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A focus on ethics and researcher wellbeing

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Introduction

This chapter is primarily about the ethics of *researcher* care where victim-survivors are participants and/or researchers, but has wider implications for researcher wellbeing in any research area (e.g. by addressing researcher stress and need for long-term career development). Ethical procedures have substantially improved over the last three decades, such that university ethics committees now adopt independent peer review, provide standardized information, and offer template documentation (e.g. consent forms). Despite this, we continue to find ourselves arguing for enhanced support to maintain participants' *and* researchers' wellbeing. In this chapter, we have come together as victim-survivors and/or researchers/supervisors, to review the utility of existing ethical guidance for researcher wellbeing. We talk candidly about our own needs as researchers/supervisors, to develop a protocol (*not* one-size-fits-all) for moving forward ethically in this field. The authors have supported vulnerable people, campaigned for change, and/or researched gender-based violence (for example Bloomfield-Utting, 2018; Ballantyne, 2004;

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Skinner and Taylor, 2009; Smith and Skinner, 2017). Our research involves qualitative and quantitative work with victim-survivors (interviews, questionnaires, secondary data), support services (Sexual Assault Referral Centers, Rape Crisis, Independent Domestic Violence Advisors, Independent Sexual Violence Advisors), and criminal justice institutions (police, trial observations, probation).

Key sources of ethical frameworks in research include subject councils and research associations (including the Economic and Social Research Council 2019; British Sociological Association 2017; British Society of Criminology 2006; American Society of Criminology 2016), as well as the protocols of individual universities (for example University of Bath, 2021). Specialist guidance for those working within the field of gender-based violence, such as the World Health Organization (2001, 2007, see also Ellsberg and Heise 2005) and Women's Aid (2020), have also been developed. Although differences between guidelines exist, where wellbeing is discussed the focus is primarily on the needs of the research participant rather than the researcher. Where researcher wellbeing is considered it is usually brief. For example, at the time of writing the University of Bath Social Sciences Research Ethics Committee form asks one question of the principle investigators on research wellbeing: "Describe potential risks to researcher/s and how this will be managed". In the guidance and forms we have encountered there is little attention paid to how researcher care should/could be managed. For instance, the British Society of Criminology (2006) acknowledged the role of "appropriate training and support and protection" for those working in circumstances which threaten physical and/or emotional wellbeing, but do not indicate what "appropriate" is or indeed who should fund it. The World Health Organization (2007) and Women's Aid (2020) are notable exceptions, with the former providing information about what topic/skills/safety training should be provided and stating the field researcher should have "access to a worker appropriately trained in providing psychological support for private discussion, if required" (p.26). Women's Aid (2020, p.7) take this further, urging organizations and sponsors to include in their budgets and application process money and protocols to address researcher safety. This, they argue, should include access to counselling and "ideally" (p.7) clinical supervision. But further specifics on the protocols are not given by Women's Aid, other than one question in their checklist similar to that of the University of Bath.

There are, however, (i) responsibilities on employers under the Equality Act 2010 Public Sector Duty of Care, and Health and Safety at Work etc Act 1974 and the Management of Health and Safety at Work Regulations 1999, and (ii) on educational institutions under the Higher Education and Research Act 2017. (i) The Equality Act 2010 provides the legal framework for the public sector employers' duty of care to their employees who are marginalized (including on the basis of gender, which is relevant both for those who are victim-survivors of sexual violence and those who are more likely to work in the field of gender-based violence). The Health and Safety at Work etc Act 1974 and the Management of Health and Safety at Work Regulations 1999 aim to protect the health and wellbeing of employees; including a legal duty to risk assess and protect workers from stress at work. There is also what the Chartered Institute for Personnel Development (2021) call a psychological contract: a perceived relationship between employee and employer, including expectations, that can positively or negatively influence productivity if it is perceived by the employee to be imbalanced. As such, there is not only a moral but also a legal and business case to proactively support staff who could experience secondary trauma (see Health and Safety Executive, undated). In relation to (ii), the Higher Education and Research Act 2017 regulatory framework Condition B2 states that students must be provided with “the support that they need to succeed in and benefit from higher education”, this relates to all students, including undergraduate, Masters and PhDs doing research on potentially traumatizing topics. Further, in relation to supporting victim-survivors of gender-based violence, and many researchers wishing to study GBV are victim-survivors, the OfS (2020) ‘Statement of Expectations’ encourages staff training to enable more effective student support, as well as effective specialist support services. Further, the duty of care, within the Equality Act 2010, means HE institutions must actively work to eliminate discrimination. We argue that, as marginalized people, including victim-survivors, women, ethnic and religious minorities, LGBTQi and disabled people, may be more likely to study topics linked to their own experience that could cause them secondary trauma, and may experience abuse for doing so (see Coles et al, 2014), it is particularly important to ensure that researcher wellbeing is attended to.

Whilst the gradual formal recognition of the potential for secondary trauma in researchers is welcomed, few institutions are affectively addressing this. What is needed is a more detailed open discussion of researchers needs and how to address them before some researchers, funders and institutions will take this issue seriously and/or in a well-informed manner. To do this, this chapter explores the potential issues relating to researcher well-being, including secondary trauma, before discussing the ways in which these can be addressed, introducing a researcher wellbeing checklist (see also Appendix 1), and indicating where institutional responsibilities should lie.

Potential effects on researchers

It is worth noting that the terms secondary trauma (Pearlman and Saakvitne, 1995; Saakvitne et al, 1996), vicarious trauma (British Medical Association, 2019; McCann and Pearlman, 1990; Pearlman and Saakvitne, 1995), burnout (Freudenberger, 1974) and compassion fatigue (Campbell, 2002; Figely, 1993) have been used in various contexts to describe the experiences of those undertaking very challenging emotional work. The British Psychological Society (2020:4) draws on Saakvitne et al (1996) to define secondary trauma as “the stress caused by helping or wanting to help a traumatised or suffering person”. The American Counselling Association (2010) and American Psychiatric Association (2013) define secondary trauma as the suffering and anxiety that can result from witnessing another person’s trauma, with the latter emphasizing the extreme or repeated nature of the exposure. However, Sprang et al (2019) refute this definition, arguing that although extreme and repeated exposure may link secondary trauma with Posttraumatic Stress Disorder levels of symptoms, lower levels of secondary trauma may occur without extreme or repeated exposure.

The British Psychological Society (2020) acknowledge that secondary trauma can be the result of engaging with victim-survivors or offenders. For example, when working with victim-survivors in a Sexual Assault Referral Centre (Horvath, et al., 2020; Massey et al. 2019), but also in other professions such as journalism (Maxson 1999) and aid work (Shah et al 2007). However, recognition of secondary trauma in researchers has been slow to materialize (Dickson-Swift et al., 2008, 2009; Williamson et al., 2020).

Williamson et al (2020) argue that a lack of recognition may arise because researchers rarely directly witness the victimisation being discussed, may meet with victim-survivors for “a handful of occasions” (p. 56), and are not required to directly help victim-survivors. However, secondary trauma can and does occur for academic researchers (Campbell 2002). In actuality, Becket (2020) argued that the ‘one off’ or limited engagement researchers have with the participant, coupled with the victim-survivor ‘opening up’, but with the researcher having little or no possibility to actually intervene, could be distinctly challenging. Researchers in this field often may hear narratives and feel their interviewee’s distress, in a similar way to counsellors or psychologists when they first meet new clients at the start of therapy. However unlike therapists, researchers will rarely get to hear the more positive narratives of therapeutic change and will often be left wondering what happened next for those who have shared with them such a deeply personal and difficult part of their lives.

Secondary trauma is not limited to researchers who have face-to-face contact with victim-survivors. The British Psychological Society (2020) acknowledge that it can result from analyzing crime. Campbell (2002) and Williamson et al. (2020) also indicate secondary trauma may occur throughout the research process, including reading and engaging with literature, the recruitment of research participants, generation and transcription of qualitative data, coding and analysis of both quantitative and qualitative data and when writing up the analysis. It may also arise: as the result of supervising such research; with the frustration at the lack of change in policy and practice; because of many social interactions where a lay person trivializes the subject (e.g. by using rape myths); or after years of receiving research related disclosures (e.g. of sexual violence) from acquaintances or/and students. Indeed, Kumar and Cavallaro (2018) remind us that such emotionally demanding work is not just limited to obviously sensitive topics: it could come up when a respondent, on almost any research project, discloses something highly distressing; or when the researcher/colleague experience (secondary) trauma due to life a event that is outside of the research process but still impacts on their ability to work and requires employer/colleague care/kindness.

When talking about the symptoms of medical professionals who have recently worked with victim-survivors of trauma, the British Medical Association (2020:1) indicates that possible signs of secondary trauma include:

- “experiencing lingering feelings of anger, rage and sadness about patient's victimization
- becoming overly involved emotionally with the patient
- experiencing bystander guilt, shame, feelings of self-doubt
- being preoccupied with thoughts of patients outside of the work situation
- over identification with the patient (having horror and rescue fantasies)
- loss of hope, pessimism, cynicism
- distancing, numbing, detachment, cutting patients off, staying busy
- avoiding listening to client's story of traumatic experiences
- difficulty in maintaining professional boundaries with the client, such as overextending self (trying to do more than is in the role to help the patient).”

Sprang et al (2019) neatly categorized many of these responses into: intrusion (e.g. distressed dreams/memories); avoidance (e.g. of reminders of the person's trauma); alteration in arousal/reactivity (e.g. hypervigilance, exaggerated startled responses; limited concentration/sleep, irritability); and alteration in condition/mood (e.g. impaired memory, distorted thinking about safety, withdrawal, negativity). Many of these could combine as symptoms of Posttraumatic Stress Disorder after extreme or repeated exposure to trauma (Sprang et al, 2019). In short, the British Psychological Society (2020) state that the symptoms of secondary trauma are alike to those felt by a victim-survivor of a traumatic event.

We, the authors, have at one time or another experienced feeling: “empathy”, “trauma”, “despair”, “shock”, “anger”, “frustration”, “numb”, “helpless”, “powerless”, “inadequate”, “anxious”, “tired”, “guilt”. Skinner reports that in the process of doing research she has experienced feeling

“like a sponge soaked in the pain of others”, “has tended not to trust males easily particularly with children, avoided fiction that might contain gender-based violence, and temporarily dropped out of the research area due to untreated secondary trauma”. A key indication of the effect the research was having on Skinner early in her career was when she caught herself reading case files and thinking one horrific story was not as bad as another one, and then being shocked at how hardened this response was. For Smith, transcription and analysis are times where particular care was needed, as seeing the experiences of others written in ‘black and white’ emphasised the feelings of shock, powerlessness, and anger. The analytical approaches used by Smith also involve identifying counter-arguments, which could feel like complicity, and seeking to develop pragmatic recommendations from data can feel simplistic and inadequate. For example, during trial observation research, it was the difficulty of identifying routes for meaningful change that created feelings of despair and exhaustion, rather than the detailed accounts of sexual violence within the cases. One author (Sweetland) has had to consciously try to detach her own experiences of gender-based violence from those of participants, and has felt the need to “bottle up” her personal trauma because it may appear minimal to examples in the literature or data. Another author (Taylor) can still remember vividly how helpless she felt walking away from interviewing teenage victim-survivors nearly twenty years ago, and how thanking them for sharing their experiences so their voices could be heard never felt enough. Similarly, for Geoghegan-Fittall, asking victim-survivors to share their vulnerability and experiences of trauma, can feel somewhat disingenuous and evoke feelings of guilt given the low rate and scale of change which may result.

The experiences described within the few academic texts that exist, and our own words above, are repeated over decades and across different countries. These sources highlight many effects of secondary trauma in academics, such as: anger, aggression, burnout, illness (Massey 2020); and avoidance behavior, such as not viewing films and other media on topics related to gender based violence (Campbell 2002; Brown 2017; Massey 2020; McKenzie et al 2016). Such impacts can be amplified if the researcher is themselves a victim-survivor (Ellsberg and Heist 2002; Caringi et al., 2015) as listening to other people’s traumatic experiences can trigger their own difficult and/or traumatic life experiences.

Some of the fullest accounts of impacts on researchers are from studies that have interviewed the research teams at the end of a project, for example, Campbell (2002) in the USA after a study on rape and Williamson et al (2020) in the UK after a study on domestic abuse. Despite being almost two decades and an ocean apart, these two studies (and our own experienced) have strikingly similar findings. Campbell's (2002) research team talked of the "fear, grief, pain, and horror as the crime of rape intruded into our lives" (p.101); "difficulty sleeping [...] nightmares" (p.101); being "afraid to go out [...] afraid to stay home after hearing so many stories of rape committed by friends, boyfriends and husbands" (p.102); snapping "at the slightest startle" (p.102); and in especially difficult interviews they talked of needing to "shut down and work on emotional autopilot" (p.105). Some also practiced avoidance by keeping a "list of books and movies that contained images, characters, and story lines that make reference to violence against women so we would know what to avoid if we wanted to escape the topic" (p. 147). A further theme, added to fear, was anger regarding other people's ignorance about the topic; about the lack of accountability for offenders; as well as how it impacted their own sense of safety:

"I was swimming in feelings, and it took a while to get ahold of each one and identify and label it [...] I was walking to my apartment [...] and I noticed I was walking really fast, looking all around me, and I practically ran up my stairs and locked the door behind me. I remember standing there looking at my locked door for a second, thinking I had locked out everything bad and nothing could touch me, and then I got mad, really mad [...] so angry realizing that no matter what I did, I was still at risk." (Campbell, 2002 p. 83).

Williamson et al (2020), in their candid account, also talked of "feeling very angry, frustrated and helpless" (p.61); with "overwhelming fear" that the victim-survivor being interviewed would not get the justice she sought (p.61); as well as "empathy" and "pain" both when interviewing victim-survivors and when reading through case notes. For example, one analyst "gasp[ed] out loud" when they found a note stating "DEAD" on a victim-survivors file they were reading (p.61).

Williamson et al (2020) also highlighted the myth that such research gets easier with experience, arguing that cumulative trauma is more likely and may result in the need to avoid all direct contact with victim-survivor participants or indeed to leave the subject area completely. Becoming 'senior' as an academic specialising in a potentially traumatic topic does not leave one immune to the

emotion in such research. The workload and responsibility of management can be an added burden. It may also be that the longer the time in such a field the less ‘healthy’ the coping mechanisms are because such researchers may be more likely to work in older more established teams where the presumption is that they should ‘just get on with it’ (see also Ellsberg and Heist 2002). This may, itself reflect the ‘damage’ that they and their managers in the past had taken in academic institutions where, despite feminist intervention, distanced ‘objectivity’ is prized (Campbell, 2002; Williamson et al, 2020) and secondary trauma is constructed as something to be ashamed of. Campbell (2002, p104) draws on Hochschild (1983) to explain that in academia there is emotional labor where “the feeling rules are that there are no feelings. The display rules are that no emotions are displayed”. So, previous generations of researchers, and indeed the current ones, are pushed to hide their emotions, despite increasing wellbeing discourse to the contrary. Whilst there may have been a policy change (e.g. the addition of a question about research wellbeing in an ethics form), the culture is slow to follow, as is the practice.

In addition to the aforementioned cumulative trauma, seniority in this type of research may also result in feelings of guilt. Campbell (2002) talks of her sense of loss, guilt and sadness of initiating others into this field of research. In talking about her feelings the night before her research team were about to do their first victim-survivor interview as the final part of their training, Campbell (2002, p. 67) wrote in her field diary:

“The interviewers will hear their first stories, and then many more thereafter. But tonight, their minds don’t know many details, their realm of possibilities is still narrow. I mourn for this unfettered space within each of them because I know it will soon be spoiled [...]”
(p.67)

Campbell (2002, p.69) goes onto say: “[...] I hope they will not long too strongly for their innocence. I hope that they can all find a way to live with what they are about to learn”. Whilst this assumes the researcher is not themselves a victim-survivor, service provider and/or already well-versed in the topic of gender-based violence, it is important to acknowledge the guilt a senior colleague may feel for the pain the student/researcher may experience in the research process. In short, it is a myth that carrying out potentially traumatising research becomes easier with time and experience. In fact, it may bring about a unique set of challenges.

Addressing secondary trauma

Lack of research in this field means that evaluations are needed to establish how to effectively treat secondary trauma (Sprang et al, 2019). Whilst institutions tend to employ more general strategies such as wellbeing and health promotion, training and ad hoc wellbeing sessions (Molnar et al, 2017), this is not enough to address secondary trauma. With the lack of institutional responses, researchers may themselves employ a number of steps to ‘deal with’ the aftermath of research, some of which are generally considered ‘healthy’, such as walking, exercising, “taking time to calm myself down” (Williamson et al 2020, p.60); however, others are potentially ‘unhealthy’ and closely linked to self-abuse, such as drinking as a means to “switch off” (p.65); or linked to avoidance and/or fear, including avoiding watching the news or films where their research topic may come up; or being over-protective of their own children (Massey 2020).

Becket (2020) has the following in place to address secondary trauma: scenario planning and practice with other staff; having ‘down time’ between interviews; acknowledging that analysis can sometimes be harder than data generation; supervisors proactively checking in with researchers; senior staff on call so people are able to talk through potential issues; building in money for support; and normalizing emotion. Campbell (2002) described nine key measures that can be adopted within a research team as a means to avoid and manage the effects of traumatic research. The first measure is “careful selection of team members” (p.145) to ensure that the reasons for application are in line with the project ethos, as well as making case by case decisions about candidates (including victim-survivors) ability to cope with the material (see below for critique). The second is providing detailed information about the potential impacts on the researcher in terms of personal relationships, physical and mental health, so the applicant is able to make an informed choice as to whether or not they want to be a part of the research team. Thirdly, Campbell acknowledged that different backgrounds (e.g. religion and culture) may illicit different coping mechanisms; while fourthly establishing a research team identity via mandatory weekly meetings to discuss both practical issues and to enable group debriefing, thus allocating time to ‘vent’, discuss emotional wellbeing, share stresses and places to access further support. This also included social events, both work and non-work related (for example, craft evenings). The fifth measure is

providing detailed collective training, for example on interviews and analysis. The sixth is to schedule work to allow breaks (down time) and rotation of tasks (for example interviewing, then contacting service providers before interviewing again). The seventh of Campbell's measures is stating when the 'end' of the project and researcher roles are to provide clarity and closure; closely related to the eighth principle of group events at the end of the project to offload images and experiences, as well as laugh with colleagues, before the final measure of debriefing each researcher.

However, Coles et al (2014) indicate that researcher wellbeing does not only need to be attended to by the individual and supervisor, the institution also has a key role to play. Since Campbell was writing, there has been some change in universities, and Williamson et al (2020) highlight that it is now common for many UK institutions to have a formal ethics committee approved plan to manage researcher (self-)care. These plans can contain measures such as time to debrief after research interviews, either by phone or in person; regularly scheduled team meetings with emotional well-being being included on the agenda; opportunities for researchers who have experienced a difficult interview or situation to seek support from colleagues; and, if the above is not adequate, to seek out their own counselling from a list of suggested services (ibid).

Williamson et al (2020) also discussed their own informal self-developed coping mechanisms relating to "mindfulness, meditation, and running... counting my blessings" (p.65) as well as "taking a walk/getting fresh air" (p.66), spending time with friends and family, "stand[ing] still and let[ting] it pass" (p.66). In line with the observations of Edwards (1993) and Abrahams (2017), Williamson et al (2020) also find it helpful in their coping techniques to reflect upon the potential rewards of carrying out research in this field, particularly "mak[ing] a difference to real people" (p. 66).

In addition to these, we have our own measures developed over the last decade (see Appendix 1, which also includes things we are still campaigning for e.g. specialist trauma focused counselling paid for by the institution/funder). In the development of this, we have tried to avoid placing undue

emphasis on the individual researcher. Whilst it is not contested here that researcher's self-care and development of personal resilience is important, institutions also have a responsibility to ensure that the working environments of researchers is conducive to supporting effective self-care (see next section). It must also be noted that we have never had the opportunity to work as part of a research team together, so the following developed in projects involving an individual lead research/supervisor and researcher, but can be adapted for teams.

Prior to the formal funding application process (e.g. before a PhD proposal is submitted), or as part of the job interview process, *informed consent* needs to be obtained from the potential researcher. We recommend a candid discussion with the potential researcher to ensure they are fully aware of the challenges of (i) being an academic (e.g. difficulty of obtaining a permanent contract) and (ii) an academic researching a potentially distressing topic. For the latter we would discuss the potential emotional effects of engaging in this type of research, recognize that it is normal to be affected by such work, and help them consider how these challenges may be managed. It is also made clear that the researcher can, but does not have to, disclose if they are victim-survivors themselves; *not* for the purpose of the supervisor/lead to decide if they are able to undertake the research¹ (see Campbell, 2002), but to acknowledge the potential insights this will bring to the study, how it may aid their coping skills and empathy (see Horvath et al, 2020), and the additional challenges the applicant may face, and how best to address these. This allows for an informed decision to be made by the student/researcher in terms of continuing the application or accepting the post.

Regular (weekly or two-weekly depending on need) one-to-one supervision meetings are also used to establish a positive working relationship, discuss the work that week (e.g. what has been completed), discuss any challenges (e.g. interview content), and plan the next week. The meetings also feature a two-way discussion of well-being and the proactive sharing of positive coping strategies (such as mindfulness, meditation, exercise, limiting workload, limiting time interviewing/observing/coding, taking regular breaks, not working weekends/evenings, taking holidays, drawing on existing network where this is supportive). Limiting workload should be focused particularly on limiting the amount of exposure to traumatic material (see Sprang et al, 2019), for example number/spacing of victim-survivor interviews in their workload. Particular

junctures in the research process may also shape the focus of the meeting, for instance a researcher may be particularly apprehensive before going into the field to observe probation service domestic abuse perpetrator group session. Here attention in the supervisory sessions can be payed to safety planning.

The researcher is also asked to write their own wellbeing plan (see example in Appendix II) and discusses this with the academic (and clinical) supervisor. Where appropriate/needed, the supervisor accompanies the researcher on one piece of field work (e.g. court observation or interview) early in the project to support. The supervisor also reads initial coding of data to assist in analysis and share the emotional ‘burden’ of the information and aid the trustworthiness of the analysis. Where possible, connections are also proactively fostered between other PhD students and researchers working with the supervisor (e.g. all going to the same conference).

In order to aid confidence in building academic skills, reduce anxiety, enhance future career prospects and reduce the pressure of the obligation to ‘make the data count’ by making a difference, the lead/supervisor encourages: co-presentation of findings at conferences; joint authorship of at least one paper; joint authorship of first press release; practice of first media interview; and access to contacts (e.g. introductions to policy makers, subject networks). However, this must be done in the interested of the junior researcher (e.g. they are lead author), and not be part of an exploitative relationship where the lead researcher is the primary beneficiary (e.g. putting their name as lead on a paper the junior researcher wrote).

Such a commitment to ethical support goes beyond the duration of the research project; if successful it is the building of a long-term relationship: continuing to support career development of the researcher through references, reviewing of CVs and job applications, being a ‘sounding board’ for new research and policy ideas, for example. The long-term relationship is also not one way, over time, as the expertise of the researcher may equal or exceed the supervisor, joint projects may evolve and mutual support becomes more common.

As Campbell (2002) and Williamson et al (2020) also indicate, it is important to nurture hope (see also Coles et al 2014; Thompson et al, 2014): maintaining hope that the research can make a difference, even if it is just to one individual victim-survivor having their voice listened too and taken seriously, or one practitioner being more reflexive/supportive in their work. Whilst it is also important, both ethically for the participants and for the researcher's wellbeing, to also campaign for positive change in policy and practice, this can weigh heavily on the researcher. This 'burden' needs to be shared by the team, and it needs to be made clear that change may take decades and many projects/campaigns to come to fruition.

In terms of counselling, the researcher should be encouraged to use wellbeing services if required, and professional clinical supervision provided monthly while undertaking field work, data analysis and write-up. The minimum standards for Sexual Assault Referral Centres published by the Department of Health, Home Office and Association of Chief Police Officers (2009) indicate that *all* staff in direct contact with victim-survivors – not just counsellors – should have such supervision (see also Horvath et al 2020). We, and Williamson et al (2020) argue, that the approach for *all* researchers potentially at risk of secondary trauma needs to be the same; with clinical supervision paid for by academic funders and employers (see also Dickson-Swift et al 2009). Although, clinical supervision is an effective means by which secondary trauma can be addressed (Hensel et al, 2015; Miller and Sprang, 2017), its' implementation is rarely mentioned in research ethics literature, and it is unusual for it to be advocated for, approved, funded, and incorporated into research practice (Berger and Quiros 2016). However, clinical supervision is at the forefront of the very best ethical practice in academia. For example, it has been provided at Bristol University, under Professor Gene Feder; University of Bath under Dr. Tina Skinner; Canterbury University and Middlesex University, under Dr. Kristina Massey and Dr. Miranda Horvath respectively, and all South West Doctorial Training Partnership ESRC funded PhD students who require it can request funding for it from the partnership. For a detailed discussion of appropriate content of clinical supervision, counselling and other interventions in trauma related work please see Sprang et al (2019).

Institutional responsibilities

Research by Bennett and Windle (2015) indicates that whilst an individual can have and build resilience, this alone cannot sustain a person who is working in a potentially traumatizing context. They argue that a community is needed to nurture resilience. Thompson et al (2014) similarly argue that a supportive work environment is needed to address secondary trauma. Whilst we have tried to nurture such a community/environment ourselves, we join Campbell (2002) in calling for help of employers/funders for the wellbeing of all those researching potentially traumatizing topics. Such help, she argued, could release the pressure to carry out and publish such sensitive work quickly; reflect the time needed - for self/team care in potentially traumatising research - in promotion procedures, teaching and research workloads; and ensuring training for managers and colleagues to raise awareness of the needs of researchers undertaking this necessary emotional work.

Management of Health and Safety at Work Regulations 1999 in the UK require employers to undertake a risk assessment and, if a risk is identified, to plan, organize, control, monitor and review protection and prevention measures, including appropriate health and safety training. These may be physical risks (e.g. potential of physical violence when interviewing perpetrators and the need to work in pairs, see Coles et al 2014 and Ellsberg and Heise, 2005) and as well as mental health risks; both need safety plans. The World Health Organisation's (2020b) information sheet on mental health in the work place indicates the need to go further, stating that employers should have a health and well-being *strategy* concerned firstly with *prevention*, then *identification*, followed by *support*. Such a strategy needs to be effectively integrated into health and safety policies, and backed up by the money/resources needed so they can be implemented into practice (ibid). Sprang et al (2019) likewise indicate that standard institutional wellbeing strategies are not enough. There needs to be more detailed Government and institutional *strategies*, and appropriate policy, qualified staff and forms, to undertake risk assessment, safety planning, training, diagnosis and intervention (see Sprang et al, 2019 for review of diagnosis techniques).

There is evidence that specialist *training* in trauma-informed care can support the mental health of workers (Sprang et al, 2007). However, wellbeing and self-care training alone is not enough to

decrease secondary trauma (Bober and Regehr, 2006). The World Health Organization's (2007) specialist guidance on gender-based violence research in emergency zones outline what the training should include: topic specific information, safety planning, how to maintain professional boundaries, and self-care. They add that "Training should assist members who have experienced sexual violence to understand the impact of the violence on themselves and how this may be the same or very different for other survivors" (p.25). Berger and Gelkopf (2011), in particular, found psychoeducational training based on skills can help symptoms of secondary trauma. Coles et al (2014) also suggest that training to normalize conversations about secondary trauma, as well as provide basic counselling and debriefing skills, and information on clear referral pathways to existing services for participants and researchers, would be particularly helpful. Nevertheless, training alone is not enough, there also needs to be clinical supervision.

The World Health Organization (2020b) emphasis that an institutional strategy should enable employees not only to participate in decision making processes about their support, but in the work that they do in order to enable a sense of *control* over their working lives. Further, staff should have proactive assistance in career development, and their contribution acknowledged and rewarded (*ibid*). Massey (2020) also indicates the imperative to add to this the need for institutions to provide effective *work tools*, which can avoid the minor stresses (for example, computer not working and preventing notes being written up) that can easily add up and have a significant effect on a researcher conducting work with already traumatic material. The *work space* should also be considered. With the increasing move to working from home within research institutions and under Covid-19, and the talk of some employers to only provide 'hot desks', there is a need to consider, within an institutional strategy, the suitability of potentially traumatizing work for home (or a 'hot desk') (British Psychological Society, 2020). The British Psychological Society (2020) also state that consideration should be given to how potentially traumatizing work should be divided between researchers, and during individual working hours, to minimize secondary trauma.

Employers must also understand that secondary trauma related to work may intersect with trauma that may be associated with other parts of an employee's life (VanBergeijk and Sarmiento, 2006), and further compounded by individual characteristics. The British Psychological Society (2020)

state that particular care may be needed for those with heightened vulnerabilities, including disabled (e.g. mental health), bereaved, pregnant, ill or financially constrained people, and those whose relationships are breaking down or have caring responsibilities. We would add that people with protected characteristics under the Equalities Act 2010, who may have experienced trauma due to prejudice, may also be particularly vulnerable. Such considerations should therefore also be built into the risk assessment, protection, prevention and intervention strategy.

Conclusions

Much progress has been made in the understanding of ethical procedures in research, but what is needed is a proactive strategic approach to managing the secondary trauma that can be experienced by researchers. That studies over the last 20 years report the same impacts of researching potentially traumatizing topics means that institutions have yet to succeed in catering for the needs of their own staff. Part of the reason why the recommendations of academics are yet to be mainstreamed, is that academia still suffers from the same feeling and display rules (Hochschild 1983) that Campbell (2002) described nearly two decades ago - we should not feel, we should not emote - and because institutions/funders are unwilling to take on the full economic cost of really looking after staff. Researching potentially traumatizing topics is necessary and painful emotional work, by its very nature, and a proactive well-funded strategic approach is needed in order to help researchers to do this work without incurring secondary trauma.

Appendix 1: Protocol for researcher wellbeing

Support and normalization throughout:

1. Prior to project application/start *gain informed consent of the potential researcher and validate the potential of secondary trauma*, so researcher is aware of the challenges of being an academic *and* researching a traumatic topic (including possible implications of having personal experience in the topic area).

2. ***Weekly or biweekly (depending on need) one-to-one academic supervision*** to establish a positive working relationship, discuss the work that week, plan the next week, discuss well-being and share coping strategies.
3. At the start of the project develop an ***ethics committee approved plan*** to manage researcher wellbeing, and once appointed researchers write their ***own wellbeing plan*** (discusses with supervisor/lead).
4. Build ***extra time*** into projects to allow for ‘time out’ of stressful tasks.
5. Where appropriate/needed, ***lead researcher/supervisor accompanies researcher on one piece of field work*** to provide support.
6. ***Supervisor/lead reads/develops initial coding of data*** to share ‘burden’ and enhance analysis.
7. Where possible, ***connections are proactively fostered between*** PhD students and researchers undertaking similar research.
8. Encouraging accessing ***wellbeing services*** (e.g. counselling, mindfulness, yoga).
9. Monthly ***clinical supervision***: for field work, data analysis, writing-up and supervisory role.
10. Throughout project ***maintain hope*** that the research can make a difference, even if it is just to one individual research participant.
11. Make it clear when the role/responsibility of the researcher on a project ***ends***.
12. ***Final debriefing*** at the end of the project.

Career development support:

13. Where appropriate/possible ***co-presentation*** of findings at one conference, with ***junior researcher as lead*** author and ***proactive positive involvement*** of the lead/supervisor.
14. Where appropriate/possible ***joint authorship*** of at least one paper, with ***proactive positive involvement*** of the lead/supervisor and ***junior researcher as lead author***.
15. Where appropriate/possible joint authorship of the junior researcher’s ***first press release***, with ***junior researcher as lead*** author and with ***proactive positive involvement*** of the lead/supervisor.

16. Where possible, for the junior researcher to be present to *observe media appearances*, by the lead/supervisor, and for the lead to help the student/researcher to *practice their first* media interview.

17. Enabling the researcher to *develop and access high level contacts* in policy, practice and academia (e.g. on advisory boards for research, shadowing at meetings, committee hearings, conferences).

18. Post project, continue to support career development of the student/researcher through *references, reviewing of CVs and job applications*, being a ‘sounding board’ for new research and policy ideas, for example.

Institutional level: funders and employers

19. Institutional level: well-funded, detailed institutional strategy focused on prevention, identification, and provision to enable the above 1-18

- *proactive acknowledgement and normalization* of the possible impacts of such research;
- dedicated post to *champion* researcher wellbeing;
- detailed *risk assessment* (that includes mental health) and *safety planning, training, guidance and forms*;
- *proactive funding* of external *clinical supervision* (e.g. built into the application process);
- provision of *long-term specialist trauma focused counselling* for those who require it;
- ensuring researcher/PhD student is *not just dependent on one supervisor*;
- *extra time in workloads* for leads and researchers to develop and implement self-care plans, generate data, analyze data, publish findings;
- *extra time in workloads* for leads to supervise research projects, including PhDs;
- *limit number of PhDs/researchers supervised* by one individual at any one time;
- take this extra time *into account in promotion procedures*;

- **specialist training** for researchers (e.g. wellbeing, mindfulness, safety planning, supervision);
- for those who need to **change research topic**, provision of research **time** and **funding** and subject specialist **mentoring** for a pilot project in a **new research field**;
- provide **reliable work resources**, **appropriate work spaces** and a **supportive work culture**.

Appendix 11 Example Wellbeing Plan



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ⁱ It is important to note that although a victim-survivor may be impacted more by the research if they have not addressed the PTSD associated with their victimisation, treated/resolved PTSD could be a protective element against secondary trauma (see Hargrave, 2006).