The experiences of clinical psychologists in treating traumatic stress at a tertiary psychiatric hospital in the Eastern Cape: A qualitative research study

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SECTION A: JOURNAL SELECTED AND SPECIFICATIONS FOR AUTHORS

Journal Selected

The content and technical requirements of the article are based on those for the ***Qualitative Health Research (QHR)***. The journal is an international, interdisciplinary, refereed journal for the enhancement of health care and furthering the development and understanding of qualitative research methods in health care settings. The forum welcomes manuscripts covering the following areas: the description and analysis of the illness experience, health and health-seeking behaviours, the experiences of caregivers, the sociocultural organisation of health care, health care policy, and related topics. The journal publishes critical reviews; book reviews; articles addressing qualitative methods; and commentaries on conceptual, theoretical, methodological, and ethical issues pertaining to qualitative inquiry. ***Qualitative Health Research*** only considers Original Research for publication and does no longer accept Literature Reviews, Systematic Reviews, Meta-Analyses, or Meta-Synthesis articles.

The journal is an invaluable resource for researchers and academics, administrators and others in the health and social service professions, and graduates who seek examples of qualitative methods. The journal is on e-mail to help readers make the journal more interactive.

Specifications for Authors

All papers should be compiled in the following order: title page, abstract, keywords; main text introduction, materials and methods including ethics, results, discussion; conclusion; table(s) with caption(s)/ (on individual pages); references and, finally appendices (as appropriate). A word limit is not included. The paper should contain an unstructured abstract of maximum 150 words, and a typical article for this journal should preferably not exceed 30 pages inclusive of tables and references. Manuscripts should be written in English and conform to the publication guidelines of the latest edition of the American Psychological Association (APA) publication manual of Instructions for Authors. Manuscripts should be prepared in MSWord or PDF, with standard 1 inch margins in standard font (i.e., Times New Roman) at 12 point. ***Qualitative Health Research*** is hosted on SAGE Track, a web based online submission and peer review system powered by ScholarOne™ Manuscripts. (Refer to Appendix A for detailed specifications).

SECTION B: ARTICLE SUBMITTED FOR EXAMINATION

The experiences of clinical psychologists in treating traumatic stress at a tertiary psychiatric hospital in the Eastern Cape: A qualitative research study

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Abstract

Traumatic encounters are highly prevalent within the South African population. Clinical psychologists working with these trauma narratives, within a psychiatric context, are therefore at risk of experiencing vicarious trauma, Post Traumatic Stress-Disorder (PTSD), and secondary traumatic stress. This study aimed to explore the lived experiences of clinical psychologists who treat patients that are either trauma survivors or perpetrators in a psychiatric hospital. Individual semi-structured interviews and follow-up interviews were conducted with three clinical psychologists based at a psychiatric hospital in the Eastern Cape. Data was analysed using Interpretive Phenomenological Analysis. All participants reported experiencing symptoms of vicarious trauma and secondary traumatic stress while treating both victims and perpetrators. The findings also discovered an element of danger, as well as socio-political factors that clinical psychologists experience. Participants also reported experiencing vicarious post-traumatic growth, enhanced by their coping strategies, while providing psychological services to traumatised patients.

Keywords: Clinical psychologists; psychiatric hospital; patients; traumatic stress; vicarious trauma; secondary trauma; trauma narratives; vicarious post-traumatic growth; South Africa.

*Ethical approval was granted by the Rhodes University Ethical Standards Committee (RUESC) (Reference number: 2020-1341-3524)

Introduction

The mental health of the South African population has been greatly affected by racial segregation and, additionally, characterised by traumatic events that transpired during the Apartheid era. Many adults and children were left to deal with the effects of traumas deeply embedded within the South African society today (Atwoli et al., 2013; Kaminer, Grimsrud, Myer, Stein, & Williams, 2008). The World Health Organisation's (WHO) World Mental Health (WMH) survey (n = 125 178) found that an estimated 70% of persons across 24 nations directly experienced a traumatic event, and only 30% reported to have witnessed a traumatic

event (Benjet et al., 2016). The South African Stress and Health (SASH) study reported that an alarming 73.8% of the population are exposed to trauma (Atwoli, Stein, Koenen, & McLaughlin, 2015). The country is currently faced with the most violent crimes and health care crisis, such as sexual violence, armed robberies, domestic abuse and witnessing severe harm or loss of another; along with the Human Immunodeficiency Virus (HIV), Coronavirus disease (COVID) and Tuberculosis (TB) (Kim, Nyengerai, & Mendenhall, 2020; Wyatt et al., 2017; Sui & Padmanabhanunni, 2016; Atwoli et al., 2013).

A traumatic event occurs when an individual is faced with or is indirectly exposed to an experience that is both overwhelming and disturbing (Kleber, 2019). The impact affects the way an individual makes sense of their traumatic experiences, negatively influencing their emotions, thoughts, behaviours, and their outlook on life (Atwoli et al., 2013; Kaminer et al., 2008). There is an interest in exploring the development and prevalence of traumatic stress (Atwoli et al., 2015; Atwoli et al., 2013; McCann & Pearlman, 1990). For example, Atwoli et al., (2013) indicates that exposure to a stressful experience; the unexpected loss of a loved one, or victims and witnesses to violent criminal activities cause symptomatic distress related to Post Traumatic-Stress Disorder (PTSD). Strikingly, the prevalence of trauma exposure in community-based studies in South Africa were found to be significantly high with 93.1%, suggesting that the population is at an increased risk to developing PTSD (Atwoli et al., 2015; Kaminer, du Plessis, Hardy, & Benjamin, 2013).

Symptoms of PTSD include flashbacks, distressing memories and nightmares, sensory impressions, attempts to avoid internal and external cues that are a reminder of the trauma; and negative changes in thoughts, behaviours and mood (American Psychiatric Association, 2013). The public mental health system in South Africa is presented with countless cases of individuals experiences that resemble symptoms of depression and traumatic stress that stem from childhood trauma (Kim et. al, 2020). Therefore, the topic of PTSD has saturated the current literature on mental health disorders (Wyatt et al., 2017; Atwoli et al., 2013). The prevalence of traumatic stress in psychiatric contexts are under researched, which emphasis the concern for potential risks to mental health practitioners treating victims in distress as a consequence of the high rates of trauma in South Africa.

Clinical psychologists treat psychological disorders, usually within a psychiatric setting such as a hospital (Government Gazette, 2018, “Acts of different categories of psychology”, para. 1). Clinical psychology is a branch of psychology in which practitioners specialise as clinical psychologists to diagnose, assess, and treat severe pathology (Khan, 2008). Working

in a psychiatric hospital includes working in a multi-disciplinary team, treating inpatients and outpatients who are either victims or perpetrators (Liberman, Hilty, Drake, & Tsang, 2001). Clinical psychologists undergo extensive training that involves coping with the draining effects their work carries. They do so by maintaining a healthy emotional distance from their patients traumatic experiences (Sinaj & Dibra, 2015). Treating trauma is understood to be demanding as it requires re-telling's of the trauma narrative using Cognitive Behavioural Therapy (CBT) and cognitive restructuring (Kennerley, Kirk, & Westbrook, 2017). However, listening to the details of patients trauma narratives expose practitioners to traumatic stress, vicarious trauma and secondary trauma (McCormack & Adams, 2016; Sui & Padmanabhanunni, 2016; MacRitchie & Leibowitz, 2010).

In the United States, between 40% and 85% of health and service practitioners develop vicarious trauma and secondary trauma, leading to burnout and compassion fatigue (Mathieu, 2012). Vicarious trauma is an impaired view of the self, others or the world. This occurs in response to repeated exposure to trauma narratives when a mental health practitioner engages empathically with traumatised clients (Finklestein, Stein, Greene, Bronstein, & Solomon, 2015). An international study focusing on mental health practitioners found that PTSD correlated with vicarious trauma in Gaza, an area exposed to trauma and violent attacks (Finklestein et. al, 2015). In South Africa, vicarious trauma and sub-clinical symptoms of PTSD were found in psychologists exposed to details of client's traumatic experiences in private practice (Sui & Padmanabhanunni, 2016). Kaminer and Eagle (2010) similarly found that mental health practitioners treating trauma in South Africa experience vicarious trauma.

Secondary traumatic stress occurs when mental health practitioners are exposed to patients traumatic experiences, and develop symptoms of traumatic stress themselves (Mathieu, 2012). Symptoms include somatic responses, negative emotions and psychological distress (Manning-Jones, de Terte, & Stephens, 2015; Cohen & Collens, 2013). A study based in the United Kingdom included 253 mental health practitioners treating trauma clients found that 70% of the scores indicated a high risk of secondary trauma (Cohen & Collens, 2013). Concurrently, research in South Africa found secondary trauma to be experienced by mental health practitioners and emphasised the need to provide training that will enable them to cope with the emotional impact (MacRitchie & Leibowitz, 2010). There are few recent studies on the impact trauma work has on mental health practitioners (Booysen & Kagee, 2021; McCormack & Adams, 2016; Sui & Padmanabhanunni, 2016). Moreover, little research focused on the qualitative experiences of clinical psychologists treating trauma, specifically in

inpatient public service psychiatric hospitals. Risks practitioners are exposed to are conceptualised by vicarious trauma and secondary trauma. Aspects of these risks include distressing somatic symptoms and PTSD symptoms, negative emotions, issues of self-identity, including a high level of alertness to safety and fears of dangerous patients (Olashore, Akani, Molebatsi, & Ogunjumo, 2018; Sui & Padmanabhanunni, 2016). Mental health practitioners are also susceptible to psychological distress within inpatient settings. While it is known that the mental well-being of practitioners is at risk when treating trauma clients, it is still yet to be discovered as to what extent these risks extend to clinical psychologists working in public psychiatric hospitals.

In contrast, individuals who treat trauma also develop a positive belief system that leads to psychological growth and resilience (Silveira & Boyer, 2015; MacRitchie & Leibowitz, 2010). Positive findings in mental health practitioners treating trauma include experiences of vicarious post-traumatic growth in their personal lives (McCormack & Adams, 2016; Sui & Padmanabhanunni, 2016). Vicarious post-traumatic growth is the development of positive emotional, cognitive and spiritual changes in response to direct exposure of trauma survivors' narratives. It is associated with life satisfaction, personal strength, happiness, psychological and physical well-being (Manning-Jones et al., 2015). A sense of joy and personal growth working with trauma was also found (Silveira & Boyer, 2015; Johnson, 2010). In addition, practitioners who engaged in supervision and supportive developmental activities were shown to experience more compassion and empathy toward the patient (Sodeke-Gregson, Holttum, & Billings, 2013).

Public psychiatric hospitals and private hospitals differ from each other in terms of resources, challenges and case load (Docrat, Besada, Clearly, Daviaud, & Lund, 2019). A range of studies investigated the impact on mental health practitioners who treat trauma survivors in communities and private practice. However, there still remains an unexplored interest in the phenomenological experiences and challenges faced by clinical psychologists. Expanding on the literature in the current study is distinctive in that it provides qualitative insights into the phenomenological experiences of a group of clinical psychologists who work with trauma survivors, specifically, in a public psychiatric hospital. This information will contribute to the field of psychology and the clinical psychology profession, guiding the structure of training material and sensitising practitioners who wish to work with trauma narratives. To this end, the present study was guided by the following research question: How do clinical psychologists experience working with traumatic stress in an inpatient public psychiatric hospital?

Methods and materials

Participants

A heterogeneous purposive sampling process was used to recruit participants according to the design of Interpretive Phenomenological Analysis (IPA), gaining insight into a particular experience (Smith, Flowers, & Larkin, 2009). Four public psychiatric hospitals in the Eastern Cape and Western Cape were approached to participate in the study, of which only one site had interested participants. A sample of three voluntary participants with the age range of 40-53 years were recruited from a psychiatric hospital in the Eastern Cape. All participants were clinical psychologists who are registered with the Health Professions Council of South Africa (HPCSA) and had experience with varied pathological cases, including trauma. Interpretive Phenomenological Analysis studies are known to use small idiographic samples for a deeper, detailed understanding of participant's perceptions (Smith et al., 2009). The inclusion criteria were based on levels of experience. Participants who had more than three months of work experience as a clinical psychologist at the psychiatric hospital were invited to participate in the study (Smith et al., 2009). The current participants had an average of 18 years' experience.

Procedure

Ethical clearance was granted by the RUESC (refer to Appendix B), including permission from gatekeepers at the Psychology Department of the psychiatric hospital. The Psychology Department of the hospital was contacted, requesting for the recruitment advert to be e-mailed to all clinical psychologists, as well as the professional e-mail addresses of each clinical psychologist to follow-up on their interest to volunteer as a participant. Those interested received the consent form (refer to Appendix C), and interview schedule with interview questions prior to the interviews. Data collection was conducted via one-on-one, semi-structured interviews in person. Each participant consented verbally and signed a consent form. Participants were cautioned prior to the interview that should they become distressed, they are able to terminate the interview and seek support from someone they trust, or by accessing psychological services from their own personal therapists.

Each interview's timeframe was between 1 hour and 1 hour and 30 minutes. In total, six interviews were conducted in a manner which was open-ended. Three of these interviews were follow-up interviews one week after the first interview to facilitate a reflective account of their experiences. Through obtaining a deeper reflection of their experience, it allowed for more accurate findings which helped myself and the participants refine certain questions, thoughts

and reflections. It also aided in uncovering the potential layers of their professional responses and getting to a point of phenomenological understanding (Hoover & Morrow, 2015). Interviews were conducted using an audio-recorder, with the participants signed consent (Smith et al., 2009). All data was transcribed using a transcriber who was a graduate student in politics and Spanish language, who also signed a confidentiality agreement.

Interview Guide

An interview schedule was developed and underwent refinement to corroborate with the aim of the study (Smith et al., 2009). Items for the first interview focused on areas of interest (refer to Appendix D). Item areas with probing questions included how they came to work in a psychiatric hospital and their experiences working there. The participants' opinion and experiences of treating trauma and PTSD were also explored, along with their coping strategies. The follow-up interview included questions based on the account of participants experiences in the first interview, clarifying their experiences and obtaining deeper reflections. Treating trauma based on their gender came up as an area of interest in the subsequent interviews.

Data Analysis

The current study used IPA as an experiential qualitative research method. The IPA approach is underpinned by three core philosophical perspectives identified as phenomenology, hermeneutics and idiography (Smith et al., 2009). The analysis took a double hermeneutics and idiographic approach by making sense of participants' experiences in a given context, whilst also interpreting and contextualising them. The data retrieved was analysed using the IPA analysis guidelines; in other words, a step-by-step analysis (Smith et al., 2009). The process first involved reading and re-reading each transcript to create an overall impression for each participant. The transcript was placed in a single column with two subsequent columns for notes and sub themes. Comments and notes were made on significant reflections in the second column and broad sub themes were identified based on these notes in the third column for each transcript. The analysis deviated slightly as transcripts were then re-read, and the sub themes were numbered according to the page numbers of the participants' narratives. Two new columns were made on a separate document, clustering new superordinate themes with sub themes according to similar patterns (refer to Figure 1 below). Sub themes were reviewed and refined thereafter. Thoughts and reflections of the interviews were noted down and kept in a journal, which was later considered when refining, selecting and writing-up significant findings.

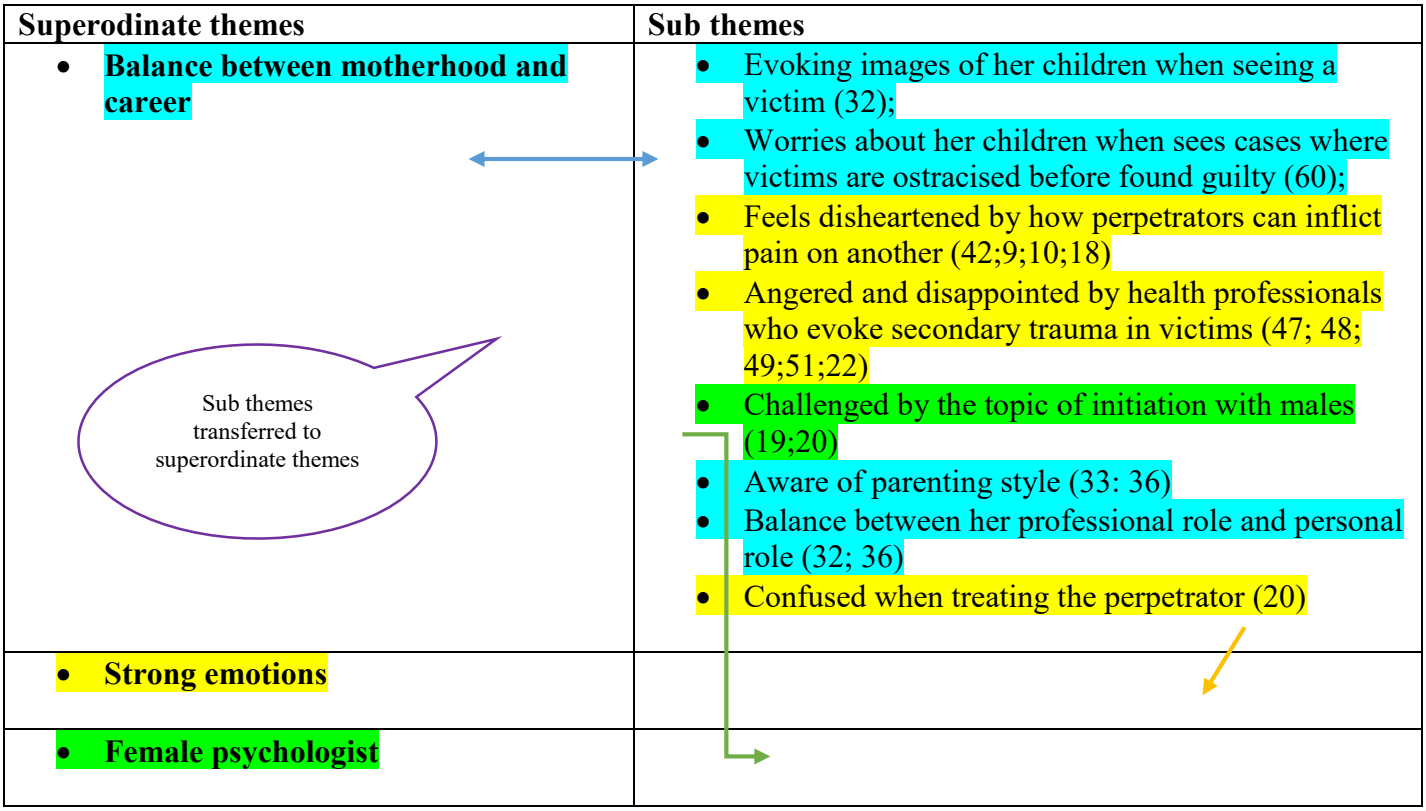

Figure 1: A step in the analysis process

Trustworthiness

Trustworthiness of the present study was ensured by conducting the research through the 'lens' of IPA (Smith et al., 2009). Credibility of the study is warranted by re-reading transcripts, comparing them to the audio recordings to achieve reliability, and the follow-up interviews contributed by clarifying participant's experiences through probing for more elaborative and deeper reflections of their narratives. Obtaining a deeper reflection of their experiences further allowed for more accurate findings in terms of conceptualising the participants reflections and how it relates to them within a psychiatric context. Researcher reflexivity was also recognised during the research process that allowed for more accurate interpretations of the findings.

Findings

Each theme elicited from the data describes unique aspects of the individual's professional and personal experiences working with traumatic stress within a psychiatric hospital. The themes for each individual will be discussed phenomenologically reflecting their experiences. Pseudonyms will be used to protect the identities of the participants. The results will be presented ideographically, in line with the IPA guidelines (Smith, et al., 2009).

Participant 1: "Allen"

Table 1. Summary of themes for Allen

Superordinate themes	Sub themes
Distressing responses to treating traumatic stress	Emotional reactions Lack of closure
The presence of gender	Treating female patients
Conscious of the effect on his personal life	Personal experiences

Superordinate Theme 1: Distressing responses to treating traumatic stress

Allen vividly described distressing experiences related to treating traumatic stress in practice at the hospital. This superordinate theme includes two sub themes:

Emotional reactions

Allen described a feeling of shock in response to severe trauma cases. He stated: "*There are times when I'm shocked at what I hear. We're shocked at what we hear is happening out there, but it's not a feeling that seems to stay, it's not something that I find myself thinking about later on.*"

This highlights a particular reaction he has to severe trauma narratives. Allen noted that it was short-lived and brief, rather than emotional distress that he would ruminate about. This speaks to a transformative process of the feeling itself moving away, where he has no control or contribution to how he engages with this feeling of shock. The shock is a feeling he doesn't sit with, but he transcends to a possible resistance to fully engage with the magnitude of what he hears. Aligned with his experience is to acknowledge the normalisation of trauma narratives that influence his distinctive reaction, thereby desensitising him from the effects of trauma. In his experience, this is an adaptive coping strategy in a trauma-saturated work setting.

Allen also made reference to his feelings of sadness and irritability when treating trauma victims of domestic abuse. He stated, "*It makes me sad that there are people living lives that are empty, where there's fear in a situation like this.*" Allen sees his patients who are living a life in a home without love, joy and peace. He captures a sense of the patients unhappiness and fears living in an "empty" home with an abuser, feeling sympathy for the patient who is living a life of no self-worth. He observes that the trauma they experience is taking everything

out of them and depletes them, which makes him feel sad for the victim. This forces him to make sense of the perpetrator causing such emotional turmoil, wondering about the perpetrators upbringing. This appears to be a strategy he developed to help him manage his own feelings of frustration with the patient's situation in order to hold the therapeutic frame.

"*The problem is I can't allow my sympathy to come into that room. So maybe in a situation like that, the battle is between sympathy and empathy, irritability towards the other and empathy; why is he this way, what was his dad like, what was his grandfather like, how does he turn into this man? That's also sad.*" In contrast to feeling sorry for the patient, Allen empathises with their perpetrator by wondering about their life challenges and how that may have contributed to them becoming the abusive person they are. Due to the context in which he works, he holds himself back from feeling sympathy. Instead, he tries to make sense of the perpetrator through his patients experiences, and perhaps thinks that he can help the patient by understanding the perpetrator. He engages with this encounter as he also tries to make sense of his patient's first-hand experience with the perpetrator. This leads to him feeling frustrated and empathetic as he chooses to be concerned about the perpetrator too.

Lack of closure

A theme unique to Allen's experience as a clinical psychologist is starting a process with a patient in a ward, but having to hand over the case to the next ward as a result of the patient's progress in the recovery system.

"*And so one of the experiences of being a therapist in this setting is you often don't get to see the end product. You get to start something, you get to hand over that something, but you don't get to see the end most of the time.*"

Allen feels an underlying sense of disappointment and discontent. He is unable to reap the complete reward of the role he played in the inpatient's treatment process. For him, it is unsettling sitting with an incomplete canvas of the patient who he cared for, which is only shaded by his treatment contribution. He was there to capture the deep inner feelings and traumas of a patient, adding to the patients progress, but unable to see their life transform over time as a completed canvas. This experience shapes how he conceptualises working as a psychologist in a psychiatric hospital: receiving limited closure in the profession. For Allen, he finds solace by being aware of his role in the patients progress and its significance to the therapeutic relationship. In an attempt to find closure, Allen states, "*What I put into a vegetable garden is what I get out*". Here, he finds reassurance and closure in growing a vegetable garden,

a process he nurtures and is certain that what he puts in, he will get out. For Allen, it is a symbolic representation of being in control of the outcome by the effort he puts in to water and maintain his vegetables, to reap the rewards of the end product, rewards he does not always get to see with his patients.

Allen continues to reflect on his experience by stating: "*So it's not something that's on my mind anymore. It might have been on my mind earlier on as a psychologist, and of course there are a couple of people that I've wondered about*". This highlights his experience of working in a psychiatric system which only allows for a certain way of engaging with inpatients resulting in a feeling of no closure. To this end, he learnt a form of acceptance through the experience he obtained overtime, trusting that the seed he planted allowed for the patient to grow in their own way with who they are treated by after him. By trusting his colleagues, he trusts that all his patients are in good hands, and this helps him detach from them. Detachment of this kind he finds necessary in the context of working with many patients.

Superordinate Theme 2: The presence of gender

Allen emphasised a prominent theme across his narratives that is associated with his role as a male clinical psychologist treating trauma. He acknowledged that the majority of his trauma patients are female, most of whom have been sexually assaulted or raped by a male; this creates the presence of an uncomfortable feeling in the therapeutic relationship.

Treating female patients

In witnessing a female victim's early termination in therapy due to their traumatic experience with a male, Allen found this relationship difficult to address.

"*So I was in front of a lot of young 'coloured[1]' girls from 17 and going up into the 30s and 40s--who'd been raped by a man, and here they are sitting in front of a man and there not being anybody else. And first of all, needing to talk about that and on some level, apologising for the fact that I'm it. The sad thing is, for many of them that was too much, and there'd be some kind of inauthentic goodbye at the end of the first session and they wouldn't return.*"

He describes a situation where there are no other female psychologists to attend to the victims. He refers to a sense of helplessness experienced by both him and the patient. Perhaps he feels that they are stuck with him in the room as their therapist, alluding to a process they

[1] The term 'coloured' was used as a racial classification category under the Population Registration Act of the previous dispensation and is still commonly used in South Africa today to refer to individuals who are of mixed race (Adhikari, 2009).

feel somewhat forced into, where ‘choice’ is taken from them. The difficulty in treating trauma is that there is an aspect of her trauma narrative that is linked to him, referring to himself in an emotionless manner being “it”. The unspoken “it” is understood to be the uncomfortable experience in the room, unsure of how to address but easy to avoid. This creates an uncomfortable atmosphere for him, knowing that being a male is the reason for the patients early termination. By receiving an inauthentic goodbye, it makes him feel devalued in a context he is unable to control. In trying to manage his own feelings of discomfort, he is unable to address the patients needs as she distances herself from the process, robbed of the opportunity to draw her back in.

Allen dances between understanding the patients fears and the reason they do not want to return to therapy, choreographed by the perceived need to apologise for being a man too. Something he found tough was being a man and a clinical psychologist at the same time, as he later stated: “*the awareness of the discomfort, the gently coaxing them into something that's difficult to talk about, you know?*”. Allen describes the early stage of therapy where patients have a preconceived perception of men, not yet comfortable and trusting of the therapist. As a white man, there is also stigma associated with the former system of Apartheid, causing her to feel intimidated and scared. By acknowledging this, Allen feels unsettled by persuading the patient to see a different side of a male while they are not ready, as he is guided by his therapeutic skills. He is aware of his own positionality with patients, and his role in therapy is juggled by his characteristics in the room while trying to create a safe space for the trauma survivor.

He finds solace in accepting who he is and how he can help the patient in the best way he can: “*I’m aware that what I am, other than a psychologist, is an example of the other kind of man out there; the man that won't do that*”. Allen has his own belief system and view of morality characterising him as a man which he conveys to the patient that there is an alternative, to not paint all men with the same brush. Here, he makes reference to the man that he is, the other man out there that is humble, just and respectful.

Allen elaborates on his experience of treating women who have been sexually assaulted and raped. In this instance, he found it difficult to hold the therapeutic frame while exploring safety measures and helping her process the trauma: “*When a man does a terrible thing like that to a woman, so many things can be misinterpreted by a male therapist, not the male therapist doing the misinterpreting, but the client misinterpreting. It's hard. It's very hard, because that's not what you're saying; you're not saying it's their fault*”.

As a male therapist, conscious of his male presence in the room and aware of the emotional turmoil the patient is sitting with, Allen provides a safe and steady professional structure for therapeutic work to take place. Although he ultimately feels misjudged, perhaps causing him to feel a sense of disappointment. Allen recognises that patients have their own perceptions based on their experiences, and that impairs honest interpretations he makes in therapy. He finds himself walking the fine line between helping them and acknowledging that an event like it may occur again, while also trying not to blame the victim. A delicate engagement is roped between them as the patient does not feel understood and is supported by someone who resembles the perpetrator. While he tries to be engaged and hold the patients distrust, an uncomfortable tension is present because the patient sees him as a threat, projecting their unresolved fears onto him.

Superordinate Theme 3: Conscious of the effect on his personal life

Allen made reference to how treating trauma influenced his personal life.

Personal experiences

"*Perhaps if more of the trauma victims were men, maybe then I would be more hyper-vigilant; I don't have to always look around, I don't always have to think about those kinds of things.*"

Allen acknowledges that in his work experience, there are fewer male trauma cases in comparison to females. As a male he feels safer in his environment which brings him a sense of relief, and is perhaps grateful that he does not have to constantly be on edge. He developed a perception which shaped his behaviour and way of thinking in terms of not worrying or feeling anxious in response to a dangerous cue. It could be that Allen perceives himself as physically capable to be able to handle himself in dangerous situations, aiding in his ability to feel safer instead of hyper-vigilant.

Although, when listening to the trauma narratives of his patients, Allen formed an appreciation for his life: "*It makes me realise that irrespective of whatever has happened to me in my life, there are other people out there that have had it much worse than I. So, actually, it doesn't make me down on life, it makes me appreciate it more and my history*."

Allen learns from his patient's difficult life experiences, and feels grateful for his life journey when comparing himself to them. Existentialism emphasises Allen's capacity to use the world and his experiences to make decisions and develop views centred around himself,

rather than the fear which society generates. This experience seems to have formed his personal view of life, appreciating and focusing on the little things that are pleasurable. Being a male who was called to the military for national compulsory service, working in townships and other communities, he feels empathy towards others for their struggles. He has encountered and witnessed first-hand trauma injustices being committed, in this way, exposed to the darkness of the world. His current profession enables him to make a difference, while valuing his life and the opportunities afforded to him.

Participant 2: "Annie"

Table 2: Summary of themes for Annie

Superordinate themes	Sub themes
Strong emotional reaction	Anger
	Confused when treating the perpetrator
Balancing roles	Balancing maternal and professional roles
Experience as a female clinical psychologist	Faced with the topic of initiation

Superordinate Theme 1: Strong Emotional Reaction

Annie vividly made reference to experiences that marked negative emotions for her while treating trauma victims and perpetrators. This superordinate theme includes two sub themes:

Anger

Annie described an experience of treating child rape victims, particularly cases of incest*:* "*And I suppose that's inherent with child work in a way, that they're more vulnerable, and it just dials up certain responses in me; a lot of anger*".

Here, she expresses anger in response to cases where children are betrayed by their family members and are unable to defend themselves. With cases of incest, this sentiment may have left her in disbelief by how a father or other male family figure has the capability to inflict pain on a minor. As a result of being a married woman and a mother coming from a close family setting, her natural expectation of the male figure in the home is of a protector and nurturer. When confronted with a situation opposite to her perception of safety, where the male figure is the perpetrator, it becomes appalling to her as her perceived idea of a safe family home

is shattered. This interpretation is supported by a similar reflection where she expresses disbelief: "*So that's a bit disheartening, like, how could someone do this to someone else?*" Annie struggles to sit with how someone could be so disconnected from someone else's suffering.

In Annie's experience, treating mothers who lost their children during childbirth and who were insensitively cared for by medical practitioners, also triggered a strong emotion of anger within her. She stated: "*For my client, as her baby came out, the nurse said, 'Oh she's dead'. Just like that. No softening, nothing!*". She hears narratives that are difficult to comprehend, wondering how these practitioners can react in such an insensitive way. She is angered by the lack of care that is given and that trauma is not always recognised in a medical setting as it is in a psychiatric setting. She encounters these experiences through the narratives of her patients and empathises with the brutal, cold and uncaring experiences people go through. The experience of childbirth is a platform in which they both find common ground. Annie can directly relate to the pain felt by her patient as a result of being a mother herself, experiencing both anger and sadness; disheartened knowing that this type of trauma exists.

Confused when treating the perpetrator

Annie explained that she read an inpatients file before seeing him and was dismayed by horrific details of his criminal charges.

"*I closed the door and I wept for an hour because I was so...maybe traumatised from reading what this person had done and was horrified by it, and then trying to consolidate how do I know this about this person and do my job to help him? And something I reflect on many times is that I don't have that response anymore.*"

Her response to the case marked a rollercoaster of emotions as she was shocked by the nature of the crime the patient committed. After reading the file, she felt conflicted by how she would treat the inpatient knowing what he had done. Thoughts around whether he is deserving of her treatment and care emerged, and fear of being present in a room with him. Annie reflects on her thoughts of being able to tolerate horrific narratives, referring to the fact that she is still able to do her job. Here, she uses her own insight to navigate the negative outcomes present in the workplace like a compass, seeking direction in order to feel less affected and more available to her patients. She is able to distance herself from cases through the use of her own coping strategies. This being self-awareness, personal supervision, and mindfulness, while also learning to apply "*acceptance and trust with the use of collegial support*".

Annie states, "*I also worry that my clinical judgement and decisions would be affected, probably negatively, and I don't think that's right*". She has strong feelings towards law and order, and when she experiences a narrative that goes against her perceptions, those which she perceives as morally wrong, she becomes unsettled. Professionally, she reached a space where she choreographed her own understanding that she must treat and not judge, staying within her role to rehabilitate the patient. The more she is exposed to trauma, the more she develops an emotional hardening as opposed to compassion fatigue. In other words, Annie developed an ability to remain professional and separate her emotions from her work.

Superordinate Theme 2: Balancing roles

Interestingly, Annie reflected on how treating trauma affected her role as a mother and her role as a clinical psychologist.

Balancing maternal and professional roles

Annie described an opportunity to get involved with victim assessments and young offenders, a forensic branch of psychology she enjoyed.

"*I thought about it, and it was interesting because there was such a tension between the professional clinical part of me and the personal part of me. Every time I'll see a victim, I'm gonna see my kids, and I don't want that to affect how I bring them up.*"

Annie is aware of the internal conflict she feels by wanting to engage in forensic work, however, she is conscious of her sensitivity to working with child trauma. As a clinical professional, she is directed by her ethical principles so as to not impair her clinical judgment through being affected by child trauma cases. As a mother, her negative emotions are triggered by these narratives as she has children of her own, causing her to resonate with the case on a deeper, personal level. She knows that by engaging in child trauma work, it will trigger images of her children. Annie is mindful that this will elevate her worries, influencing how overprotective she will be while raising her children.

"*So it's interesting how I have different fears for my son than I do for my daughter.*" Here, she compares her children to the trauma cases she works with. Annie is on guard in response to the high prevalence of crime in South Africa, and with exposure to many cases of youth's trauma narratives, she is scared that such darkness could be in their future. Work related stress transfers into her home environment, and rattles her maternal instincts, which in turn elevates her anxiety. The commonality of trauma shapes her way of thinking as she dances between her role as a mother and a psychologist.

In response to the trauma she works with, Annie described a sense of fear she experienced leaving her children with the nanny or around the gardener even after interviewing them: "*Could I trust this person on my property while my kids are running around? Sometimes, I look at how great they interact with the kids and I base it on that*".

She grapples with issues of trust in others due to her experience treating both victims and perpetrators. She is aware that being in her profession comes with a price to pay, as she developed a distorted view of society and lost faith in humanity. For her, this evolves into an overprotective nurturer: "*I've spoken to her about stranger danger, and it kills me to shatter that naivete that the world is a good place*". Although, she observes her children's positive interactions with the nanny or gardener, and is reminded that there is good in the world. Annie considers her children's freedom and wants them to think and play like children should, as opposed to worrying about the dangers of the world: "*So decisions about the kids' freedom is significantly thought about very carefully*". To this end, Annie balances her needs and those of her children like a seesaw through ensuring they live a normal life; she does this by separating her personal life from the fears of her professional life. She finds a balance by trying to make calculated decisions based on risk, but careful not to instil her fears within her children.

Superordinate Theme 3: Experience as a female clinical psychologist

Annie emphasised an experience associated with her role as a female clinical psychologist.

Faced with the topic of initiation

During a group session, Annie recognised a trauma associated with cultural initiation in black male patients. The group discussion veered into the direction of initiation as patients expressed experiencing pain, fear and shame around the topic of culturally-sanctioned rites of passage, a topic she felt she was intruding.

"*As a female psychologist, something that I know is such a conflict is initiation. And I really kind of stumbled across this tension when we were doing a sex offender program, where initiation and speaking about initiation was basically earmarked for male conversations*."

The above extract describes a specific trauma which caused Annie to feel uncomfortable and overwhelmed, knowing that in an historical-cultural understanding is strictly out of the domain of a female's topic of conversation. Being a white English female herself, she would not engage in the topic voluntarily, and experienced the space to be disconcerting to her as if she were tiptoeing on hot coals where male patients are vulnerable.

Annie acknowledged the sensitivity of the topic by being respectful of the traditions of the patients culture, and perhaps also distressed that such a sacred ritual can perpetuate trauma.

Participant 3: "Ruby"

Table 3: Summary of themes for Ruby

Superordinate theme	Sub themes
Responses in dangerous settings	Delayed response to trauma and danger Wondered about patients
Strong reactions in secure settings	Hopelessness
Motherhood vs Career	Managing roles

Superordinate Theme 1: Responses in dangerous settings

Ruby reflected on her experiences working at the hospital in a context that is perceived as dangerous. This superordinate theme includes two sub themes:

Delayed response to trauma and danger

She referred to a case where she was tasked to conduct interviews with a patient and chose not to read the file prior to the sessions. She later saw that the patient murdered five people including a three-year-old child. Ruby stated: *"And there are times when I would find that actually I might not have seen something as trauma but later, my response or my reactions made me realise that was actually quite traumatic*".

Ruby does not conceptualise a narrative as traumatising at first because her mind-set is goal-oriented to her profession. She is not only treating trauma but is working within a space of trauma. As she steps into the room with the patient, she reflects on the symbolism of a metaphorical light versus darkness; the light being a place of safety, the known and a sense of security, and the darkness representing the fear she holds as the danger she is entering by seeing this patient. She has become used to treating and assessing highly dangerous patients, familiar with trauma narratives and, as a result, she does not see the situation as an immediate personal danger. Afterwards, when sitting with her thoughts or relooking at the details of the case, she realises the high risk situation she put herself in, as evident in her narrative:

"*I saw the pictures, including that of the little girl. And it took me by surprise; it really shocked me. I had a little girl, and I was like, woah, and I started feeling...not panicky, but I*

started trembling and shaking, like, oh my word, I'd sat with this guy so relaxed and so chilled, and this is what he's capable of doing?"

The pictures and details of the patients crime became real, as she internalised the seriousness of the case. In this instance, Ruby was reminded of her own daughter and experienced shock after realising how dangerous the patient was. Based on her preconditioned way of responding, being informed by her training, she reacts with an automatic response at first. As a mother, she is reflecting on how she would have felt had that been her daughter in the picture. She felt threatened and scared, as if she were standing in a dark passage, in the presence of a strange figure, feeling physiological symptoms which can only be understood to be secondary traumatic stress. A feeling of terror arises later in the form of panic as she is faced with the reality of the dangers and the fragility of life, and the knowledge that this dangerous man could have harmed her in the open room in which they sat.

Another experience she had with a patient who made sexual advances towards her caused her to have a delayed reaction to the danger she was in. She stated: "*I had to negotiate and talk him down. So those are the things that I've found threatening and q*uite traumatic*, but in hindsight most of them, not at the time they were happening, but after.*" To this end, she draws on her skills as a psychologist to handle the alarming situation, however, only afterwards does she realise the high-risk situation once the danger has been internalised. In the given scenario she had to persuade him, knowing that, as a woman she had to protect herself using her words as a shield. It appears that treating trauma in a psychiatric hospital is not only related to past trauma narratives, but also involves encountering an aspect of trauma that she experiences as an immediate threat to herself whilst working with perpetrators.

With reference to the dangerous settings she works in, she highlighted her reactions to a distressing situation where she was assessing a dangerous inpatient:

"*I need to always be on guard. It made me quite hyper-vigilant after like I needed to make sure that I keep the security quite alert. So I felt like I had two jobs to do because, for some reason, most of the security guards often fell asleep, so I kept having to bring them back to life.*"

Here, a sense of fear illuminates as there is always a present threat. Ruby finds that she is not always safe, even with a security guard. In order to protect herself, and alleviate her anxiety, she uses her professional insight to manage her fears by keeping the security guard awake. She safeguards herself against the trauma of a potentially life and death encounter,

where the security is supposed to be her lifeline however instead they fade into a blissful sleep, seemingly unbothered by a life in danger. She alludes to how she reacted afterwards: "*Only afterward did all the "what ifs" go through my mind*". Ruby reflects on how scary the situation was while trying to maintain her professionalism. She responds naturally to the danger, becoming anxious as she ruminates on possible scenarios of how the dangerous patient might have harmed her, similar to the narratives of her trauma victims. Her accounts link to intense interpersonal transferences in the work place, as she is conscious of what the inpatient is capable of doing; therefore, she moves between feeling unprotected by the guards, having to defend herself, and feeling unsafe.

Wondered about patients

Ruby reported that she assessed a man on trial who murdered two children.

"*I can understand if he is mentally unwell because he has no control or understanding or knowledge of what he was doing, but this person is well. So he knew. What can drive a person to be like that? But the other thing is, that was not my job to find out what drove him to do that. My job was, 'he did it, so he's responsible', and I had to battle with that.*"

As a clinical psychologist, she understands the psychological functioning of a perpetrator who is unwell. Although, it appears that she was so shocked by the horrific crime the patient committed in a normal state of mind, she wondered what drove him to do it. She expressed interest in seeking answers to understand him, and her distorted view of humanity caused her to feel curious about the perpetrator's motives for his actions. She reminds herself of her professional role, not allowing her personal curiosity to cross the bridge into her professionalism and she does this by maintaining her boundaries.

Superordinate Theme 2: Strong reactions in secure settings

Ruby experiences strong reactions to treating and assessing child victims of sexual assault and rape within a secure therapeutic context.

Hopelessness

When assessing whether a child is able to testify or not, she finds this to be the most difficult and recalled becoming overwhelmed with emotion in a particular case. She stated: "*It happened at the time when I'd just had my little girl, so looking at her crying sitting up there and I see my daughter and think, Oh my gosh*".

Ruby was reminded of her daughter when she saw the little girl in court, astounded at how a little girl can go through such emotional turmoil at such a young age. Here, she was triggered by her own recent childbirth and, during the interview, reflects on her experiences as a mother as well as seeing the child's helplessness first hand. Ruby shared that when children are hurt it triggers negative emotions within her, however, she takes the responsibility upon herself, internalising the little girl's hopelessness, evidenced by the following statement: "*So I would pick up their helplessness. I feel like I'm going to give them justice, the guy is gonna be incarcerated but is that enough?*". In her professional capacity she believes that she can do everything she can to give the victim justice, however, she is shackled with powerlessness because she can't give the child the justice they deserve. She experiences feeling stuck, unable to gift her child patients with the jewels of freedom to live without fear.

In another reflection, Ruby mentioned that she sometimes wonders about child trauma cases after she assessed them. Her care for children comes through prominently as she is reminded of her role as a mother and prompts her concern for them*: "I used to wonder and I used to make follow-ups on the Department of Social Development".* "*Self-awareness, personal therapy and peer supervision helped me cope*". With time she learnt that she cannot be in control of every case she refers. She engaged in a transformative process of inner artistry, giving meaning to her desire to save her patients by realising that it is out of her sphere of influence.

Superordinate Theme 3: Motherhood vs Career

Ruby describes her experience balancing the role between motherhood and her career.

Managing roles

She narrated a challenging experience treating a female victim in therapy who struggled to adapt to trauma treatment and regressed.

"*A difficult part was to marry being a person--a mother, sister--and being a psychologist. Because in a work situation, I had to be professional and a psychologist and I had to keep the faith that once she's back on treatment we will start again and she will eventually realise the process.*"

Trauma treatment is demanding, and she found herself juggling her role as a psychologist and as a mother. Each role carries its own emotional demands, and it appears her professional role became too overwhelming. In her experience of treating trauma, making the patient relive details of their experience, she views this process as inhumane, cold and

disconnected from the patients suffering characterised by a therapeutic technique: "*And it's hard and painful to watch them struggling trying to work with it and accept it. And then there are patients who become angry with you because you are making them feel what they didn't want to*". Here, she feels a sense of guilt at being the perceived cause of her patients setback, making her patient relive the trauma as they begin to feel disgusted and angry towards her, with no apparent light at the end of the tunnel. In an attempt to separate her work life and personal life, she uses optimism and reassurance like a rose with a boundary of thorns to manage her stressors at work, so as to prevent her frustrations from slipping into her personal roles when she leaves her place of work. She aims to maintain her parental accountability and doesn't want her experience to influence how she treats her children.

In another reflection, her exposure to trauma narratives across all age groups made her hyper-vigilant to her environment and reminds her of her children. "*I have kids of my own, and it made me become more overprotective and hyper-vigilant, to a point that I think I became neurotic*."

Ruby expresses an underlying sense of fear and is essentially over-aware of the dangers of the world due to the trauma narratives she works with. Her exposure skewed her perception of society and she sees the world as terrifying. She attempts to control her anxiety by engaging in overprotective behaviours with her children checking for any physical harm, and exhibits safety behaviours in her home environment to the extent of becoming obsessive. This experience causes her mind to dive deep into the unknown, trying to find ways to bring herself up for air. This is evident in the following account of her experiences: "*With my daughter, if I'm bathing her or the nanny has bathed her, when I'm changing her nappy, I check*"; "*other charges that the patients had like housebreaking, I keep checking if the windows and doors are locked*". Engaging in behaviours neurotically became a cause of concern, conversely, with therapy she was able to accept what she can and can't control: "*with therapy I started realising there's only so much I can do*", bringing her some relief.

Discussion

This study found that the lived experiences of clinical psychologists working with trauma in a psychiatric context is complex. In the existing literature, little is known about the nature and prevalence of traumatic stress in psychiatric hospitals, however the findings of the current study have brought much needed attention to the notion that treating trauma comes with both risks and benefits. From the interpretive analysis, findings depict that trauma work evoked

psychological distress within participants in response to the trauma narratives of their patients (Sui & Padmanabhanunni, 2016; MacRitchie & Leibowitz, 2010; Harrison & Westwood, 2009).

When talking about psychological distress, the findings identified shared feelings of shock, sadness, and frustration amongst all participants in response to trauma narratives. Allen's brief feeling of shock speaks to his resilience which allows him to recover quickly, thereby experiencing a normal reaction to an abnormal event (Herman, 2019; Southwick, Bonanno, Masten, Panter-Brick, & Yehuda, 2014). Ruby and Annie differed from Allen in terms of feeling anger and fear. These experiences put clinical psychologists at risk for vicarious trauma (Booysen & Kagee, 2021; McCormack & Adams, 2016; MacRitchie & Leibowitz, 2010; McCann & Pearlman, 1990). Each emotional reaction was triggered by the participants experiences. For example, Ruby experienced physiological symptoms in response to a dangerous patient she interviewed, evident in her trembling fearful reaction and this adds emphasis on her experience in a setting which she perceived as threatening. In support of this finding, Sui and Padmanabhanunni (2016) similarly found that somatic complaints of physical exhaustion are common with trauma work.

In addition, this study found that working in a psychiatric hospital means also working with perpetrators who are state patients. These results contribute to the limited research within the trauma context, highlighting the effects of working in dangerous settings that evoke traumatic stress. Literature on traumatic stress has discussed both positive and negative responses within trauma workers (Booysen & Kagee, 2021; McCormack & Adams, 2016; Silveira & Boyer, 2015; MacRitchie & Leibowitz, 2010). However, the current study found that there is an added element of exacerbation based on the trauma work in a psychiatric hospital specifically. The nature of the trauma is not confined to trauma narratives, and access to pictures contributes to a different experience that forces participants to understand and think about trauma differently.

Both Annie and Ruby reflected on treating victims and perpetrators. Annie experienced feeling confused having to treat someone who inflicted pain on another; whereas Ruby described being hyper-vigilant sitting in the presence of a dangerous patient. Although, Allen differed in this regard as he was rather curious about the perpetrator's presentation as opposed to fearful of it. A similar study to the current by Olashore et al., (2018) explored the prevalence and predictors of PTSD in a psychiatric setting in Botswana, where findings depicted that mental health practitioners who were physically harmed by patients were at risk for PTSD.

Recently, Booysen and Kagee (2021) supported this finding in the Eastern Cape and Western Cape by highlighting that the context in which mental health practitioners work can perpetuate the burdens of traumatic stress. In corroboration with the findings of the current study, McCann and Pearlman, (1990), as well as Sui and Padmanabhanunni (2016), identified that feeling unsafe and experiencing mistrust were common amongst psychologists working with trauma. In contrast, treating child victims of trauma reflected a converging sense of helplessness between Annie and Ruby and, although the literature is limited, the theme of helplessness is also present in Allen's narrative and existing literature (Booysen & Kagee, 2021; Sui & Padmanabhanunni, 2016; Figley, 1995). Ruby diverges from both Allen and Annie in that she experiences a sense of guilt when engaging with the difficult process of treating a trauma patient, and this is an interesting finding that alludes to a unique feeling during the treatment process.

Furthermore, in the findings, participants highlighted powerful complex meanings related to a socio-political context while treating trauma in a psychiatric hospital. This finding speaks to the overall message that one cannot treat trauma devoid of its social context (Sui & Padmanabhanunni, 2016; Edwards, 2009). The experiences of the participants made reference to gender and culture, suggesting that socio-demographic factors perpetuate challenges when treating trauma in a psychiatric hospital. The existing literature does not point to these findings directly, however, Booysen and Kagee (2021) found that socio-demographic factors do in fact precipitate traumatic stress, but in low-resource communities. Issues of gender, race, culture, and politics are not readily referred to in the treatment of trauma yet there is an awareness of the interplay between trauma and the social context from which it stems. For example, Allen referred to his role as a white male clinical psychologist treating 'coloured' trauma victims in post-apartheid South Africa, reflecting on how his presence affected the therapeutic process. Annie, in contrast to Allen struggled with the topic of initiation as a white English female psychologist. These reflections refer to this overlooked dimension in understanding and treating traumatic stress.

The female participants had a distinct reflection related to family and work. Specifically, motherhood emerged prominently as Annie and Ruby's experiences treating trauma influenced how they parented their children and how they themselves felt about the safety of the world around them. Annie and Ruby's experiences reflected suspicious and hyper-vigilant behaviours in their personal lives, which influenced protective roles as mothers. Vicarious symptoms of hyper-vigilance seem to be more common among Annie and Ruby,

whilst Allen had no noticeable concerns for safety. Arguably the difference in experiences alludes to how men and women might experience treating trauma, especially in a psychiatric hospital, diverse in terms of gender. This finding corroborates with the existing literature, that women are more at risk to traumatic stress than men (Olff, 2017; Christiansen & Hansen, 2015). The impact of treating traumatic stress on the personal and professional lives of clinical psychologists in a psychiatric hospital illustrates the importance of navigating ways to maintain their mental well-being (Laurenzi et al., 2020; Ling, Hunter, & Maple, 2014).

Findings in research depict that coping strategies for developing well-being and fostering work satisfaction is emerging (Patsiopoulos & Buchanan, 2011; Harrison & Westwood, 2009). All three participants expressed using supervision and peer supervision as a means for support, whilst reflecting on the psychiatric hospital to be a supportive environment. This suggests that a supportive collegial environment is helpful and can mitigate the effects of vicarious trauma (Smith, Kleijn, Trijsburg, & Hutschemaekers, 2007). In addition, they expressed trauma work to be "taxing but rewarding", feeling hopeful and grateful to be part of a patients process and progress, despite the process being tumultuous at times (Hyatt-Burkhart, 2014; Arnold, Calhoun, Tedeschi, & Cann, 2005). All participants expressed no debilitating effects of vicarious trauma, although a shared resilience and motivation emerged for the work that they do, understood to be vicarious post-traumatic growth (Sui & Padmanabhanunni, 2016; Silveira & Boyer, 2015; Johnson, 2010; Calhoun & Tedeschi, 1996). All three participants also reflected on upholding their boundaries, developing successful coping strategies and trusting the process with years' experience. Zaccari (2017) supports this finding on boundaries and self-care as a way to create balance and maintain healthy lifestyle choices.

In managing coping with traumatic stress, Allen uniquely expressed a hobby of growing vegetables with the aim of seeing the end product of his efforts. This significantly corroborates with the meaning of the theme "lack of closure". In contrast, Annie externalises her anxiety through activities and is careful in choosing cases that won't trigger anxiety or fear; whereas Ruby realised that she has no control over everything and through therapy developed acceptance of what was out of her control. Here, both Annie and Ruby diverge from Allen as they set boundaries based on their self-awareness and experience (Zaccari, 2017; Ling et al., 2014).

This study has a number of limitations. The interviewer was known to two participants previously through a brief professional capacity. This prior contact was seen as an advantage in obtaining honest reflections, although it is possible that the participants may have felt an

obligation to participate. Generalisability of this study needs to be considered with caution as the sample size was relatively small with only three interested psychologists. There was also a concern that the results may generate a negative impression of clinical psychologists in practice however, by paying attention to the participants coping strategies, the study's results have in fact enriched the understandings of their lived experiences. The study was conducted during the eased lockdown restrictions of the Corona Virus pandemic, which may have captured added burdens of the impact of traumatic stress during this trying time.

It is further recommended that future research focuses on how socio-political factors and dangers in the workplace influence clinical psychologists service delivery. In addition, content on healthy coping strategies; vicarious trauma; boundaries in professional and personal roles; dangers in psychiatric hospitals and socio-political considerations could be included in training programs to enlighten future clinicians on the implications of working with trauma in psychiatric hospitals. Finally, future qualitative studies will benefit from using follow-up interviews as it allows for an elaborative exploration of participants lived experiences.

Conclusion

The study revealed interesting findings that point to a number of insights. It is evident that implications do arise when clinical psychologists treat trauma survivors at a psychiatric hospital which can lead to vicarious trauma and traumatic stress. This study observed an added element of danger whilst treating dangerous state patients, exposing psychologists to traumatic stress. However, the participants highlighted that trauma work can also be rewarding and creates vicarious post-traumatic growth. With the use of unique coping strategies, participants showed to be equipped with resilience, and as a result, are less likely to experience debilitating symptoms of trauma. This concludes that clinical psychologists who engage in self-care and supportive strategies protect themselves from long-term risks. Furthermore, a socio-political aspect to treating trauma that was not found extensively in previous research was present in the current study. Psychologists recognised culture, their gender, race, and the impact this has on their roles in their personal and professional lives while working within the field of trauma.

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Appendix A: Full Specifications of Journal

Aims and scope:

Qualitative Health Research is an international, interdisciplinary, refereed journal for the enhancement of health care and to further the development and understanding of qualitative research methods in health care settings. We welcome manuscripts in the following areas: the description and analysis of the illness experience, health and health-seeking behaviors, the experiences of caregivers, the sociocultural organization of health care, health care policy, and related topics. We also seek critical reviews and commentaries addressing conceptual, theoretical, methodological, and ethical issues pertaining to qualitative enquiry.

Articles in *Qualitative Health Research* examine an array of timely topics such as: experiencing illness giving care institutionalization substance abuse food, feeding and nutrition living with disabilities milestones and maturation monitoring health children's perspectives on health and illness.

Specifications for Authors:

This Journal is a member of the Committee on Publication Ethics

This Journal recommends that authors follow the Recommendations for the Conduct, Reporting, Editing, and Publication of Scholarly Work in Medical Journals formulated by the International Committee of Medical Journal Editors (ICMJE).

Please read the guidelines below then visit the Journal's submission site https://mc.manuscriptcentral.com/qhr to upload your manuscript. Please note that manuscripts not conforming to these guidelines may be returned. Remember you can log in to the submission site at any time to check on the progress of your paper through the peer review process.

Only manuscripts of sufficient quality that meet the aims and scope of *Qualitative Health Research* will be reviewed.

There are no fees payable to submit or publish in this journal.
As part of the submission process you will be required to warrant that you are submitting your original work, that you have the rights in the work, and that you have obtained and can supply

all necessary permissions for the reproduction of any copyright works not owned by you, that you are submitting the work for first publication in the Journal and that it is not being considered for publication elsewhere and has not already been published elsewhere. Please see our guidelines on prior publication and note that ***Qualitative Health Research*** **may accept submissions of papers that have been posted on pre-print servers**; please alert the Editorial Office when submitting (contact details are at the end of these guidelines) and include the DOI for the preprint in the designated field in the manuscript submission system. Authors should not post an updated version of their paper on the preprint server while it is being peer reviewed for possible publication in the journal. If the article is accepted for publication, the author may re-use their work according to the journal's author archiving policy. If your paper is accepted, you must include a link on your preprint to the final version of your paper.

1. What do we publish?

1.1 Aims & Scope

Before submitting your manuscript to *Qualitative Health Research*, please ensure you have read the Aims & Scope.

1.2 Article types

Each issue of *Qualitative Health Research* provides readers with a wealth of information —, commentaries on conceptual, theoretical, methodological and ethical issues pertaining to qualitative inquiry as well as articles covering research, theory and methods.

1.2.1 What types of articles will QHR accept?

QHR asks authors to make their own decision regarding the fit of their article to the journal. Do not send query letters regarding article fit.

- Read the Mission Statement on main *QHR* webpage.
- Search the *QHR* journal for articles that address your topic. Do we publish in your area of expertise?
- Ask these questions: Does it make a meaningful and strong contribution to qualitative health research literature? Is it original? Relevant? In depth? Insightful? Significant? Is it useful to reader and/or practitioner?
- Note the sections: General articles, critical reviews, articles addressing qualitative methods, commentaries on conceptual, theoretical, methodological, and ethical issues pertaining to qualitative inquiry.

• *QHR* accepts qualitative methods and qualitatively-driven mixed-methods, qualitative meta- analyses, and articles addressing all qualitative methods.

• *QHR* is a multi-disciplinary journal and accepts articles written from a variety of perspectives including: cross-cultural health, family medicine, health psychology, health social work, medical anthropology, medical sociology, nursing, pediatric health, physical education, public health, and rehabilitation.

• Articles in *QHR* provide an array of timely topics such as: experiencing illness, giving care, institutionalization, substance abuse, food, feeding and nutrition, living with disabilities, milestones and maturation, monitoring health, and children's perspectives on health and illness.

• QHR does NOT publish pilot studies.

Look Out for These Regular Special Features

Pearls, Pith and Provocation: This section fosters debate about significant issues, enhances communication of methodological advances and encourages the discussion of provocative ideas.

Mixed Methods: This section includes qualitatively-driven mixed-methods research, and qualitative contributions to quantitative research.

Advancing Qualitative Methods: Qualitative inquiry that has used qualitative methods in an innovative way.

Evidence of Practice: Theoretical or empirical articles addressing research integration and the translation of qualitatively derived insights into clinical decision-making and health service policy planning.

Ethics: Quandaries or issues that are particular to qualitative inquiry are discussed.

Teaching Matters: Articles that promote and discuss issues related to the teaching of qualitative methods and methodology.

1.3 Writing your paper

The SAGE Author Gateway has some general advice and on how to get published, plus links to further resources.

1.3.1 Make your article discoverable

For information and guidance on how to make your article more discoverable, visit our Gateway page on How to Help Readers Find Your Article Online.

2. Editorial policies

2.1 Peer review policy

Qualitative Health Research strongly endorses the value and importance of peer review in scholarly journals publishing. All papers submitted to the journal will be subject to comment and external review. All manuscripts are initially reviewed by the Editors and only those papers that meet the scientific and editorial standards of the journal, and fit within the aims and scope of the journal, will be sent for outside review.

QHR adheres to a rigorous double-blind reviewing policy in which the identity of both the reviewer and author are always concealed from both parties. Ensure your manuscript does not contain any author identifying information. Please refer to the editorial on blinding found in the Nov 2014 issue: http://qhr.sagepub.com/content/24/11/1467.full.

QHR maintains a transparent review system, meaning that all reviews, once received, are then forwarded to the author(s) as well as to ALL reviewers.

Peer review takes an average of 6–8 weeks, depending on reviewer response.

As part of the submission process you may provide the names of peers who could be called upon to review your manuscript. Recommended reviewers should be experts in their fields and should be able to provide an objective assessment of the manuscript. Please be aware of any conflicts of interest when recommending reviewers.

Examples of conflicts of interest include (but are not limited to) the below:

• The reviewer should have no prior knowledge of your submission

• The reviewer should not have recently collaborated with any of the authors

• Reviewer nominees from the same institution as any of the authors are not permitted

You will also be asked to nominate peers who you do not wish to review your manuscript (opposed reviewers).

Please note that the Editors are not obliged to invite/reject any recommended/opposed reviewers to assess your manuscript.

Qualitative Health Research is committed to delivering high quality, fast peer-review for your paper, and as such has partnered with Publons. Publons is a third party service that seeks to track, verify and give credit for peer review. Reviewers for *QHR* can opt in to Publons in order to claim their reviews or have them automatically verified and added to their reviewer profile. Reviewers claiming credit for their review will be associated with the relevant journal, but the article name, reviewer's decision and the content of their review is not published on the site. For more information, visit the Publons website.

The Editor or members of the Editorial Board may occasionally submit their own manuscripts for possible publication in the journal. In these cases, the peer review process will be managed by alternative members of the Board and the submitting Editor/Board member will have no involvement in the decision-making process.

2.2 Authorship

Papers should only be submitted for consideration once consent is given by all contributing authors. Those submitting papers should carefully check that all those whose work contributed to the paper are acknowledged as contributing authors.

The list of authors should include all those who can legitimately claim authorship. This is all those who:

(i) Made a substantial contribution to the concept or design of the work; or acquisition, analysis or interpretation of data,

(ii) Drafted the article or revised it critically for important intellectual content,

(iii) Approved the version to be published,

(iv) Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content.

Authors should meet the conditions of all of the points above. When a large, multicentre group has conducted the work, the group should identify the individuals who accept direct responsibility for the manuscript. These individuals should fully meet the criteria for authorship.

Acquisition of funding, collection of data, or general supervision of the research group alone does not constitute authorship, although all contributors who do not meet the criteria for authorship should be listed in the Acknowledgments section. Please refer to the International Committee of Medical Journal Editors (ICMJE) authorship guidelines for more information on authorship.

2.3 Acknowledgements

All contributors who do not meet the criteria for authorship should be listed in an Acknowledgements section. Examples of those who might be acknowledged include a person who provided purely technical help, or a department chair who provided only general support.

Please do not upload or include the acknowledgments during the initial submission and review. IF your article is going to be accepted, you will be instructed to "unblind" the manuscript, and then you may add this section to your document.

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Individuals who provided writing assistance, e.g. from a specialist communications company, do not qualify as authors and so should be included in the Acknowledgements section. Authors must disclose any writing assistance – including the individual's name, company and level of input – and identify the entity that paid for this assistance. It is not necessary to disclose use of language polishing services.

2.4 Funding

Qualitative Health Research requires all authors to acknowledge their funding in a consistent fashion under a separate heading. Please visit the Funding Acknowledgements page on the SAGE Journal Author Gateway to confirm the format of the acknowledgment text in the event

of funding, or state that: This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

2.5 Declaration of conflicting interests

It is the policy of *Qualitative Health Research* to require a declaration of conflicting interests from all authors enabling a statement to be carried within the paginated pages of all published articles.

Please ensure that a 'Declaration of Conflicting Interests' statement is included at the end of your manuscript, after any acknowledgements and prior to the references. If no conflict exists, please state that 'The Author(s) declare(s) that there is no conflict of interest'. For guidance on conflict of interest statements, please see the ICMJE recommendations here

2.6 Research ethics and patient consent

Medical research involving human subjects must be conducted according to the World Medical Association Declaration of Helsinki

Submitted manuscripts should conform to the ICMJE Recommendations for the Conduct, Reporting, Editing, and Publication of Scholarly Work in Medical Journals:

• All papers reporting animal and/or human studies **must state in the methods section that the relevant Ethics Committee or Institutional Review Board provided (or waived) approval.** Please ensure that you blinded the name and institution of the review committee until such time as your article has been accepted. The Editor will request authors to replace the name and add the approval number once the article review has been completed

• **For research articles, authors are also required to state in the methods section whether participants provided informed consent and whether the consent was written or verbal.**

Information on informed consent to report individual cases or case series should be included in the manuscript text. A statement is required regarding whether written informed consent for patient information and images to be published was provided by the patient(s) or a legally authorized representative. Please do not submit the patient's actual written informed consent with your article, as this in itself breaches the patient's confidentiality. The Journal requests that you confirm to us, in writing, that you have obtained written informed consent but the

written consent itself should be held by the authors/investigators themselves, for example in a patient's hospital record.

Please also refer to the ICMJE Recommendations for the Protection of Research Participants

2.7 Clinical trials

Qualitative Health Research conforms to the ICMJE requirement that clinical trials are registered in a WHO-approved public trials registry at or before the time of first patient enrolment as a condition of consideration for publication. The trial registry name and URL, and registration number must be included at the end of the abstract.

2.8 Reporting guidelines

The relevant EQUATOR Network reporting guidelines should be followed depending on the type of study. For example, all randomized controlled trials submitted for publication should include a completed CONSORT flow chart as a cited figure and the completed CONSORT checklist should be uploaded with your submission as a supplementary file. Systematic reviews and meta-analyses should include the completed PRISMA flow chart as a cited figure and the completed PRISMA checklist should be uploaded with your submission as a supplementary file. The EQUATOR wizard can help you identify the appropriate guideline.
Other resources can be found at NLM's Research Reporting Guidelines and Initiatives

2.9. Research Data

At SAGE we are committed to facilitating openness, transparency and reproducibility of research. Where relevant, The Journal **encourages** authors to share their research data in a suitable public repository subject to ethical considerations and where data is included, to add a data accessibility statement in their manuscript file. Authors should also follow data citation principles. For more information please visit the SAGE Author
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3. Publishing Policies

3.1 Publication ethics

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3.1.1 Plagiarism

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4. Preparing your manuscript

4.1 Article Format (see previously published articles in QHR for style):

• Title page: Title should be succinct; list all authors and their affiliation; keywords. Please upload the title page separately from the main document.

• Blinding: Do not include any author identifying information in your manuscript, including author's own citations. Do not include acknowledgements until your article is accepted and unblinded.

• Abstract: Unstructured, 150 words. This should be the first page of the main manuscript, and it should be on its own page.

• Length: QHR does not have a word or page count limit. Manuscripts should be as tight as possible, preferably less than 30 pages including references. Longer manuscripts, if exceptional, will be considered.

• Methods: QHR readership is sophisticated; excessive details not required.

- Ethics: Include a statement of IRB approval and participant consent. Present demographics as a group, not listed as individuals. Do not link quotations to particular individuals unless essential (as in case studies) as this threatens anonymity.

• Results: Rich and descriptive; theoretical; linked to practice if possible.

• Discussion: Link your findings with research and theory in literature, including other geographical areas and quantitative research.

• References: APA format. Use pertinent references only. References should be on a separate page.

Additional Editor's Preferences:

• Please do not refer to your manuscript as a "paper;" you are submitting an "article."

• The word "data" is plural.

4.2 Word processing formats

Preferred formats for the text and tables of your manuscript are Word DOC or PDF. The text should be with standard 1 inch margins (APA formatting). Text should be standard font (i.e., Times New Roman) 12 point.

4.3 Artwork, figures and other graphics

• Figures: Should clarify text.

• Include figures, charts, and tables created in MS Word in the main text rather than at the end of the document.

• Figures, tables, and other files created outside of Word should be submitted separately. Indicate where table should be inserted within manuscript (i.e. INSERT TABLE 1 HERE).

• Photographs: Should have permission to reprint and faces should be concealed using mosaic patches – unless permission has been given by the individual to use their identity. This permission must be forwarded to QHR's Managing Editor.

o TIFF, JPED, or common picture formats accepted. The preferred format for graphs and line art is EPS.

o Resolution: Rasterized based files (i.e. with .tiff or .jpeg extension) require a resolution of at least 300 dpi (dots per inch). Line art should be supplied with a minimum resolution of 800 dpi.

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If you do not already have an ORCID ID please follow this link to create one or visit our ORCID homepage to learn more.

5.2 Information required for completing your submission

You will be asked to provide contact details and academic affiliations for all co-authors via the submission system and identify who is to be the corresponding author. These details must match what appears on your manuscript. The affiliation listed in the manuscript should be the institution where the research was conducted. If an author has moved to a new institution since completing the research, the new affiliation can be included in a manuscript note at the end of the paper. At this stage please ensure you have included all the required statements and declarations and uploaded any additional supplementary files (including reporting guidelines where relevant).

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Please also ensure that you have obtained any necessary permission from copyright holders for reproducing any illustrations, tables, figures or lengthy quotations previously published

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6. On acceptance and publication

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7. Further information

Any correspondence, queries or additional requests for information on the manuscript submission process should be sent to the *Qualitative Health Research* editorial office as follows: Vanessa Shannon, Managing Editor - Email: vshannonqhr@gmail.com

Appendix B: Ethics Letter

RHODES UNIVERSITY
Where leaders learn

Human Ethics subcommittee
Rhodes University Ethical Standards Committee
PO Box 94, Grahamstown, 6140, South Africa
t: +27 (0) 46 603 8055
f: +27 (0) 46 603 8822
e: ethics-committee@ru.ac.za

www.ru.ac.za/research/research/ethics
NHREC Registration no. REC-241114-045

21 July 2020

Kuriesha Munishvaran

Email: g20m8907@campus.ru.ac.za

Review Reference: 2020-1341-3524

Dear Mr. Booysen

Title: Clinical Psychologists' experiences of treating traumatic stress at a tertiary psychiatric hospital in the Eastern Cape: A qualitative research study

Principal Investigator: Mr. Duane Booysen

Collaborators: Ms. Kuriesha Munishvaran,

This letter confirms that the above research proposal has been reviewed and **APPROVED** by the Rhodes University Ethical Standards Committee (RUESC) – Human Ethics (HE) sub-committee.

Approval has been granted for 1 year. An annual progress report will be required in order to renew approval for an additional period. You will receive an email notifying when the annual report is due.

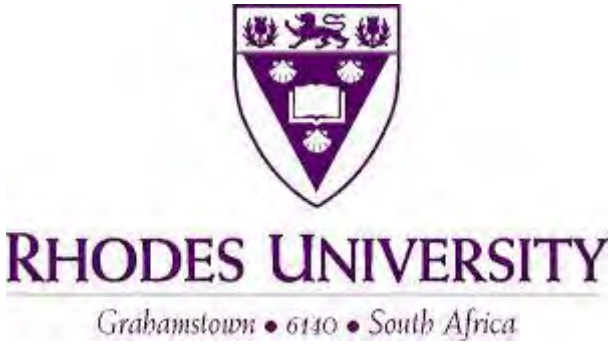
Please ensure that the ethical standards committee is notified should any substantive change(s) be made, for whatever reason, during the research process. This includes changes in investigators. Please also ensure that a brief report is submitted to the ethics committee on the completion of the research. The purpose of this report is to indicate whether the research was conducted successfully, if any aspects could not be completed, or if any problems arose that the ethical standards committee should be aware of. If a thesis or dissertation arising from this research is submitted to the library's electronic theses and dissertations (ETD) repository, please notify the committee of the date of submission and/or any reference or cataloging number allocated.

Sincerely,

Prof Arthur Webb

Chair: Human Ethics Sub-Committee, RUESC- HE

Appendix C: Consent Form



RHODES UNIVERSITY
CLINICAL PSYCHOLOGIST CONSENT TO PARTICIPATE IN RESEARCH

I _____ (participant's name) agree to participate in the research project of _____ (researcher's name) on _____ _____ (short title / topic of research project).

I understand that:

1. The researcher is a student conducting the research as part of the requirements for a Master's degree at Rhodes University. The researcher may be contacted on 072 944 8965 (cell phone) or kurieshamunishvaran@gmail.com (email). The research project has been approved by the relevant ethics committee(s), and is under the supervision of Mr Duane Booysen in the Psychology Department at Rhodes University, who may be contacted on 078 167 6607 (cell phone) or (email) d.booysen@ru.ac.za.

2. I am aware that verbal audio consent will be recorded at the start of the interview.

3. The purpose of the study is to investigate clinical psychologist's experiences while working with patients presenting with symptoms of PTSD at a tertiary psychiatric hospital.

4. My participation will involve expressing my experiences of working as a Clinical Psychologist, and my experiences of working with trauma narratives of my patients. I consent to the interview being recorded with an audio-recorder. The interview timeframe will be open ended, and there will be a follow-up interview on a different day.

5. I may be asked to answer questions of a personal nature, but I can choose not to answer any questions about aspects of my life which I am not willing to disclose.

6. I am invited to voice to the researcher any concerns I have about my participation in the study, or consequences I may experience as a result of my participation, and to have these addressed to my satisfaction. I will receive a list of psychological service providers to contact should I feel distressed as a result of the interviews.

7. I have the right to decline and/or exit the study at any time. However, I commit myself to full participation unless some unusual circumstances occur, or I have concerns about my participation which I did not originally anticipate.

8. Confidentiality will be maintained by means of removing my personal details from documents. Any patient's biographical information disclosed will be held confidential. I am aware that all paper documents will be safeguarded at the personal office of the principal researcher, and electronic data will be encrypted and stored on Dropbox storage. These storage spaces will have controlled access. The principal investigator and research supervisor will have access to the Dropbox stored data. I have the right to request a copy of the audio-recorded interview.

9. The results of the study will contribute to a Master's thesis, and academic publication(s), and conference presentation(s).

10. I consent to meet virtually via ZOOM or face-to-face in a setting that has constant air flow, while both myself and the interviewer are socially distanced and wearing masks. I am aware that screening measures are required in line with the COVID-19 protocols prior to the interview.

SIGNATURE OF PARTICIPANT

_____ _____

Signature of Participant Date

SIGNATURE OF INVESTIGATOR

I declare that I explained the information given in this document to _____ [*name of the subject/participant]* and/or [his/her] representative _____ [*name of the representative]. [H*e/she] was encouraged and given ample time to ask me any questions. This conversation was conducted in [*Afrikaans/*English*] and [*no translator was used/this conversation was translated into* _____ by _____].

_____ _____

Signature of Investigator Date

Appendix D: Interview schedule and items

BEGINNING OF THE INTERVIEW:

The researcher will verbally outline all domains set out in the informed consent, and will answer any questions the participant may have. The researcher will also verbalise the schedule of the interview so that they are aware of what is to come. Interviewees will be reminded that they should only answer questions which they deem comfortable enough to answer. Interviewees will also be reminded that the primary aim of the interview is essentially for them to tell a story, in their own words, about their lived experience.

ITEMS ASKED DURING THE INTERVIEW:

1. Can you tell me how you came to work in a psychiatric hospital?
   Prompt: How long?
2. How do you experience working as a clinical psychologist in a psychiatric hospital?
   Prompt: Specific experiences? Most challenging aspect? How does it make you feel?
3. Describe your opinion of traumatic stress (i.e. PTSD) in a psychiatric context?
4. What is it like working with patients trauma narratives in a psychiatric context?
   Prompt: Types of trauma? Has it affected you personally? Professionally? If so, how?
5. How do your views of trauma contribute to how you experience working with traumatic stress?
   Prompt: Any specific experiences you are comfortable to share?
6. Tell me about how you cope/process your experiences of working with traumatic stress?
   Prompt: Any specific strategies? Examples?

END OF THE INTERVIEW:

The researcher will thank the participant for their time and willingness to participate. The researcher will ensure that the participant is not distressed by the contents of the interview before closing. The researcher will remind the participant of the follow-up interview and schedule a tentative date.