UNIVERSITY OF
BATH

The Researcher Wellbeing Project Report

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December 2023

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Executive Summary

The Researcher Wellbeing Project (RWP) focused on understanding the potential impacts, including secondary trauma,[2] of researching emotionally challenging topics; and establishing what, if anything, researchers have in place to help them cope and what they would like to be in place. The overwhelming reception the RWP received from staff was very positive, because it addressed a topic that has been "a really invisible issue" (Participant 22) within academia until recently. The project involved 31 semi-structured interviews with researchers who did potentially emotionally challenging research. These participants were also asked to do follow-up questionnaires; 25 completed the coping mechanisms/interventions questionnaire and 20 completed the secondary trauma scale. In this summary, we outline the key findings of the RWP related to: (i) impacts and (ii) coping mechanisms and recommended support/interventions. This project was funded by the Research England Enhancing Research Culture Fund.

Top line impact findings

The majority of academics interviewed were positive and passionate about their research. Despite this, symptoms linked to secondary trauma were common across topics and disciplines. Of the participants that completed the Secondary Trauma Scale, in reference to their most distressing research experience, 16 out of 19 'had trouble concentrating', 17 out of 20 'experienced negative emotions', and 18 out of 20 thought about distressing aspects of their research when they did not intend to. In addition, seven out of 20 also had more severe indicators of secondary trauma (such as gaps in memory, feeling jumpy, feeling like they were reliving the experiences of others, and avoiding people and places linked to the distressing topic). Three of the 31 interviewees took up the offer of trauma-focused counselling provided by the RWP to help address their symptoms; seven were already accessing self-funded counselling/therapy.

Whilst six out of 20 have very low overall secondary trauma scores, some of these still had challenging symptoms. For example, Participant 21 stated, "*I remember sitting on a bench, and I couldn't enjoy anything, […] I was totally out of it in many ways, and I couldn't even enjoy eating an ice cream!*" Other symptoms for those less affected were sadness, crying, feeling guilty about being unable to help their participants and being 'cold' to the feelings of others (particularly their students). It is also important to note that not all impacts were solely seen as detrimental. In particular, anger was constructed as a positive drive of their research, and sadness was seen as also linking to empathy for participants.

A major difference in impact was between participants who: controlled the topic/process and had secure posts/careers (e.g. lead researchers) and those who did not (e.g. contract researchers); had shared experience with their respondents (e.g. Participant 16 stated interviewing and analysing the data was "*like somebody's touching or putting salt in a wound that we have*") and those who did not; had current/other difficulties (e.g. current relationship problems, existing dis-ability, parenting) and those who did not; and had training/knowledge of how to cope with impacts (e.g. had wellbeing plans and/or clinical supervision) and those who had little training/knowledge/support.

Top line coping mechanisms and requested support/interventions

Most academics had coping mechanisms in place, with varying levels of success. Most of these were informal, including things that they did for themselves individually, such as physical activities (walking, swimming, music); and things they did with others, from (i) outside of work (family, friends, people 'in the field' and from spiritual groups/leaders), and (ii) inside of work (colleagues, networks, open discussion). For the minority who had training and/or experience from other professions before becoming a researcher, they took their previous formal support mechanisms (including wellbeing plans, clinical supervision and counselling) and slotted them

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[2] Secondary trauma is the suffering and anxiety that can result from witnessing the trauma of others (American Psychiatric Association, 2013).

into their academic routine (mainly paying for these themselves). Only a minority had started to get some form of formal support (meaning paid for by their institution as part of an agreement with their supervisor/line manager). When we asked interviewees what formal support they wanted from the University, a key theme is illustrated by Participant 13. They stated this should not be a "one size fits all" but rather: *"a toolbox of options that are available to researchers in a flexible way according to their needs […] both informal and formal mechanisms within each research team or the wider department or an organisation. But also that there are those independent people, expert people to go and talk to in more depth if required."*

In short, to go beyond the existing ad hoc - primarily individualised - approach, changes are needed to the management and provision for emotionally challenging research. Interventions indicated as potentially or already particularly helpful in the coping mechanisms/interventions questionnaire results include:

- A supportive research culture where wellbeing issues can be openly discussed.
- Written guidance/pathways so staff know what to do if the researcher or participant gets distressed.
- Develop supervisor/management skills to: provide effective regular supervision for emotionally challenging research and manage teams (see below); debrief research staff; and delineate clear role/responsibilities for junior research staff.
- Team approach to working to share the higher 'burden' of emotionally challenging research through: meetings that include discussions about wellbeing; and shared data coding/analysing, presentations and other impact work.
- Funded Researcher Wellbeing Plans that are flexible and could include: independent clinical supervision, 10-20 trauma-focused counselling sessions if needed, specialist mentoring or coaching, Researcher Wellbeing Network, expert facilitated wellbeing workshops, being taken out of distressing work with consent when needed, as well as exercise and non-sporting hobbies.

In relation to the limits of academic supervision and need for clinical supervision, Participant 25 stated: *"Whilst we have all the debriefs and everything, I am not clinically trained to either diagnose trauma or to diagnose mental health issues or declining mental health. And whilst I hope they would come to me if they were feeling traumatised or feeling like it was having an effect, I am very conscious of the fact that […] I'm their line manager, and they may not want to share that with me, or […] they may worry about what conclusions I will draw about their competency or skill."*

How participants decompressed from their work was key to how many coped with their research: *"So, the self-care plan, the initial one was. Uh, very calming. So, for example, I would use the swimming pool. And to decamp from work to home life. So, I'd physically immerse myself in water, and it was no good surface swimming. No, you have to immerse yourself completely, fully, and to literally wash off the day before entering the home life in the evening."* (Participant 1). This participant later stated that as the amount of trauma in their data escalated, they had to revise their wellbeing plan to include an extreme sport to release the anger.

As already stated, many of the recommendations identified by participants could be facilitated through Researcher Wellbeing Plans. However, staff that were aware of the need for these were frustrated by the lack of institutional support/funding in this regard. In addition, there were institution-wide issues identified in the data that need to be addressed, such as effective risk assessment, and time in workloads. For example, whilst most questionnaire respondents thought effective risk assessment and safety planning would be helpful, our qualitative data indicates this is currently a "ticking boxes exercise, […to] make sure that the university has the right paperwork rather than a genuine concern in how I cope" (Participant 21). Time in workloads was also wanted for managing emotionally challenging research. Private campus office space was needed to conduct the research, so it does not 'pollute' their homes. And vital for a minority was support/seed money to change the research topic. These are strategic policy decisions that need to be taken at the departmental/faculty/institutional level.

Key recommendations

The following recommendations have come out of the RWP findings, a detailed outline of which is in Section 5 of the full report. It may not be possible for an institution to implement all of the recommendations, so we have formulated a phased approach: Bronze, Silver and Gold standard (where the former requires minimal funding and is working towards the latter, Silver would include most elements in Bronze, Gold is proactive and well-funded):

- Well-funded strategy on *prevention* of and *provision* for secondary trauma in research.
- A supportive research culture that proactively and positively acknowledges and discusses the issue. This can be facilitated through awareness raising and specialist training on: impacts of emotionally challenging topics, how to develop wellbeing plans, effective risk assessment, and effective supervision/management of emotionally challenging research (including individual supervision and team working).
- Written processes and guidance, and clear written pathways so staff know what to do if the researcher or participant needs help. These should be easily accessible (e.g., on a researcher's wellbeing and/or ethics committee webpage).
- Researcher wellbeing embedded in ethical processes/forms within the institution to prompt researchers to think about the issue and how they will address it.
- Regular and effective supervision/management of emotionally challenging research.
- Team approach to emotionally challenging research (including team discussions that include wellbeing).
- Proactive funding of Researcher Wellbeing Plans, including independent individual clinical supervision[3], specialist trauma focused counselling if required and other elements important for wellbeing (e.g. gym membership).
- Specialist mentoring and/or coaching for researching emotionally challenging topics (can be linked into existing institutional schemes).
- Researcher Wellbeing Group/Network (such networks exist nationally).

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[3] For silver, this would be *proactively* provided through individual research grants, *reactively* provided by the institution if distress / secondary trauma has occurred.

Section 1: Introduction

The Researcher Wellbeing Project (RWP) focused on understanding the potential impacts, including secondary trauma[4], of researching emotionally challenging topics, and establishing what, if anything, researchers had in place to help them cope and what they would like to be in place in the future. The overwhelming reception the RWP has received from staff has been exceptionally positive, because it addresses a topic that has been *"a really invisible issue"* (Participant 22) within academia. This report outlines the key findings of the RWP related to impacts, coping mechanisms and recommended support/interventions. This project was funded by the Research England Enhancing Research Culture Fund.

Section 2: Approach

We undertook 31 semi-structured interviews with researchers undertaking potentially emotionally challenging research (ethics ref: S23 012). Participants also completed pre- and post-interview questionnaires, which captured: demographic information; the stages of research that can be emotionally challenging; symptoms of secondary traumatic stress; and relevant coping mechanisms/interventions (see Appendix 1 for detailed discussion of methods).

Section 3: Impacts

In the analysis of the impact of conducting sensitive research on researchers' wellbeing, several key findings emerged. The overwhelming majority of respondents were positive and passionate about their research. However, symptoms of secondary trauma were pervasive across different topics and disciplines, with a few participants showing signs of direct trauma as a consequence of their work. There was considerable variation in the extent, presentation and evaluation of these impacts, both within and across individuals. For instance, one participant only experienced distress when the complexity of the topic intensified, while another, despite claiming to be unaffected, reported feelings of sadness and a growing emotional detachment from others. Not all individuals reported negative impacts, with those solely analysing secondary quantitative datasets generally being less affected. Furthermore, not all emotional responses were perceived as detrimental. Some researchers saw anger as a driving force behind their work, and feelings of sadness were occasionally linked to a heightened sense of empathy.

Whilst shared experiences can foster empathy, they also risk triggering personal traumas, intensifying the researcher's emotional engagement. For example, Participant 16 described what shared experience feels like: *"It's […] like somebody's touching or putting salt in a wound that we have"*. Fourth, life challenges can further exacerbate researcher vulnerability. Various life events, such as becoming a parent, facing relationship issues, or health concerns, and existing conditions (such as poor mental health) can strain researchers' capacity to engage with specific research topics or aspects of their work.

It is essential to recognise that some psychological and physical symptoms were not solely due to the distressing research topic and aspects *per se* and may be interconnected with other factors. For example, increased stress levels were often associated with work-related issues, such as increased workloads and tight deadlines. Loneliness was also an issue due to not having colleagues to work with and push the challenging research field forward. Nevertheless, findings from the interviews demonstrated that staff researching potentially sensitive topics are susceptible to symptoms associated with secondary trauma. This is also reflected in the post-interview questionnaire on secondary trauma, indicating that symptoms of secondary trauma are present in our sample (see Figure 1.).

Participants report that all stages and aspects of potentially distressing research work may contribute to the development of symptoms associated with secondary trauma. Results showed that all stages, including literature review, participant recruitment, writing up and impact work, can lead to symptom development. Yet, research stages such as qualitative interviews and other fieldwork involving direct interaction with participants, transcription, and impact work tended to be the most challenging. The most frequently used approach by participants in the study was qualitative research methods.

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[4] Secondary trauma is the suffering and anxiety that can result from witnessing the trauma of others (American Psychiatric Association, 2013).

Figure 1

Symptom distribution from the Secondary Trauma Stress Scale (STSS) for each participant
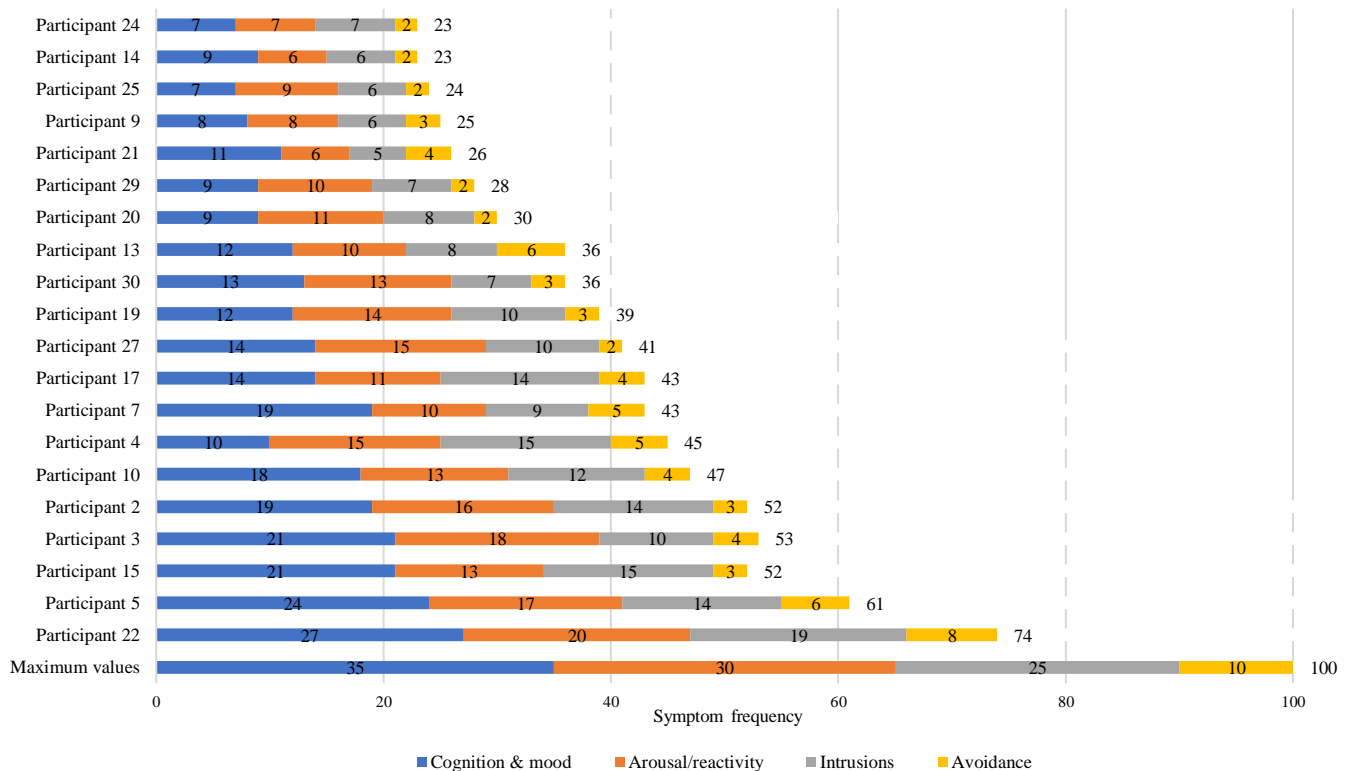
Note. N = 20 participants who completed this questionnaire. The minimum score is 21.

3.1 Alterations in cognition and mood

Alterations in cognition and mood were the most common domain of symptoms in the current sample; both in the interview and questionnaire data. Seventeen participants reported experiencing some negative emotions (5 often/very often, n=20). Qualitative data revealed feelings of distress, anxiety, feeling drained, disgust, guilt, frustration, powerlessness, sadness and fear. Some participants reported feeling depressed at times, including those scoring relatively low on the Secondary Trauma Scale, such as Participant 21: "*I remember sitting on a bench, and I couldn't enjoy anything, […] I was totally out of it in many ways, and I couldn't even enjoy eating an ice cream!*". Numbness was reported among eight participants (4 often/very often, n=20). Three participants described being "cold" towards issues and people, such as family, friends or students, generally outside of their research in the qualitative interviews. For example:

> "*It probably makes me cold. […] I think a danger of this kind of research is when someone has a problem which to them is quite important, you know a student, […such problems] don't seem as significant […] but I try and act like they are!*" (Participant 28).

Furthermore, 11 participants reported feeling less active than usual (2 often/very often, n=20), 13 reported little interest in being around others (none often/very often, n=20), and 12 participants had at times experienced negative expectations about the self, others and the world (5 often/very often, n=20). Participants described the latter as a shift in their perceptions:

> "*The most acute part is when you're […] seeing the things that you write about, and you read about, […] there's a real helplessness in those moments, and a real sort of despair […] feeling what I was doing is very meaningless and such a drop in what needs to be done. […]*" (Participant 15).

Similarly,

> "*it was moving and it was upsetting. And it was kind of difficult to see what kind of suffering exists in the world that we live in. And it's never very far away from us.*" (Participant 16)

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In relation to their careers, some participants decided to go part-time and gave up the idea of career progression in favour of wellbeing and having the time needed to cope with the topic. Others, like Participant 15 above, indicated a loss of hope that their work can make a difference. They went on to say:

> *"sort of thinking about a career as an academic and researcher and doing this kind of work and just sort of despair at the state of the world and feeling so enthusiastic at the beginning and wanting to see some small change and the sort of being confronted with in a very deep structural [prejudice] and discrimination and seeing the pain, seeing what some people will do to other people."*

One proactively talked about wanting to get out not only of doing emotionally distressing research but of academia and research altogether:

> *"You know when you're doing a research job where you know it kind of leaves you having dark thoughts in the middle of the night, you do have to think, well is this really worth it, you know? So I've been doing a whole load of questioning, I would say, since this XXX project. [...] So it all feels very dry and burdensome. So I've been, for the last two years very proactive about applying for jobs outside of academia. I'm writing a job application right now, actually. Because I just think if this is the future, it's not worth it. [...] I can start having fun! (laughs) [...] Less money but more fun! (both laugh)"* (Participant 22)

Many of the impacts could combine, such as fear and existential anxiety, and be linked to physical sensations such as fatigue, tightness in the chest, changes in their voice (e.g., when talking about the research), repulsion and/or feeling sick. For example, in relation to their experience, while generating data, Participant 15 went on to describe *"a sort of fear, I guess a physical repulsion [...] that this could be possible today, that people would do this. [...] I would feel it in my body [...] remember feeling sort of quite sick"*.

3.2 Altered arousal and reactivity

Changes in arousal and reactivity were the second most frequently observed domain of symptoms. The spectrum of symptoms described by participants indicated the multifaceted nature of these responses. The inability to concentrate was also reported by 16 participants (3 often, n=20), and interviews indicate this was often in relation to qualitative aspects of their work (e.g., while reading interview transcripts). Sleep disturbances were reported by 14 participants (2 often/very often, n=20), and could even impact those who felt generally 'unaffected' by their research and scored low on the Secondary Trauma Scale:

> *"The only sleepless nights I've had about my research have been where other people have been interviewing [participants]. And I've worried about: 'will my researchers be OK?', 'could something happen to a [participant]?'"* (Participant 25)

Fourteen participants also reported feeling easily annoyed (3 often/very often, n=20). In interviews, some also acknowledged general irritability and anger, while almost all participants described feeling angry about the trauma and suffering experienced by their participants and the lack of positive change in service/State policy and practice. For example:

> *"One of the issues is actually managing anger. And Yeah, resentment, you know, seeing what goes on and the lack of accountability that can be very frustrating, upsetting, infuriating. Yeah. One of the things I've had to manage over the years is how one deals with that rage that, you know, that sense of injustice."* (Participant 8)

Other symptoms of hyperarousal/reactivity tended to be less common. Hypervigilance was reported by 11 participants (2 often, n=20). Some participants expected something bad to happen as they described heightened alertness related to their or others' safety. Feeling jumpy was reported by 7 participants (1 very often, n=20) and engaging in reckless or destructive behaviour by 5 participants (1 often, n=20).

3.3 Intrusions

Eighteen participants reported thinking about their research when they did not intend to (4 often/very often, n=20), with participants recalling thoughts and memories that lingered vividly in their minds, occasionally resurfacing years after the exposure to other's trauma. Participant 22 described this as mentally *"polluting"*. For some researchers, intrusive thoughts link to their own experience of primary trauma:

> *"Listening to other people's suffering reminds me of my own, and some stuff that you know I've kept buried for a long time. [...] it just sort of lands on you, doesn't it? It comes up behind your back, and the thoughts come into your head!"* (Participant 22).

Less commonly reported were nightmares by 8 participants (1 often, n=20). Interviews indicated that these tended to occur shortly after exposure to another's trauma: *"I was getting like nightmares. I was having problems with sleeping. Nothing super serious, but I noticed that I was being disturbed by the data that I was working on"* (Participant 4).

3.4 Avoidance
Avoidance of working on their research was reported by 12 participants (3 often/very often, n=20). This manifested in numerous ways and often served as a means of self-preservation:

> *Yeah, it's called avoidance [of data analysis] by getting up and just going, oh fuck this, I'm off to [do a hobby]! But then equally, doing that classic thing that you're not really enjoying your time [doing a hobby] because you feel guilty that you're not at your desk coding your data!* (Participant 22)

Lastly, avoidance of people, places, or things that reminded them of the research was reported by 7 participants (none often/very often, n=20).

3.5 Additional impacts
In addition to the impacts measured within the Secondary Trauma Scale and/or raised above, there were additional impacts indicated in the interview data. A key one was on participants' relationships. Some participants were worried about their changing mood affecting their family relationships (e.g., being irritated or stressed/anxious affecting interactions with partners and/or children), some were concerned about bringing home their research, and it being a burden on family, friends or colleagues and limited what they shared in order not to upset others. For example:

> *"I realised I was coming home and I … and it was just kind of whirring round my head. And I couldn't tell anyone about what was in my head, but I needed a way to kind of decompress because when […my child is…] at home, [… they are…] not aware of what's going through my head on what sort of day, […they want…]to play or […] to talk or watch TV or play games or you know we're doing [their] homework. So I knew I needed something to just give me space … to decompress".* (Participant 25)

Participant 1's partner moved out of their home for a while in order to avoid encountering the project data, but they did not do this before checking on Participant 1's wellbeing, indicating that partners are also helping with this emotionally challenging work:

> *"[during transcription] my husband had to move out, […] that was an extended period because as you can imagine, that took a long time to do and have great sympathy for him in not hearing that in the house. And but obviously he didn't leave before really, you know, checking that I had a self-care plan"* (Participant 1).

3.6 Section Summary
While most researchers were passionate about their work, there were numerous impacts of researching potentially sensitive topics that went beyond the measures in the secondary trauma scale. As well as the emotional and physical symptoms and existential crisis that can be linked to the systemic injustices of human suffering described above; effects can also extend to disruptions in social relationships and career. Even those who claim no impact may exhibit emotional and behavioural shifts, such as growing indifference to students' issues. Given these insights, our study emphasises the need for a structured strategy to prevent, protect against, and address distress, secondary trauma, and trauma in research.

Section 4: Coping mechanisms
The data suggest that academics employed various coping mechanisms, with differing degrees of effectiveness. Most of these mechanisms were informal (section 4.1). At the individual level (section 4.1.1), they included activities such as physical exercise and other hobbies. On a micro-level, meaning interactions with others (section 4.1.2), support came from two primary sources: outside of work (section 4.1.2.1), such as family and friends, and within the workplace (section 4.1.2.2), from colleagues, networks, and peers in the field. Interestingly, some academics had prior training or experience in other relevant professions. These individuals often brought with them formal support mechanisms, such as wellbeing plans, clinical supervision, and counselling. However, they typically integrated these supports into their academic life without the funding or support of the University. Only a minority accessed formal support (section 4.2) that was funded by their institution and arranged in agreement with their supervisor or line manager. However, when asked about formal support from the University, the overwhelming response was that there needed to be more support in place for staff.

In the following sections, we outline the informal coping mechanisms that staff used to help them, followed by some coping mechanisms that they thought should be avoided (e.g., alcohol use). We then discuss the formal support that they want from the University. As Participant 13 states, such support for researchers should not be *"one size fits all"* but rather:

> *"a toolbox of options that are available to researchers in a flexible way according to their needs […] both informal and formal mechanisms within each research team or the wider department or an organisation. But also that there are those independent people, expert people to go and talk to in more depth if required."*

4.1 Informal coping mechanisms
4.1.1 Individual level

Engaging in different types of exercise, such as walking the dog, running, swimming, yoga, and going to the gym, was highlighted as a key coping mechanism among all staff (25 out of 25, 13 very/extremely helpful). For example,

> *"So, the self-care plan, the initial one was. Uh, very calming. So, for example, I would use the swimming pool. And to decamp from work to home life. So, I'd physically immerse myself in water, and it was no good surface swimming. No, you have to immerse yourself completely, fully, and to literally wash off the day before entering the home life in the evening."* (Participant 1)

One participant particularly described physical activity as a "vehicle" to transition from darker periods in their lives. Similarly, non-sporting hobbies, including gardening, sewing, knitting, reading, cooking, connecting with nature, having a pet, and enjoying music, were also considered effective coping mechanisms for all participants. It is essential to note that coping mechanisms, in general, were highly individualistic and may change over time, so there was not a "one-size-fits-all" approach. For instance, while meditation was a very/extremely helpful coping mechanism for five participants, eight did not find it helpful (17 out of 25 found it helpful). Notably, working only office hours and weekdays was favoured by 23 out of 25 participants (14 very/extremely helpful). This was emphasised not just as a coping strategy but also as a means to enhance productivity. Participant 2 shared: *"I've also realised since I work towards a better work-life balance that I'm actually far more productive when I'm better within myself rather than when I'm working too much."* Furthermore, most researchers (23 out of 25, 15 very/extremely helpful) underscored the significance of sustaining hope and a sense of purpose in their research. The belief that their work has a meaningful impact is a crucial coping mechanism.

> *"They have definitely been sometimes quite challenging to research for sure. They've definitely been emotive and sometimes distressing. But I like that on some levels because I feel like it gives me some sort of evidence that, yeah, we are researching something here that really does…It feels like it matters."* (Participant 16)

Figure 2

Most helpful individual coping mechanisms
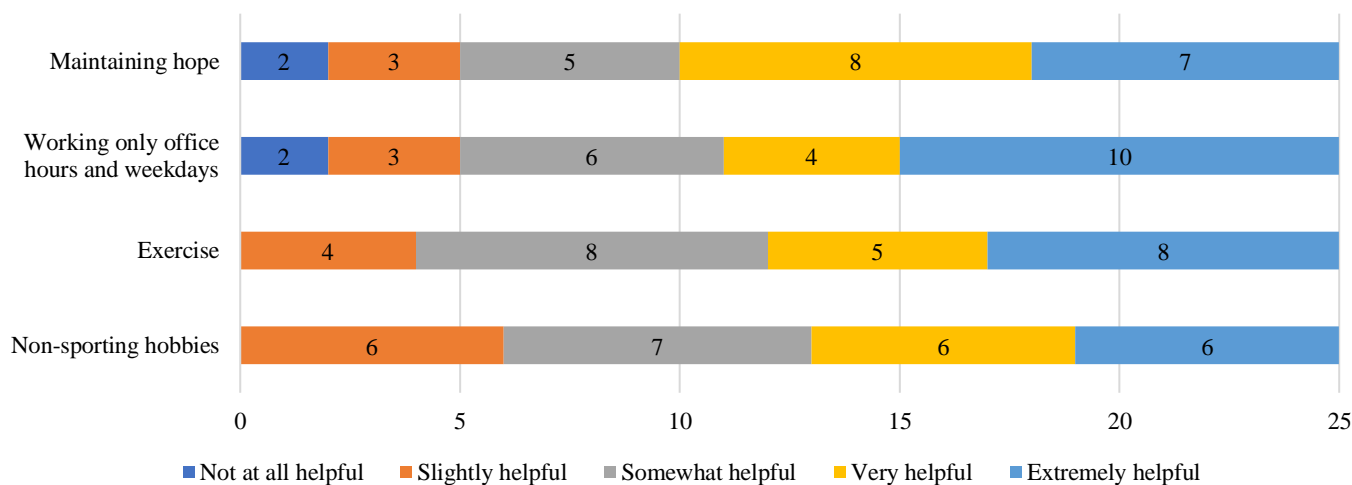
N = 25 participants who completed this questionnaire.

Qualitative analysis further strengthened findings on individual informal coping strategies. Of the participants, 23 saw their 'predisposition' as a key foundation for their ability to cope. It was observed that these 'predispositions' arose from either training, accumulated research experience, personal or other professional experiences, what some respondents perceived to be 'innate' qualities (e.g., ability to compartmentalise) that foster 'resilience,' or a combination of these things. A recurring theme was acceptance, which manifested in various ways, helping researchers to cope. This included acknowledging and normalising their emotional and physical responses, accepting the inherent challenges of their research

topic, their limited capacity to assist individuals, the lack of University support, and accepting the eventual need for emotional decompression. For example:

> *"I think I'm just comfortable with the fact that it's going to be difficult. And that's kind of just part of it, because you can't expect to go into these topics in these populations and like, and it's just going to be easy and straightforward"* (Participant 14).

Some researchers recognised that, at times, they or other individuals might not be suited for specific topics or research tasks. Specifically, eight people talked about their experience of consciously disengaging or partially disengaging in one form or another to maintain and protect their wellbeing. For example, they discussed disengaging from emotional labour with students because of their research and/or family, from participants' lives, from particular topics or more challenging parts of the research job (e.g., data generation and impact), or switching from full-time to part-time work.

> *"I suppose you know, it's about… it's partly about personal disposition. […] I can do research in an organisation and talk with professional people, but I couldn't be out on the ground listening to those stories. I just know that I couldn't do it. So there's an element of kind of self-selection."* (Participant 8)

Conversely, participants in the study highlighted several harmful 'coping' mechanisms. Alcohol emerged as a significant concern for two participants, with one participant acknowledging its use as a way to numb their emotions or deal with stress. Two participants admitted to being unable to set limits taking on more tasks than they could handle, which led to feeling overwhelmed, as a way of appeasing their sense of guilt at the lack of support available for their research participants. Lastly, staying up late and sacrificing sleep was another potentially destructive way of 'coping' with excessive workloads, with one participant recognising its detrimental effects on their wellbeing. For the same reason, participants skipped self-care activities, such as yoga or walks, due to a sense of guilt or obligation to work.

4.1.2 Microsystem
4.1.2.1 Outside of work
Where possible, substantial support was gained from interactions outside of work, including family, friends, and spiritual groups/leaders within the participant's microsystem[5].

Family and friends
Social interactions with family and friends were highly valued as support sources for most staff (24 out of 25, 14 very/extremely helpful). Specifically, nine participants talked overtly in interviews about gaining support from family and/or friends, and, for some, these informal relationships were their primary source of support. For some, the reliance on personal networks was rooted in the lack of trust in the University and the formal support it offered:

> *"So the times that I've got frustrated or stressed or, you know, struggled, I think the sort of better option is to talk it through with my husband, and I think, you know, to kind of reach for those personal support mechanisms that serve me well, […]."* (Participant 31).

While getting informal support through friends, family, (and colleagues, see section 4.1.2.2) was seen as good, some worried about how much time and space they were taking to talk about those things: *"if […] you need to speak to a friend or some partner or someone about what's going on with your mental health, I think there's always a sense […] how much space am I taking up? And what about them? how are they feeling and that kind of thing […]."* (Participant 9).

Religion/spirituality
Three participants highlighted in interviews the significant role of spirituality/religion in providing communication, understanding, and meaning amidst challenges. For this reason, we included this category in the questionnaire and 16 (out of 25) indicated this was helpful for them (9 very/extremely helpful). This helped interviewees to maintain hope and offered a framework to navigate and respond to the complexities of human suffering or other research-related challenges.

> *"I went on a long kind of learning and spiritual journey through this learning, primarily as a response to things in my personal life, fighting with my partner, for example, or conflict within my family and recognising how alienated our ways of communicating were, and that … so it's like a … personal life motivated set of learning*

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[5] See the work of Bronfenbrenner (1979 and onwards) on ecological systems theory. We are developing his work to help us understand how individual experiences are shaped within the microsystem (e.g. in relations between peers and family members), mesosystem (e.g. institutional/departmental interactions and interpretations of rules/laws and development of work cultures), exosystem (e.g. interaction of senior management with national policy making bodies), macrosystem (e.g. national law and work culture), super-macrosystem (international/global influences/interactions), and chronosystem (e.g. how all of this changes over time).

choices, from which massively professionally and politically impact and made me much more able to do what it is that I do, healthily and effectively [...]" (Participant 29)

4.1.2.2 Inside work
Another key way of gaining informal support was through colleagues, sometimes individually, in groups and networks, but invariably, the wellbeing support offered was informally sought rather than formally offered. The need to talk with colleagues was also supported by two other codes in the data: the need for 'open discussion' and a 'supportive environment'.

Colleagues
In the interviews, 16 participants emphasised the importance of trusted colleagues as support sources, whether within their research group, the broader University, or networks developed nationally or internationally. From this, four participants specifically indicated they talked to colleagues whom they considered friends, thus blurring the friend/colleague boundary. A reason identified for why this specific group was particularly helpful was the perceived understanding of common issues researchers go through and, for many, the topic: *"I think you end up getting informal support like you have friends and peer ... like people who are doing similar work, you end up sometimes like talking, and it's not really support, but you'll talk about how like, oh like that's so ... like this is ridiculous!"* (Participant 28). In addition, nine interviewees had a group of colleagues working on a particular project, or simply the same topic, that unofficially/informally came together to form a support group (see also groups/teams in section 4.2 and Figure 3), for instance: *"And the only thing that really happened for us was we kind of formed our own mini-support group. As in, we just talked to each other. We would meet for coffee. And we would just chat about how this was going for us, which we all found hard times. All of us"* (Participant 16).

Wanting opportunities for open discussion in a supportive research culture
Questionnaire respondents unanimously indicated that they would find (or found) helpful a research culture that recognises and openly discusses the potential of distress and (secondary) trauma in research (see also section 4.3 and Figure 3). This was reflected in the qualitative data where participants discussed the need and benefits of open discussion about researcher wellbeing and distressing topics within academia. For example, Participant 29 felt that they were already in a supportive research culture, where open communication about issues researchers were struggling with at work or in their personal lives could be talked about, saying that it is possible to have: *"open, frank, vulnerable conversations about their time and their experiences."* While awareness has grown over the years, this perception was not yet widespread. Participant 25 noted that even though more individuals are beginning to discuss certain issues, it is still not true for the majority. This was reflected by other respondents. For example, Participant 27 stated that although there are lots of different entities within the University (e.g., research centres, beacons), none of them provides a safe space to talk:

> *"I'm a member of like XXX different centres, and God knows what else, but none of them [...] provides like a place like you were saying, like safe space, where you could like talk about your research. And I ... I feel like that is an obvious thing that could be done"* (Participant 27).

Having a safe place to talk not only allows individuals to realise they are not alone in their struggles, which can be empowering, but it also provides an opportunity to gain a different perspective on the issues they face. Participant 3 described what open communication might look like - a *"safe forum"* or *"network"* where people doing *"similar stuff"* could *"talk confidentially to people"* about their emotionally *"difficult work"*. Similarly, Participant 8 referred to such a community as a *"marketplace where people kind of share what they.. how they cope, what they found useful"*.

While all participants agreed that a supportive research culture and environment would be beneficial, not everyone currently experiences this. For instance, one participant described a detrimental research group environment that negatively affected their wellbeing and added extra work, primarily due to a specific team member. Similarly, another participant lacked a supportive environment, with no one knowing their activities or checking in on them during fieldwork. Moreover, when they attempted to address specific issues, their experiences were dismissed by colleagues. However, it is important to recognise that fostering a supportive team or community can be challenging for supervisors:

> *"I know what I've tried to foster, within my, my PhD students. I have tried to foster kind of a sense of community where they kind of trust each other, they can talk to each other, they can talk to me that we can all feel kind of comfortable sharing our difficulties, but [...] it is difficult"* (Participant 2).

4.2 Formal coping mechanisms

The most (potentially) helpful formal coping mechanisms are shown in Figure 3. As stated above, a supportive research culture was indicated as important for all participants. For some, the academic environment has seen shifts in attitudes towards wellbeing; Participant 25 reflected on this change, stating, *"It is much more accepted, I think, for people to say, I'm really struggling right now, or this has really bothered me. I grew up as an academic in a culture where that wasn't valued."* Despite this evolving perspective, many respondents revealed that they rarely discussed their wellbeing needs in relation to their research at work. A significant reason for this was the perceived absence of formal support mechanisms. Some believed that the University did not offer such mechanisms. Participant 13, for instance, acknowledged the existence of support at the University, saying, *"I do know the formal support is there at Bath."* However, the same participant also admitted to not seeking it proactively: *"I might have had to more proactively go out and ask for it."* This reluctance was, for some, tied to a deeper mistrust of the institution. Participant 16 expressed: *"I don't think we really trusted the organisational culture to help us and the kind of formal.. the formal systems. We didn't expect or trust that there would be help there."* Similarly, Participant 21 shared, *"to be honest, I don't trust the University in terms of taking care of ... seriously taking care of mental health."* Another reason given for not seeking support was the belief that it was the University's responsibility to offer these services and inform the staff proactively.

The formal support that was occasionally available was often reactive rather than proactive. For example, clinical supervision might be arranged after a researcher explicitly requested it following a distressing event. Meanwhile, interventions such as the standard six counselling sessions were often perceived as too little, too late, and not tailored to the unique needs of academics. Most interviewees indicated reluctance to utilise the standard University counselling services for profound or prolonged issues stemming from their research. Some common reasons included the limited number of sessions, a lack of trust in these services, an absence of follow-up, and generally inadequate awareness about these services. Participant 2 shared, *"I did a few years ago,[...] the University programme, where you get six sessions with a therapist, but it was too short, I think, and it's not what I needed. I needed something a bit more long-term"*. Similarly, Participant 10 said, *"I wish it was more readily available to people. I wish it was, you know, accessible beyond some of the quick fix, CBT mindfulness that's out there"*.

Exceptions were noted among participants with training or awareness, often from previous employment outside of academia. These individuals reported a more supportive environment, where team meetings and regular supervision were more prevalent, suggesting a proactive approach to wellbeing. For example:

> *"We have monthly meetings currently, and more often if [.. they need] them in between, [...] we have those fixed in the diary, if we don't need them we cancel them, [...] And particularly when [...they start] getting the data, and we start ... then we start looking at the data together, that is really helpful to debrief on what [...they've] discovered from those things." (*Participant 30)

Most participants expressed a desire for the University to develop formal support, indicating they do not currently get it. While there were various ideas and suggestions about its potential form, the overarching perspective was that there's no *"one size fits all"* solution. As Participant 13 described, it should be a flexible *"toolbox of options"*. This toolbox should be adapted to the diverse needs of each researcher, the changing demands of different research projects and external and internal pressures (see Figure 3 for possible contents of this 'toolbox').

Generally, negative perceptions existed regarding the University's 'formal' one-off or brief wellbeing sessions. There was uncertainty about awareness of these offerings and their actual or potential content. Participant 9 commented, *"The answer is not more therapy and more treatment,"* suggesting the University should be proactive, not just reactive, and offer more than just counselling: *"whether it be an online resource or something that provides guidance across either at a university level or even more nationally,[...]. More standardisation, I think, and clarity"*. Despite recognising increased discussions about staff wellbeing at the University, it was often viewed as mere *"lip service"* without genuine commitment or adequate funding, especially for those doing potentially distressing work: *"I guess it's also putting their money where their mouth is..."* (Participant 2). As outlined below, several services and interventions were identified as (potentially) helpful, such as academic supervision, mentoring/coaching, professional clinical supervision, and group interaction.

Improved academic supervision and line management

Supervisors and line managers were perceived to hold an important role in researcher wellbeing (see also Figure 3). More senior participants emphasised that part of their role was to ensure they were available to the Early Career Researchers they supervised. Questionnaires indicated the importance of regular academic supervision (weekly or fortnightly depending on need) to check in on emotional wellbeing, discuss the previous week's work and plan next week's work. Responses to the questionnaires also indicated the importance of more senior researchers being effectively and sensitively

line managed themselves. However, staff also suggested that supervisors and line managers should respect the privacy of their researchers, understand that distress thresholds vary among individuals, and accept that some researchers may prefer not to share sensitive matters with them.

> *"Whilst we have all the debriefs and everything, I am not clinically trained to either diagnose trauma or to diagnose mental health issues or declining mental health. And whilst I hope they would come to me if they were feeling traumatised or feeling like it was having an effect, I am very conscious of the fact that [...] I'm their line manager, and they may not want to share that with me, or they may worry about ... I hope they don't, but they may worry about what conclusions I will draw about their competency or skill."* (Participant 25)

As such, it is important that Principle Investigators design project to include funding for clinical supervision (see also other elements of Researcher Wellbeing Plans, section 4.3). Having the opportunity to debrief with supervisors or other team members was reported as an effective strategy to offload emotions and research challenges for all staff, as evidenced by unanimous agreement from all 25 respondents. Drawing from the qualitative data, it is evident that some participants

Figure 3

Perceived to be the most helpful coping mechanisms linked to (future) University provision

Coping mechanism	Not at all helpful	Slightly helpful	Somewhat helpful	Very helpful	Extremely helpful
Clear pathways if the participant becomes distressed	1	1	2	8	13
Referral pathways if the researcher becomes distressed	1	1	3	6	14
Written processes if the researcher gets distressed	1	2	2	7	13
Debrief	1		4	12	8
Generally good work resources	1		5	9	10
Written processes if the participant gets distressed	1	3	3	6	12
Funding to help cover the costs of wellbeing plans	1	2	4	8	10
Effectively addressing equality and diversity issues		2	5	9	9
Supportive research culture		3	5	5	12
Being taken out of distressing work with consent	3	2	4	11	5
Team social events	3	5	1	11	5
Extra time for additional academic supervision	1	3	5	3	12
Written guidance on researcher's role in relation to participants	3	5	2	5	10
Legal support	3	3	4	6	9
Private space/office	2	5	3	9	6
10-20 weekly trauma focused sessions of counselling	2	3	6	6	8
Regular one-to-one academic supervision of less senior researchers		4	7	8	6
Regular and effective line management of PIs and Co-Is		5	5	7	7
On-going open-ended counselling	2	3	7	6	7
Independent clinical supervision (one-to-one)	1	3	8	7	6
Researcher training (e.g., risk assessment, supervision of sensitive research)	1	5	6	7	6
Comprehensive guidelines and resource repository (e.g., webpage)		5	4	3	7
Independent clinical supervision (group)	4	4	4	9	4
Team approach to initial data coding to share 'burden' and enhance analysis	2	1	9	10	3
Team meetings (including discussion about wellbeing)	1	6	5	10	3
Training for academic leads	1	4	7	4	8
Clear delineation of researcher's role/responsibility	2	1	10	5	7
Mentoring/Coaching (mentor who does research on challenging topics)	2	3	8	7	5
Extra time in workloads for emotional work	4	1	9	3	8
Mentoring/Coaching (mentor who does not research on challenging topics)	6	4	4	4	7
Connections/Networking between researchers of all levels	1	7	6	7	4
Emergency counselling available 24/7	3	4	8	5	5
Connections/Networking separate for senior and early-career researchers	1	7	7	6	4
Expert facilitated group wellbeing sessions	5	5	5	6	4
Informed consent to be gained from less senior researchers	4	5	6	8	2
Team approach to presentations and attempts to influence policy/practice	4	7	4	8	2

Number of participants

Legend: ■ Not at all helpful ■ Slightly helpful ■ Somewhat helpful ■ Very helpful ■ Extremely helpful

Note: N = 25 participants who completed this questionnaire. The figure is ranked first by the sum of the numbers of participant finding a mechanisms (potentially) very/extremely helpful. If this number is the same, the mechanism with the highest number finding it (potentially) extremely helpful is placed highest.

desired more frequent debriefing sessions. Notably, these tended to be early career researchers or those involved in particularly sensitive research tasks, such as interviewing and transcribing. *"I think it would be nice to have like some sort of debriefing or something like this! You know, so being able to talk about the experience."* (Participant 21). Researchers also reported benefits when they were informed of their roles and responsibilities throughout the project and provided with clear processes to follow by their supervisors and line managers. Additionally, participants acknowledge the advantage of being temporarily taken out of tasks when necessary for their wellbeing. This was particularly emphasised by more senior academics, highlighting the importance of such measures, for example,

> *"So even now, with the early career researchers I've got working, I was with them last XXX […] to ask them how they're doing and what they do outside of their work and if I see them stressed, then telling them to take some breaks and stuff like that!"* (Participant 24)

Similarly,

> *"I might say, look, it sounds like this is getting a bit much, why don't you take tomorrow off, have a break and then go back in a week's time, because sometimes that's actually what people need I find, like you know and that's the thing I've found a little bit, is it's really intensive to do interviews on a really regular basis, so I try and build in lots of rest time for them and breaks and decompression zones as a team."* (Participant 25)

Building on the importance of developing open and clear rapport between researchers and supervisors/line managers, it may be crucial to consider the initial research phase. To promote open communication, clarify researcher roles, and address potential research implications and support options, obtaining informal informed consent (rather than the written process currently used for participants) from junior team members may be beneficial before initiating research on potentially distressing topics. Among 10 participants, such an approach was rated as very or extremely helpful.

Building on this, to further enhance research support and pinpoint effective coping strategies, implementing risk assessment and safety planning could be beneficial. However, the post-interview questionnaire indicated that only nine participants viewed this strategy as very or extremely helpful. This perception might stem from the prevailing sentiment that current risk assessment and safety planning are mere *"ticking boxes exercise, […to] make sure that the University has the right paperwork rather than a genuine concern in how I cope"* (Participant 21). Qualitative analysis indicates that numerous researchers lack familiarity with conducting risk assessments addressing the researcher's wellbeing. Participants perceived that the current focus of the process and forms is primarily on researchers' physical safety and participants' wellbeing. Whilst there was awareness that the existing University ethics form had one question on possible impacts on the researcher, Participant 16, who had undertaken distressing research before the addition of this question, stated:

> *"at no stage did anyone say to us, 'you guys might want to keep in mind that this could be something you yourselves might need support for'. There was a lot of focus on what will you do if your participants become distressed; lots of focus on that. But nobody said to us, what if you guys become distressed?"* (Participant 16)

There was an almost complete lack of awareness of the existing question on mental health in the University's risk assessment form.[6] As risk assessment is a legal requirement (under Health and Safety at Work etc Act 1974 and Management of Health and Safety at Work Regulations 1999), this raises questions about whether supervisors are adequately trained to guide researchers through such assessments and help them pinpoint effective coping strategies. One participant suggested a potential approach:

> *"I'm going to go and interview this group of people, who are very likely to be telling me things that are emotionally distressing, and that is likely to cause me emotional distress. How would I reduce that? You know, well: I'll make sure that I'm interviewing at particular times of the day so I can debrief afterwards. And you know, things like that, just to get researchers thinking about how to mitigate those risks, in exactly the same way that they would do if they were thinking about just the practicalities of international travel and the risks there."* (Participant 31)

In addition, data from the post-interview questionnaire and qualitative analysis show interest in possible mentoring and coaching schemes. A general mentor/coach was less popular (19 out of 25, 11 very/extremely) than a mentor with experience of their research area (23 out of 25, 12 very/extremely helpful). While some only really wanted to talk to those with expertise in their research area, others wanted mentoring and coaching irrespective of the mentor's experience:

> *"Some form of mentoring system would be really helpful […] someone who doesn't have to be an expert in that area, but can be curious enough about that area so they can respond in a way that can deepen the awareness of what's happening or deepen the understanding."* (Participant 10)

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[6] The primary form that was referred to in relation to risk assessment was that linked to risks related to travel where mental health is only mentioned in relation to an existing mental health condition of researcher.

The University currently has both mentoring and coaching schemes, but there was limited awareness/use of it among the participants.

Professional clinical supervision

Psychological support was recognised as a necessary and effective formal coping mechanism. Monthly clinical supervision during fieldwork, data analysis, and writing-up, and for those supervising the research or getting disclosures, it was seen as helpful for 24 out of 25 participants (13 very/extremely helpful). Interviews indicated that while three participants benefited from independent clinical supervision as part of their University roles[7], an additional two gained this support because they experienced such significant distress from their research that they requested these services. The post-interview questionnaire adds that all staff reported individual or group-funded clinical supervision as helpful in addressing concerns arising from potentially distressing research (even if they did not currently have access to it): *"I think the universities should fund some sort of clinical supervision that's available on a regular basis."* (Participant 25). Another participant elaborated on the importance of clinical supervision, stating: *"Because it's kind of like downloading that emotional content somewhere, so it's not stuck in your head and not going round your mind all the time, which is not very helpful! In the long run!"* (Participant 30).

Seven participants mentioned undergoing therapy. Although their initial reasons for seeking therapy were not necessarily research-related, discussions in counselling sessions frequently included their research. As previously mentioned, most participants expressed reluctance about using the University's standard counselling services (whilst 20 out of 25 said it would be helpful, only 6 indicated it could be very/extremely helpful), primarily because six sessions is *"too short"* (Participant 2). In contrast, an offering of 10 to 20 trauma-focused counselling sessions, independent of (but paid for by) the University, was viewed as helpful by 23 participants. Out of these, 14 deemed it very or extremely beneficial. Moreover, emergency counselling available 24/7 was rated as very or extremely helpful by 10 participants. This service has recently been made available to staff through an external provider, Care First.

Groups/teams

Participants suggested that adopting a team-based approach can mitigate the emotional strain of researching sensitive topics. For example, to *"not [be] working in isolation. To make sure I've always worked in a team [...] not everything hinges on me, so if I [...] just can't do it, they have someone else to just step in. I think that's important"* (Participant 11). Regarding data coding and analysis, sharing the responsibility among team members can distribute the emotional burden, with most participants (23 out of 25, 13 very/extremely) acknowledging its value. Similarly, team collaboration in presentations and impact-related activities was seen as beneficial, with 10 participants considering it very or extremely helpful. Beyond the research tasks, fostering a sense of community and support within the team is vital. Regular team meetings, which include discussions about wellbeing, were recognised as helpful by the majority (24 out of 25). Additionally, as mentioned earlier, team clinical supervision was perceived as offering a structured space for collective reflection and guidance. Lastly, organising social events of choice was perceived to strengthen team bonds and provide respite from the rigours of sensitive research for most participants (22 out of 25, 16): *"The wider community of the [xxx] projects [...] there's a lot of like inter-relationship, [...] and spending time together, so there's like a community of support."* (Participant 29).

Overall, the cultivation of connections and networking among researchers was seen as vital. These platforms offer group meetings and discussions and create an environment where various conversations unfold naturally, often revolving around the effects of research, the inherent challenges, and strategies to address and cope with them. Particularly, 11 participants suggest that proactively fostered connections between researchers undertaking distressing research (e.g., Researcher Wellbeing Group) would be very or extremely helpful with 24/25 indicating this would be helpful in order to learn *"from other people about what they're doing and how they've managed certain things that have gone wrong or might go wrong or ... negotiating their ways around things"* (Participant 30); and have *"more time and space to have to talk about these things and reflect with people that value the thing that you're doing and understand those impacts"* (Participant15). Similarly, expert-facilitated wellbeing workshops for researchers undertaking distressing research were deemed very or extremely useful for 10 participants.

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[7] We cannot indicate who is receiving this. However, those interested in finding out more about how to set this up and fund it might find it helpful to know that the Research Associate on the RWP, and current PhD students under the Principle Investigator's supervision who want and require it, have access to clinical supervision (the former is paid for by the UKRI Research Culture Fund grant, the latter by the South West Doctorial Training Partnership).

4.3 Institutional

Many of the recommendations identified by participants as helpful to maintain their wellbeing can be facilitated by the institution through detailed Researcher Wellbeing Plans (see example in Appendix VI). However, staff aware of the need for these were frustrated by the lack of substantive University support/funding in this regard, with 24 out of 25 participants indicating that funded wellbeing plans would be helpful; 18 indicating they would be extremely or very helpful. They were particularly annoyed by what they saw as a tokenistic approach to wellbeing. For example, Participant 21 stated, *"I get really frustrated about e-mails telling me about the latest XXX [...] which puts all the blame on me"*, referring to one off wellbeing workshops. Funded Wellbeing Plans, including clinical supervision, counselling when needed and other important coping mechanisms such as gym membership, could be funded through project grants or the University.

In addition, there are University-wide issues identified in the data that need to be addressed, such as effective risk assessment, clear written processes and pathways of referral, and time in workloads. For example, as mentioned above, whilst 23 out of 25 of the questionnaire respondents thought effective risk assessment and safety planning would be helpful, our qualitative data indicates this is currently a *"ticking boxes exercise, [...to] make sure that the University has the right paperwork rather than a genuine concern in how I cope"* (Participant 21). Extra time in workloads was also wanted for managing emotionally challenging research, for example, to develop and implement wellbeing plans, extra supervision (24/25, 15); team discussions (24/25, 9), impact (24/5, 13) and generate data and code/analyse data (21/25, 11). For example, Participant 30 stated: *"That's why it's quite useful to have a break between doing interviews, so that you have time to reflect on that and think about that naturally, do something about it if you need to, for your own health and wellbeing."*

Indeed, some of the top-ranked coping mechanisms for the institution to put in place were clear transparent written processes and pathways so that staff know what good practice looks like and what to do if the researcher or participant is at risk of harm (24 participants indicating these would be helpful, between 18-21 very/extremely helpful). This could be achieved by creating access to guidelines and resource repositories, such as a Researcher's Wellbeing Webpage - deemed very or extremely helpful to 13 participants. Participants further suggest that they would benefit from training on topics including effective risk assessment, safety planning, supervision, and team management for sensitive research projects (24/25, 13 very/extremely). Having a researcher wellbeing 'champion' or lead within the University to advocate for researchers and attempt to improve services/culture was identified as helpful by 20/25 staff members. Private campus office space was needed to conduct the research so it does not 'pollute' their homes, and generally, good work resources were unanimously identified as beneficial to staff. For those who needed to change the research topic due to mental health, 16 staff members indicated provision of research time, funding and subject specialist mentoring for a pilot project in a new research field would be beneficial, (8 participants indicating that could be very/extremely helpful). A minority wanted to get out of academia and research altogether. For example, Participant 22 stated: *"there is some collateral damage on my mental and emotional wellbeing, and I need to go and do something else different entirely. I don't think the university is used to supporting that kind of person in a career change."* Here career guidance and training would be helpful (18/24 said this would be helpful, 8 very/extremely).

Furthermore, the data demonstrate that University-wide cultural changes need to occur. That is, staff unanimously suggested that the University should work towards fostering a research culture that recognises, acknowledges, and openly addresses the possible impacts of engaging in potentially distressing work.

> *"I don't know that the University is as responsible as it could be, in terms of protecting its researchers overall, so not just in terms of the emotional consequences of doing particular forms of research, but also, you know, in terms of providing the resources and the facilities to do good research, to you know ... even producing the research culture that allows people to debrief and discuss research."* (Participant 31)

Another participant stated:

> *"In an ideal world, [...] the University would feel like a sort of kind parent that you could.. that you could turn to, when you are distressed, who you feel looks after you. But I don't really actually think the University feels like that right now. It doesn't feel like a kind parent. It feels like quite a parent that you wouldn't want to turn to where if you had problems, and especially emotional ones".* (Participant 16)

Participants thought that cultural change was needed to what was seen by most as a prevailing perception that admitting to the toll research takes on one's mental health may be perceived as a sign of weakness, potentially raising doubts about one's suitability for a career in a particular research area: *"Because it's not seen as normal, you know you're kind of almost admitting that you're struggling and that you're a failure, and you've got some weakness"* (Participant 22). It is worth noting that researchers' experiences differ significantly in this regard. As previously stated, some expressed gratitude for the support they received, when necessary, and felt the University was *already* an open research culture where

they could have "vulnerable conversations" (Participant 29). But others were asking for the University to *become* such a "a safe space" (Participant 2). Factors including their academic career stage, level of control they had over their work (e.g., contract researcher vs Principle Investigator), years at the University, the character of the team they worked in, or other variables (e.g., other pressures, such as being a carer or having a dis-ability such as anxiety, or being otherwise marginalised) contributed to this variation.

Similarly, participants felt they would benefit from a more generally positive working environment. With questionnaire respondents indicating unanimously that they could be/were helped by a more positive response to Equality and Diversity Issues (e.g., maternity leave, caring responsibilities, reasonable adjustments for disabled people, and cultural/religious diversity) and generally good work resources. Furthermore, staff suggested they would also benefit from funded legal support and advice focused on the researcher's needs and rights (22 out of 25).

Section 5: Recommendations

The following recommendations have come out of project findings as well as our development of Skinner et al's (forthcoming)[8] Researcher Wellbeing Protocol. The recommendations are given here as four key 'levels' of intervention that should be used in conjunction in order for systems to be in place that can effectively support staff doing emotionally challenging research: institutional, supervisory/management, teams/groups and the individual researcher. It may not be possible for an institution to implement all of the recommendations, so we have formulated a phased approach: Bronze, Silver and Gold standards (where the former requires minimal funding and is working towards the latter, and Silver would include most elements in Bronze). As indicated in Figure 3, some of the most popular options involve written processes and guidance. Thus, some very positive steps can be taken relatively cheaply to achieve Bronze.

5.1 Institutional: funders and employers

Institutions that undertake and fund research need to have a well-funded strategy focused on *prevention* of and *provision* for secondary trauma linked to emotionally challenging research, including:

- Written processes and guidance, and clear written pathways so staff know what to do if the researcher or participant needs help. These should be easily accessible (e.g., on a Researcher's Wellbeing and/or ethics committee webpage).
- A supportive research culture that proactively and positively acknowledges and discusses the issue.
- Awareness raising and specialist training on impacts of emotionally challenging topics, how to develop wellbeing plans, effective risk assessment, supervision of emotionally challenging research.
- Effective risk assessment.
- Researcher wellbeing embedded in ethical processes/forms within the institution to prompt researchers to think about the issue and how they will address it (links should be made from ethics forms to written processes, guidance and pathways).
- Proactive funding and provision of independent individual clinical supervision*, specialist trauma focused counselling if required and other key elements of Researcher Wellbeing Plans (e.g. gym membership). *For silver, this would be *proactively* provided through grants, *reactively* provided by the institution if distress / secondary trauma has occurred.
- Specialist mentoring and/or coaching for researching emotionally challenging topics (e.g. this can be linked into existing institutional coaching and mentoring networks).
- Having access to private office space so emotionally challenging research does not 'pollute' researchers' home.

Institutions could also consider:

- Having clear senior leadership on researcher wellbeing within institutions (e.g., having a post with allocated hours such as a Researcher Wellbeing Lead).
- Extra time in workloads, e.g., to develop and implement wellbeing plans, generate/code/analyse data, team discussions, impact, extra supervision.

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[8] Skinner, T., Bloomfield-Utting, J, Geoghegan-Fittall, S., Roberts (ne Ballantyne), N., Smith, O., Sweetland, S. and Taylor, H. (forthcoming) A focus on ethics and researcher wellbeing, In Forester-Jones, R. (Ed) Research Handbook on Ethics in Social Research, Edward Elgar Publishing. https://researchportal.bath.ac.uk/en/publications/a-focus-on-ethics-and-researcher-wellbeing

5.2 Develop supervisor/management skills

Key to researchers' experiences was how they were supervised currently or in the past, which in turn affected how Principal Investigators' themselves designed projects and supervised individuals and teams. Given our findings on impacts and what currently works or was requested by participants in terms of effective supervision, we recommend supervisors:

- Do effective risk assessment (including mental health risks) for individual projects/staff/teams.
- Maintain hope that the research can make a difference.
- Provide regular/effective academic supervision (weekly or fortnightly, depending on need) to:
    - establish a positive working relationship,
    - establish clear role/responsibilities for junior research staff,
    - discuss the work that week, plan the next week,
    - discuss Researcher Wellbeing Plans and share coping strategies,
    - debrief research staff.
- Build extra time into projects to allow for 'time out' of stressful tasks.
- Ensure informal informed consent of the potential researcher.

5.3 Teams and groups

Working in effective teams (teams can be just two people) and reaching out to talk to groups of researchers was also something that participants either wanted or currently found helpful:

- Team approach to working to share 'burden', including:
    - meetings that include wellbeing,
    - team data coding/analysing,
    - team presentations/impact work,
    - team events to build community.
- Beyond the research team:
    - Researcher Wellbeing Group/Network (such networks exist nationally[9], but an institution wide group may also be beneficial)
    - Expert facilitated in-depth wellbeing workshops.

5.4 Individual researcher

Many of the above elements can be incorporated into funded Researcher Wellbeing Plans (see Appendix VI for example), written by the researcher with the guidance of their academic and/or clinical supervisor. This can be linked into existing wellbeing tools within an institution and include (depending on need), for example:

- Monthly clinical supervision for researchers (during field work, data analysis, writing up), and for those supervising the research.
- Encouraging accessing standard wellbeing services, and if needed, 10-20 trauma-focused counselling sessions.
- Connections proactively fostered with others (e.g. in research teams and Researcher Wellbeing Group/Network).
- Emotionally challenging research mentoring and/or coaching scheme.
- Exercise (if possible) and hobbies.

Section 6: Conclusion

The Researcher Wellbeing Project has identified that academics undertaking potentially distressing research in the majority are inspired and driven by the research they do. This is some of the most important and impactful research undertaken. However, it in turn has substantial impacts on the researchers, most of whom had symptoms that could be linked to secondary trauma at varying degrees. How well researchers cope with such emotionally challenging research is not just about them as individuals. It is about how well they are supported by the systems that are around them. Thus, individual researchers' knowledge, skills and experiences contribute, alongside how effective supervisors/managers are in designing projects and managing teams/individuals, as well as how much positive/supportive interactions researchers get within teams, and how much thought and investment institutions have put into how researchers are looked after. Ideally, institutions that undertake and fund research on emotionally challenging topics need to put plans in place to develop a well-funded strategy focused on *prevention* of and *provision* for distress and secondary trauma linked to such research. For institutions that are unable to do this fully, a phased approach working towards this would be a viable option.

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[9] Subject specific networks are currently being developed Nationally (e.g. on Gender Based Violence), there are also the national Challenging Researcher Network (https://challengingresearch.org/) and the Researcher Wellbeing Network for PGR/T and Early Career Researchers (bit.ly/ResearcherWellbeingGroup).

Appendix I: Methods

A favourable ethical opinion was gained from the University of Bath Ethics Committee (Ref: S23 012) in early 2023. Standard ethical procedures were followed, in compliance with the University of Bath's ethical guidance. Beyond that, we also planned and gained funding for clinical supervision for the Research Associate (RA, in case of distressing disclosures) and 10-20 trauma focused counselling sessions for the research participant and/or RA if needed (estimating 10-20% of participants might need it, by the end of the project only 3 used this service each taking approximately 20 sessions). The Principle Investigator (PI) already had clinical supervision funded by the Department.

The study involved 31 semi-structured interviews. A purposeful and multi-stage sampling method was applied to select participants. Those eligible for interview were: (i) staff members on a research contract or research and teaching contract, (ii) within the Faculty of Humanities and Social Sciences at the University of Bath, (iii) engaged in or who had previously undertaken research on potentially emotionally challenging topics. All students were excluded from the study, except lecturers/researchers currently undertaking a part-time PhD. Researchers were identified and contacted based on information from the University of Bath's website from April 19th to April 27th, 2023. Initially, 38 individuals were invited to participate in the study, of which 15 participated. Additionally, 29 more researchers who met the above eligibility criteria were invited using a snowball sampling technique, 14 of these were interviewed. Finally, a faculty-wide email was sent on June 22[nd,] from which two more participants were recruited. The latter two methods of sampling ensured that more junior/temporary staff who did not have a webpage, or staff that we had not subjectively identified as undertaking emotionally challenging research, could choose to take part. The number of approximately 30 interviews was settled on because of limited time/resources; however data analysis indicated a high level of data saturation by this point.

Prior to the interviews, all participants received an information sheet and asked to sign a consent form. The interviews were guided by a previously developed topic guide (see Appendix II), with 30 conducted via Teams and one face-to-face. Each interview, on average, lasted 54 minutes and was audio-recorded and professionally transcribed.

Before the interview, participants filled out a demographic questionnaire on the survey platform QuestionPro (see Appendix III). This questionnaire also asked for information about their research topics, total years spent in research, and the duration of their involvement in research that could potentially cause distress. As indicated in the Table below, 19 females and 11 males, aged between 25 and 60 years were interviewed. Representing six different departments and varying in their levels of experience, the participants, on average, had been involved in sensitive research for 12 years, with experience ranging from three months to 35 years. Whilst the sample was diverse in terms of nationality/country of origin, the majority of the participant were white; five considered themselves disabled; one indicated they were LGBTQi.

Table: *Demographic characteristics of the sample*

Variable	N = 30
Age	25 – 60 (M = 42)
Gender	
Female	19
Male	11
Job title	
Lecturer	8
Professor	3
Reader	3
Research Assistant	2
Research Associate	5
Research Fellow	1
Senior Lecturer	7
Dis-ability	
No	25
Yes	5

Note. One participant did not complete the pre-interview questionnaire.

Following interviews, participants were invited to complete post-interview questionnaires on QuestionPro: 25 completed the coping mechanisms questionnaire (Appendix IV), 20 the Secondary Trauma Stress Scale (STSS; Bride, 2013; Appendix V). The latter was used because, although the interviews clearly indicated that most participants had symptoms that could be linked to secondary trauma, the severity of the symptoms was not always clear. The secondary trauma scale was used to more clearly delineate those whose symptoms were more severe and may need interventions and those who did not. In the STSS, participants were asked to think of the most distressing study they had been involved in and then respond to 21 items on a 5-point Likert scale, ranging from 1 (never) to 5 (very often). It is important to note that the STSS was revised from its original 17-item version (Bride et al, 2004) to a 21-item format in 2013, in line with the updated PTSD criteria in DSM-5.

The coping mechanisms questionnaire contained 59 interventions / ways of coping that the participants had said in their interviews were (or could be) useful for them or others, as well as those given in existing literature. In order to enable priorities to be made in future recommendations and institutional funding decisions, we used a 5-point Likert scale ranging from 1 (not at all helpful) to 5 (extremely helpful).

Qualitative data was analysed using thematic analysis, following the six steps outlined by Braun and Clarke (2006), with analyses conducted in NVivo 14. These stages were: (1) familiarising with the data through audio recordings and notes; (2) generating initial codes systematically across the data set while closely examining transcripts; (3) collating the codes into potential themes in a codebook; (4) reviewing and refining these themes collaboratively, and creating a thematic map; (5) further defining and naming themes to form a clear narrative for each; (6) selecting key extracts to convey the core arguments and themes effectively.

In addition, to ensure coding trustworthiness, (see Korstjens, and Moser's 2018 development of Lincion and Guba, 1985) *investigator triangulation* was used at each of the above stages. Firstly all the interviews were listened to by both the PI and RA. They then independently coded five interviews to develop the codebook. The researcher's agreement was high, and any differences were resolved by discussion before the codes were applied to all transcripts by the research associate. Any new codes developed in subsequent coding, or uncertainty about coding of a section of transcript, was also checked with the PI and added to the codebook. Further analysis, selection of quotes and writing was also done collaboratively and checked by the wider team. Quantitative data (i.e., STS symptom severity and preferred coping mechanisms / interventions) were analysed for descriptive statistics only to provide further trustworthiness of the qualitative analysis through *data triangulation*.

Credibility of the research was further enhanced through *prolonged engagement*, in that the authors work in the same institution as the participants and are highly familiar with the context under investigation. For example, the PI has worked at the University of Bath for over 20 years and undertaken emotionally challenging research (gender-based violence; dis-ability, employment and wellbeing; researcher wellbeing) for 30 years. In contrast, the RA has worked at the University for 9 months, and in an area of potentially emotionally challenging research (migration; researcher wellbeing) for 4 years. *Member checks* were made through several avenues, including participants being able to feedback on the project findings before general release (via direct emails and face-to-face discussions), after presentations within the institution and reading of the project report before general release.

Further measures were also taken to help ensure the trustworthiness of the research, including researcher *reflexivity*. It was particularly helpful in both the design of the research tools and the data coding and analysis, that the team came from different perspectives, disciplines (criminology/sociology/geography/politics and psychology), job roles and career stages (academic and University professional services, (associate) professors and RA). Our strikingly different biographies have been advantageous in helping us think critically about differing impacts of researching emotionally challenging topics as well as potential coping mechanisms and institutional interventions. We will not outline these all here, but it might be helpful to the reader if we illustrate this with the two who ran the project together: the PI and RA. Reflexive accounts of the PI's experience of researching gender-based violence have been given in Skinner et al (forthcoming) and at the start of oral presentations of this project's findings. An auto-ethnography of her experience of being a disabled mother working in academia was published in 2011. In short, the PI experienced undiagnosed secondary trauma as a result of analysing data on a Home Office funded research project in the early 2000s. The project involved interviews with, questionnaire responses from, and the analysis of summary cases files of, young survivors of rape (ages

14-16) who reported to the police and were referred to a counselling, information and support service. At the time of the data analysis she also experienced an acute ectopic pregnancy which resulted in a miscarriage and major operation. She is 53; white, English; the first generation of her family to go the university; dyslexic, which means that data analysis of written text can take a considerable time; and married, with two children who are now in their late teens. She also has experienced severe menopausal symptoms, including anxiety, in the last 10 years; and has long-term pain (linked to a burst disc and arthritis in her back). The RA completed her PhD in 2023, on migrant mental health and sense of belonging in Greece and – though some of the stories were upsetting - did not find this research particularly distressing. She is 32; white; Latvian, and with a wealth of personal experience of migration from Latvia to the United States of America, Greece, Russia and the United Kingdom. The search for belonging during the numerous relocations inspired her research interests.

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Appendix II: Qualitative semi-structured interview topic guide

(Note: this is a semi-structured interview guide, <u>not all of these questions may be asked,</u> and some of them are alternatives if the more general questions are not fruitful.)

Thank participant for agreeing to be interviewed, give reminder that this research is being led and carried out by people who are empathetic to the needs of researchers who may have experienced distress as a result of their research, give reminder of confidentiality and not sharing information casually or with senior management, restate that interview can be stopped if needed, restate right to withdraw (referring to Consent Form/Information Sheet).

Section 1 Research topic.
1. Can you tell me why you decided to participate in this research please?
2. On the questionnaire, you indicated that you do research on xxx (the potentially distressing topic identified by us or them) can you tell me a little about that research, please and your involvement?

Section 2 Experiences of undertaking this research.
3. How have you found it working in this research area?
   a. How does, if at all, this research impact on you?
   b. In what way and at what stage might the research topic, if at all, be distressing for you (and/or your research team/students)?
   c. Are there, or have there been, any emotional or other consequences for you of working in this research area?
   d. Have there been any actual or potential physical consequences for you (either as a result of something you have heard or something physical that has happened to you)?
   e. Have you experienced any mental health consequences as a result of conducting research in this area?
   f. Are there any points at which you feel 'numb' towards, or without any particular feeling towards, your research or your research participants (e.g. do you ever feel like you don't have empathy for them)? How does that make you feel?
   g. What have you found interesting or beneficial from undertaking the research?
   h. What have been the things you have found hardest about work in this research area?
   i. Are there particular stages of the research process that you (and/or your team) have found distressing? If yes, please tell us about it.
   j. Was (is) there anything else going on in your life at the time that made it easier or harder for you to research this topic? What influence did that have on you?
4. Have you ever considered changing the research topic because you find it distressing?
   a. If yes, please tell us about that and if it was successful.

Section 3 Support.
5. Is there anything that makes you (or your team) more or less able to cope with the emotionally challenging aspects of your research?
6. Have you ever wanted, asked for or received support with any impacts of undertaking emotionally challenging research? If yes, what and what was that like?
7. Do you have any particular plan or coping strategies to help you cope with the impacts of your research? If yes, what is this?
8. Have you used any formal or informal support to help you cope with the impacts of your research? If yes, what are these, were they helpful (if so, how)?
9. How do you feel about the university's culture in terms of addressing/talking about mental health and wellbeing?
10. Are there particular feeling rules that we should abide by when doing potentially distressing research?
11. Was a formal risk assessment done in relation to your research? If so, by whom, and what did it say?
12. In an ideal world, what would support look like for researchers like you who are working in emotionally challenging research areas?

Debrief
The interviewer will provide a brief verbal summary of the issues raised by the participant and ask if they think this is an accurate reflection of what they have said. The interviewer will outline the debriefing sheet with the participant and hand it over, especially highlighting the possibility of getting counselling and who/by went to apply.

13. Do you have any questions for us?

<div align="center">**Thank you!**</div>

Appendix III: Pre-interview questionnaire

The information on this form will be used only for the purposes of contextual understanding of the data and to try to ensure that we have a diverse sample. You don't have to answer any of the questions if you don't want to. This form will be kept separate from the interview transcript in the interest of anonymity and confidentiality.

Name:
Age:
Ethnicity:
Gender:
Religion (if any):
Sexuality:
Disability (if any):
Job title:
Department:
How long have you been involved in doing/supervising research?:
How long have you been involved in doing/supervising potentially distressing research?:
What topics do/have you researched?:

Which, if any, of the topics you have researched could be potentially distressing?:

	Of the research that could potentially be distressing, which part of the research process were/are you involved in?	Did you find it distressing?
Reading the literature	Yes/No (please delete)	Yes/No (please delete)
Recruiting participants	Yes/No (please delete)	Yes/No (please delete)
Interviewing individuals	Yes/No (please delete)	Yes/No (please delete)
Transcription	Yes/No (please delete)	Yes/No (please delete)
Coding quantitative data	Yes/No (please delete)	Yes/No (please delete)
Coding qualitative data	Yes/No (please delete)	Yes/No (please delete)
Analysing quantitative data	Yes/No (please delete)	Yes/No (please delete)
Analysing qualitative data	Yes/No (please delete)	Yes/No (please delete)
Writing publications	Yes/No (please delete)	Yes/No (please delete)
Presenting data	Yes/No (please delete)	Yes/No (please delete)
Trying to influence policy/practice	Yes/No (please delete)	Yes/No (please delete)
Supervising research	Yes/No (please delete)	Yes/No (please delete)
Other (please state)	Yes/No (please delete)	Yes/No (please delete)

Appendix IV: Post-interview questionnaire

In this questionnaire, participants were asked to rank on a Likert Scale from 1 (not at all helpful) to 5 (extremely helpful) the following interventions / coping mechanisms (suggested in the literature and in the interviews to be helpful).

1. Regular one-to-one academic supervision of less senior researchers (i.e., other than PI and senior CIs) undertaking potentially distressing research (weekly or fortnightly depending on need, e.g., to allow for wellbeing discussions, discuss previous week's work, plan next week's work).
2. Regular, effective/sensitive line management of Principle Investigators and senior Co-Investigators undertaking potentially distressing research.
3. Have the opportunity to debrief, as needed, with supervisor or other team members (e.g., after a particularly difficult interview).
4. A private space, that is not the researcher's home, to do potentially distressing research (e.g. a private university office).
5. Extra time in workloads/project for additional academic supervision.
6. 10-20 weekly (secondary) trauma focused sessions of counselling available independently of University, but funded by the University, when the research has become distressing and resulted in (secondary) trauma.
7. On-going open-ended counselling available independently of the University, funded by the University, when the research has become distressing and resulted in (secondary) trauma.
8. Emergency counselling available 24/7 (by phone/on Teams).
9. Current standard University run counselling for staff (weekly, approx. 6 sessions).
10. Independent clinical supervision (e.g., one-to-one, monthly meeting with a psychologist or counsellor, to discuss issues raised by potentially distressing research/ research supervision and life in general) funded by the University.
11. Independent group clinical supervision (e.g., monthly clinical supervision, by a qualified counsellor or psychologist, of the research team you are in or colleagues doing similar research).
12. Being (temporarily) taken out of distressing work with consent, when secondary or primary trauma has occurred and given time to recover and given alternative work to do until able to return to original work (if appropriate).
13. Coaching or mentoring to help with particular challenges (by a trained coach/mentor who IS NOT a researcher also doing emotionally challenging research).
14. Sensitive Research Mentoring scheme (by a mentor WHO DOES research on emotionally challenging topics).
15. Funding to change research topic if needed (e.g., £2-3,000 to transcribe pilot interviews).
16. Effective careers training/advice to leave academia and/or research.
17. Limiting hours per day on distressing aspects of work (e.g., alternating with non-distressing aspects of work).
18. Working only office hours and weekdays.
19. Build extra time into workloads/projects to allow for 'time out' and extra time for distressing tasks (e.g., interviews, coding, analysis) and to implement wellbeing plans.
20. Where appropriate/needed, other team member accompanies researcher on one piece of 'field work' to provide support.
21. Team meetings (including discussion about wellbeing).
22. Extra time in workloads for team discussions (including about wellbeing).

23. Extra time in project and workloads to familiarize with the research context/community (e.g. to visit the area and get to know research participants).
24. Extra time in workloads, and support from senior managers, to amplify research participants voices and/or make the research impactful (e.g. changing police and practice).
25. Team approach to initial coding of data to share 'burden' and enhance analysis.
26. Connections proactively fostered between researchers of all levels undertaking potentially distressing research within the University and/or between universities (e.g., through informal monthly or quarterly peer facilitated Researcher Wellbeing Network, with group meetings and relevant talks). – for researchers of all levels.
27. Connections proactively fostered between researchers (separately for senior academics and early-career researchers) undertaking potentially distressing research within the University and/or between universities (e.g., through informal monthly or quarterly peer facilitated Researcher Wellbeing Network, with group meetings and relevant talks).
28. Expert facilitated group wellbeing sessions for researchers undertaking potentially distressing work (e.g., expert wellbeing facilitator runs 12 weekly face-to-face sessions aimed at enhancing medical and socio-psychological understanding of wellbeing and developing self-care skills).
29. Team approach to presentation of findings and attempts to influence policy/practice (to relieve the 'burden' of 'making a difference' from any one individual).
30. Team social events to build community (e.g., going to get coffee/tea/cake/lunch as a group, going for walks, an outing somewhere chosen by the group).
31. Mindfulness workshops.
32. Risk assessment and safety planning.
33. Training for researchers (e.g., effective risk assessment, safety planning, supervision, team management for sensitive research projects).
34. Training for academic leads, Heads of Department and ethics committee members on secondary trauma, trauma, and researcher wellbeing.
35. Researcher wellbeing 'champion' within the University to advocate for researchers and attempt to improve services/culture.
36. Informed consent to be gained from less senior researchers in the team before starting research in a potentially distressing topic (so they understand the ongoing implications of the work they will be doing, and how they will be supported).
37. A supportive research culture that is aware of, recognises and openly discusses the potential of distress and (secondary) trauma in research.
38. Throughout the project, maintain hope that the research can make a difference, even if it is just to one individual.
39. Make it clear when the role/responsibility of the researcher on a project ends.
40. Final debriefing of less senior researchers at the end of the project.
41. Having generally good work resources.
42. A more positive response within the university to Equality and Diversity Issues (e.g. on maternity leave, caring responsibilities, reasonable adjustments for disabled people, an environment that does not foster sexism, harassment, homophobia, racism and disablism).
43. Clear written guidance about what the researcher's role is in relation to the research participants.
44. Clear written processes to follow if the research participant gets distressed or there is a 'risk' of harm to themselves, the researcher or others.
45. Clear written process to follow if the researcher gets distressed or becomes a 'risk' of harm to themselves or others.

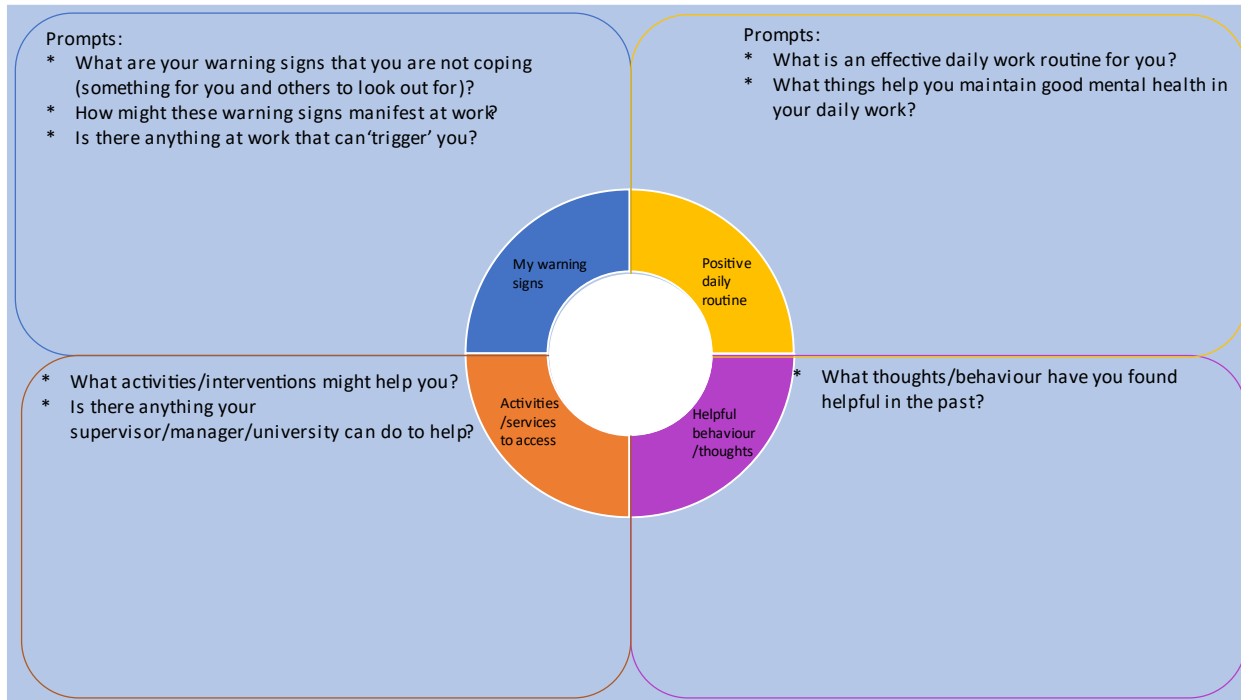| |
|---|
| 46. Clear referral pathways for the participant if they become distressed. |
| 47. Clear referral pathways if the researcher becomes distressed. |
| 48. Access to an informative Researcher Wellbeing Form to fill out that addresses potential research challenges and impacts (with questions and statements to reflect on before starting a research project). |
| 49. Researcher Wellbeing Form to form part of the formal ethics process. |
| 50. Access to comprehensive guidelines and resource repository (e.g., a Researcher's Wellbeing Handbook on the University of Bath website). |
| 51. Exercise (e.g., walking the dog, running, swimming, yoga, gym). |
| 52. Non-sporting hobbies (e.g., gardening, sewing, knitting, reading, cooking, nature, pets, music). |
| 53. Meditation. |
| 54. Spirituality and/or religion. |
| 55. Talking to and relaxing with friends and family. |
| 56. Wellbeing plan (e.g., a written down plan that can help you understand your mental health, what signs you have that indicate your mental health needs attention, and what helps you cope with your research. A wellbeing plan could include many of the things indicated above in this questionnaire). |
| 57. Researcher wellbeing plans submitted as part of the formal ethics process (in an edited form to maintain personal information if needed). |
| 58. Funding to help cover the costs of some items within the wellbeing plan (e.g., clinical supervision, counselling, gym membership, meditation classes). |
| 59. Legal support/advice that is paid for by the University but is focused on the needs/rights of the researcher. |

Appendix V: Secondary Trauma Questionnaire

The following is a list of statements made by people who have been impacted by aspects of their work that we have adapted to be relevant to researchers. Whilst responding to these statements, we would like you to **identify the most potentially distressing period in your research to reflect on**. Please read each statement and indicate to what extent the statement was true based on your experience during that period by selecting the corresponding number next to the statement **(where 1 = never, 2 = rarely, 3 = occasionally, 4 = often, 5 = very often).**

	Never	Rarely	Occasionally	Often	Very Often
1. I felt emotionally numb…..1		2	3	4	5
2. My heart started pounding when I thought about the potentially distressing aspects of my research.....................1		2	3	4	5
3. It seemed as if I was reliving the trauma(s) experienced by my participant(s) or other traumatic aspects of my research	1	2	3	4	5
4. I had trouble sleeping..1		2	3	4	5
5. I felt discouraged about the future 1		2	3	4	5
6. Reminders of the potentially distressing aspects of my research upset me 1		2	3	4	5
7. I had little interest in being around others 1		2	3	4	5
8. I felt jumpy…..1		2	3	4	5
9. I was less active than usual...1		2	3	4	5
10. I thought about the potentially distressing aspects of my research when I didn't intend to……	1	2	3	4	5
11. I had trouble concentrating 1		2	3	4	5
12. I avoided people, places, or things that reminded me of the potentially distressing aspects of my research................1		2	3	4	5
13. I had disturbing dreams about my research 1		2	3	4	5
14. I wanted to avoid engaging in some aspects of my research..............1		2	3	4	5
15. I was easily annoyed 1		2	3	4	5
16. I expected something bad to happen…...........................1		2	3	4	5
17. I noticed gaps in my memory about some of the distressing aspects of my research..1		2	3	4	5
18. I experienced negative emotions....................................1		2	3	4	5
19. I engaged in reckless or self-destructive behavior.............................1		2	3	4	5
20. There are parts of my research/work with participants which make me feel bad about possible harm that I have caused, or for which I very strongly blame others 1		2	3	4	5
21. I had negative expectations about myself, others, or the world…..1		2	3	4	5

Thank you for completing this survey. If you have any questions or concerns, please contact Dr Kristine Brance (kb2212@bath.ac.uk) or Dr Tina Skinner (sssts@bath.ac.uk).

Appendix VI: Researcher Wellbeing Plan template and example[10]

Prompts:
* What are your warning signs that you are not coping (something for you and others to look out for)?
* How might these warning signs manifest at work?
* Is there anything at work that can 'trigger' you?

Prompts:
* What is an effective daily work routine for you?
* What things help you maintain good mental health in your daily work?

* What activities/interventions might help you?
* Is there anything your supervisor/manager/university can do to help?

* What thoughts/behaviour have you found helpful in the past?

My warning signs

Positive daily routine

Activities /services to access

Helpful behaviour /thoughts

Example filled out:

* Waking up fearful/stressed all the time
* Not sleeping well/ never feeling fully rested
* Starting work earlier and earlier
* Using 'should' too much
* Obsessive thinking/overanalysing behaviours/thoughts
* Numb fingers, face, tingling in feet, brain not functioning
* Low self-care, i.e., not eating regularly/enough/too much, not going to dentist/doctor/opticians as 'too busy'
* Not exercising or exercising too much
* Working all the time
* Not taking adequate breaks/rest

* Start the day with a positive mind-set and a walk/ fresh air/meditation
* Takes breaks for short activities (e.g. walk, meditation, Japanese Radio Exercises, mindfulness) throughout working day
* Take a lunch break
* Stop work by 6pm
* Stop screens by 9pm
* Set aside time in morning/evening for exercise
* Write 'to do' list and tick it off as I do it

* Making time to connect with friends
* Revisiting old books and films for comfort (but don't binge box sets!)
* Reducing exposure to news
* Prompted journaling or 'morning pages'
* Regular exercise(yoga, walk, run or swim)
* Meditation
* Gardening, painting, board games
* Regular (weekly when needed) academic supervision meetings (to priorities workload, check wellbeing, alternative work, reduce workload etc)
* Monthly clinical supervision
* Weekly counselling sessions when needed

* Set healthy boundaries at work and home
* Stay in the present as much as possible
* Take a breath, connect to feelings, learn from them and move on
* Do the next right thing
* Working through what I can control and remembering I can't control everything
* Be aware of my perfectionism and get used to 'good enough'
* Where possible avoid: negative people, comparing myself with others, caffeine, alcohol, too much sugar

My warning signs

Positive daily routine

Activities /services to access

Helpful behaviour/ thoughts

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[10] This Researcher Wellbeing Plan example was originally written by Skinner et al (forthcoming https://researchportal.bath.ac.uk/en/publications/a-focus-on-ethics-and-researcher-wellbeing) and is further developed here.