engrained passion I had for this research area. My interest and views on the importance of promoting staff-wellbeing, and that I continued to view this as somewhat unsafe for PPs. Being mindful of this during the analysis was supportive of remaining focused on the wider picture of VPTG. I also found the use of sticky notes and spider diagrams as essential in managing the overwhelming amount of data.

At first, I found it difficult when two of the CPs did not name their experiences as VT. I was concerned that through not using the language of VT, this meant that their experiences could not be included in the analysis due to my inclusion criteria. Despite this, supervision was incredibly helpful in taking a step away from the desire to have an outright identification of VT and focusing back on what these CPs shared overall. In doing so, I recognised that these CPs had in fact described VT when asked about the impacts of their clinical work. Their accounts aligned with the literature of VT experiences, indicating that something ‘more’ was underlying. In returning to the data, it became apparent that experiences of stigma, threat, and narratives were playing a large role in whether VT was named. In doing so, I was able to make interpretations of relationships between these factors, which contributed to the overall picture developed from the interviews. This experience supported me to view the data from a different angle, which I believe mediated the rest of the research process.

Systematic Literature review (SLR)

When developing ideas for research topic, I felt a pull to better understand the experiences of VT. I considered what would complement my empirical research of VPTG and wondered about PPs' experiences before growth. I was interested in how individuals cope with VT, and whether this would have any similarities with accounts of VPTG. Although I acknowledged that coping with VT does not equal VPTG (Melaki & Stavrou, 2022). When exploring the literature, I noticed that there was no singular paper that concisely brought 'coping' together. For example, papers seemed to explore organisational coping factors or more general personal coping factors. Thinking about promoting staff-wellbeing, I wondered about the benefits of having a collected understanding of coping facilitators within one piece of research. I hoped that this would create ease of access and wondered whether this would be helpful for services to support PPs to manage VT. At first, I aimed to explore VT with CPs as to align itself with my empirical research. Despite this, I noticed that there seemed to be little literature specific to CPs and VT, raising concerns as to whether this research topic was plausible. This led to the review question broadening to include all PPs.

The process of completing the review search was at first frustrating. Due to missing search terms encompassed in 'psychological professionals', I needed to revisit and amend my searches upon two occasions. This is likely linked to my eagerness to begin the review process, but also may be linked to the vast number of professionals and titles within such a broad pool. When reviewing the papers, it was important that I ensured the studies remained focused on the research inclusion and exclusion criteria. I aimed to explore prevention and intervention strategies that encompassed 'coping'. Despite this, a vast amount of the literature was initially presented as ‘coping’, only to focus on predictive or ‘risk’ factors. It was important that I remained focused and alert to this, which was facilitated by taking regular pauses and revisiting my exclusion criteria.

The process of developing an understanding of the data was both enjoyable and challenging. Making meaning from the data enabled me to group and find connections across the coping facilitators. Despite this, it was challenging to untangle and separate some of the factors due to their interactions and mediations Once I had grouped the data and managed their interactions, I reflected on my feeling of clarity and hoped that this would translate into the review write up to support ease of read. From completing the SLR, I feel a sense of accomplishment and increased competence in following a systematic approach to research. I am hopeful that the findings will have clinical value and contribute to the discussions of VT experiences within clinical contexts.

Journal choices

For both my empirical study and SLR, the International Journal of Wellbeing was selected. This journal promotes research on wellbeing, aligning with VT and VPTG focuses of this thesis portfolio. This journal has an international scope, which was suitable for the international papers included in my SLR. While my empirical findings may be relevant to a UK based journal, the International Journal of Wellbeing may enable the findings to reach a varied audience and other healthcare settings to which may be useful. I also found it important that the journal holds open access for everyone, meaning their published content is free. This was appealing as I feel it’s important for those inside and outside of academics or access approved professions to be able to find relevant and interesting literature. I hope that both my empirical research and SLR can reach a wide audience to highlight the importance of PPs and CPs’ wellbeing.

Final reflections

The experience and process of developing a thesis portfolio has elicited a range of contradicting and difficult emotions. Naturally, at times I felt frustrations and anxieties relating to the ‘new’ and challenging demands. Despite this, I came to acknowledge that I had been developing my research competencies for some years and that these skills could be built upon during the process. It was important for me to re-visit my passion for both the research topic and overall context of staff-wellbeing. Further, for my interest and value of psychological research that contributed to my decision to apply for the clinical psychology doctorate. This mediated some of the pressures experienced throughout the research process. I feel incredibly appreciative of those that participated in my research despite CPs’ own responsibilities and clinical demands. This has elicited a new personal value of aiming to contribute to psychological research wherever possible, particularly as a participant. Looking to the future as a qualified CP, I also aim to continue to advocate for staff-wellbeing and hope that my internal value of lived experience weathers potential stigma within the NHS.

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