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

--Manuscript Draft--

Manuscript Number:	
Article Type:	Research Article
Full Title:	The experiences of clinical psychologists in treating traumatic stress at a tertiary psychiatric hospital in the Eastern Cape: A qualitative study
Short Title:	The experiences of clinical psychologists in treating traumatic stress at a tertiary psychiatric hospital
Corresponding Author:	Duane Booysen Rhodes University Grahamstown, SOUTH AFRICA
Keywords:	Clinical psychologists; psychiatric hospital; patients; traumatic stress; vicarious trauma; secondary trauma; trauma narratives; vicarious post-traumatic growth; South Africa
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Cover letter

Duane D. Booysen
Rhodes University
Makhanda, South Africa, 6140

8 September 2021

Dear Professor, Emily Chenette

We wish to submit an article entitled “*The experiences of clinical psychologists in treating traumatic stress at a tertiary psychiatric hospital in the Eastern Cape: A qualitative study*”

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In this paper, we outline a specific focus on how clinical psychologists experience treating traumatic stress in a psychiatric setting. Due to the pervasiveness of trauma related disorders in low and middle-income countries, there is limited understanding how mental health professionals experience treating traumatic stress in a psychiatric setting. We believe that the readership of the journal would benefit from engaging with the manuscript.

Please address all correspondence concerning this manuscript to the first author at D.Booyesen@ru.ac.za

Thank you for your consideration of this manuscript.

Sincerely,

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Experiences of clinical psychologists in treating traumatic stress

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

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Abstract

Qualitative data on the experiences of treating Post-traumatic stress disorder in a psychiatric setting in a low-resource context is sparse. We aimed to explore the lived experiences of clinical psychologists who treat patients who are either trauma survivors or perpetrators in a psychiatric hospital. A total of six individual semi-structured interviews and follow-up interviews were conducted with three clinical psychologists based at a psychiatric hospital in the Eastern Cape, South Africa. Data were analysed using Interpretive Phenomenological Analysis. All participants reported experiencing symptoms of vicarious trauma and secondary traumatic stress while treating both victims and perpetrators of violence. The findings also revealed an element of danger, as well as socio-political factors that clinical psychologists experience. Participants further reported experiencing vicarious post-traumatic growth, enhanced by their coping strategies, while providing psychological services to traumatised patients.

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

Introduction

Post-traumatic stress disorder (PTSD) is a global mental health priority, especially in low- and middle-income countries such as South Africa [1, 2]. In South Africa, 73.8% of the general population are exposed to at least one traumatic event, and more than 50% of South Africans experience multiple traumatic events [3, 4, 5]. To this end, South African society experiences some the most violent crimes and trauma-related experiences in the world [6].

Several psychological treatments for PTSD have been developed over the last four decades [7]. Yet health professionals, such as clinical psychologists, are still at risk

psychologically when treating persons with PTSD [1, 8]. Treating PTSD is understood to be demanding as it requires re-tellings of the trauma narrative using various psychotherapies, such as cognitive behavioural therapy [9]. However, listening to the details of patients' trauma narratives exposes practitioners to traumatic stress, vicarious trauma and secondary trauma [8, 10].

In the United States, between 40% and 85% of health and service practitioners develop vicarious trauma and secondary trauma, leading to burnout and compassion fatigue [11]. Vicarious trauma is an impaired view of the self, others, or the world. This occurs in response to repeated exposure to trauma narratives when a mental health practitioner engages empathically with traumatised clients [12]. Secondary traumatic stress occurs when mental health practitioners are exposed to patients' traumatic experiences, and develop symptoms of traumatic stress themselves [11]. Symptoms include somatic responses, negative emotions, and psychological distress [13, 14].

A study based in the United Kingdom, including 253 mental health practitioners treating trauma clients, found that 70% of the scores indicated a high risk of secondary trauma [14]. Concurrently, research in South Africa found secondary trauma to be experienced by mental health practitioners and emphasised the need to provide training for these practitioners, thus enabling them to cope with the emotional impact of treating trauma clients [15].

In contrast, individuals who treat trauma also develop a positive belief system that leads to psychological growth and resilience [15, 16]. Positive findings in mental health practitioners treating trauma include experiences of vicarious post-traumatic growth in their personal lives [8, 10]. Vicarious post-traumatic growth is the development of positive emotional, cognitive, and spiritual changes in response to direct exposure to trauma

survivors' narratives. It is associated with life satisfaction, personal strength, happiness, psychological and physical well-being [13].

Qualitative research on experiences of clinical psychologists treating PTSD, specifically in inpatient public service psychiatric hospitals, is sparse. Public psychiatric hospitals and private hospitals differ in terms of resources, challenges and case load [17]. A range of studies investigated the impact on mental health practitioners who treat trauma survivors in communities and private practice. However, there still remains an unexplored interest in the phenomenological experiences and challenges faced by clinical psychologists working with trauma narratives in psychiatric settings. Expanding on the literature in the current study is distinctive in that it provides qualitative insights into the phenomenological experiences of a group of clinical psychologists who work with trauma survivors, specifically in a public psychiatric hospital. To this end, the present study was guided by the following research question: How do clinical psychologists experience working with traumatic stress in an inpatient public psychiatric hospital?

Method

Participants

A heterogeneous purposive sampling process was used to recruit participants according to the design of Interpretive Phenomenological Analysis (IPA), gaining insight into a particular experience [18]. Four public psychiatric hospitals in the Eastern Cape and Western Cape were approached to participate in the study, of which only one site had interested participants. A sample of three voluntary participants with the age range of 40–53 years were recruited from a psychiatric hospital in the Eastern Cape. All participants were clinical psychologists who are registered with the Health Professions Council of South Africa (HPCSA) and had experience with varied psychopathological cases, including trauma. IPA studies are known to

use small idiographic samples for a deeper, detailed understanding of participant's perceptions [18]. The inclusion criteria were based on levels of work experience. Participants who had more than three months of work experience as a clinical psychologist at the psychiatric hospital were invited to participate in the study [18]. The current participants had an average of 18 years' experience.

Procedure

Ethical clearance was granted by the Rhodes University Ethical Standards Committee (Reference: 2020-1341-3524), including permission from gatekeepers at the Psychology Department of the psychiatric hospital. Permission was also granted by the Department of Health (Reference: EC_202011_013). The Psychology Department of the hospital was contacted, requesting that the recruitment advert be e-mailed to all clinical psychologists, as well as the professional e-mail addresses of each clinical psychologist to follow-up on their interest in volunteering as a participant. Those interested received the consent form and interview schedule with interview questions prior to the interviews. Data collection was conducted via one-on-one, semi-structured interviews in person. Each participant consented verbally and signed a consent form. Participants were informed prior to the interview that should they become distressed, they were able to terminate the interview and seek support from someone they trust, or by accessing psychological services from their own personal therapists.

Each interview's timeframe was between 60–90 minutes. In total, six interviews were conducted in a manner which was open-ended. Three of these interviews were follow-up interviews one week after the first interview to facilitate a reflective account of participant experiences. Through obtaining a deeper reflection of their experience, it allowed for more accurate findings which helped us and the participants to refine certain questions, thoughts

and reflections. It also aided in uncovering the potential layers of their professional responses and getting to a point of phenomenological understanding [19]. Interviews were conducted using an audio-recorder, with the participants' signed consent [18]. All data were transcribed using a transcriber who was a graduate student in politics and Spanish language, who also signed a confidentiality agreement.

Interview guide

An interview schedule was developed and underwent refinement to corroborate with the aim of the study [18]. Items for the first interview focused on areas of interest. Item areas with probing questions included how they came to work in a psychiatric hospital and their experiences working there. The participants' opinion and experiences of treating trauma and PTSD were also explored, along with their coping strategies. The follow-up interview included questions based on the account of participants' experiences in the first interview, clarifying their experiences and obtaining deeper reflections. Treating trauma based on their gender came up as an area of interest in the subsequent interviews.

Data analysis

The current study used IPA as an experiential qualitative research method. The IPA approach is underpinned by three core philosophical perspectives identified as phenomenology, hermeneutics and idiography [18]. The analysis took a double hermeneutics and idiographic approach by making sense of participants' experiences in a given context, whilst also interpreting and contextualising these experiences. The data retrieved were analysed using the IPA analysis guidelines; in other words, a step-by-step analysis [18]. The process first involved reading and re-reading each transcript to create an overall impression for each participant. The transcript was placed in a single column with two subsequent columns for

notes and sub-themes. Comments and notes were made on significant reflections in the second column, and broad sub-themes were identified based on these notes in the third column for each transcript. The analysis deviated slightly as transcripts were then re-read, and the sub-themes were numbered according to the page numbers of the participants' narratives. Two new columns were made in a separate document, clustering new superordinate themes with sub-themes according to similar patterns. Sub-themes were reviewed and refined thereafter. Thoughts and reflections of the interviews were noted down and kept in a journal, which was later considered when refining, selecting, and writing up significant findings.

Trustworthiness

Trustworthiness of the present study was ensured by conducting the research through the "lens" of IPA [18]. Credibility of the study is warranted by the re-reading of transcripts, comparing them to the audio recordings to achieve reliability, and the follow-up interviews contributed by clarifying participant's experiences through probing for more elaborative and deeper reflections of their narratives. Obtaining a deeper reflection of their experiences further allowed for more accurate findings in terms of conceptualising the participants' reflections and how these related to them within a psychiatric context. Researcher reflexivity was also recognised during the research process, thus allowing for more accurate interpretations of the findings.

Findings

Each theme elicited from the data describes unique aspects of the individual's professional and personal experiences working with traumatic stress within a psychiatric hospital. The themes for each individual will be discussed phenomenologically, reflecting their

experiences. Pseudonyms will be used to protect the identities of the participants. The results will be presented ideographically, in line with the IPA guidelines [18].

Participant 1: “Allen”

Table 1

Summary of themes for Allen

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

Theme 1: Distressing responses to treating traumatic stress

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

Emotional reactions

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

This highlights a particular reaction he has to severe trauma narratives. Allen noted that it was short-lived and brief, rather than emotional distress that he would ruminate about. This speaks to a transformative process of the feeling itself moving away, where he has no control over, or contribution to, how he engages with this feeling of shock. The shock is a

179 feeling he doesn't sit with, but he transcends to a possible resistance to fully engage with the
180 magnitude of what he hears. Aligned with his experience is his acknowledgement of the
181 normalisation of trauma narratives that influence his distinctive reaction, thereby
182 desensitising him to the effects of trauma. In his experience, this is an adaptive coping
183 strategy in a trauma-saturated work setting.

184 Allen also referred to his feelings of sadness and irritability when treating trauma
185 victims of domestic abuse. He stated, "*It makes me sad that there are people living lives that*
186 *are empty, where there's fear in a situation like this.*" Allen sees his patients who are living a
187 life in a home without love, joy and peace. He captures a sense of the patients' unhappiness
188 and fears living in an "empty" home with an abuser, feeling sympathy for the patient who is
189 living a life of no self-worth. He observes that the trauma they experience is taking
190 everything out of them and depletes them, which makes him feel sad for the victim. This
191 forces him to make sense of the perpetrator causing such emotional turmoil, wondering about
192 the perpetrator's upbringing. This appears to be a strategy he has developed to help him
193 manage his own feelings of frustration with the patient's situation in order to hold the
194 therapeutic frame:

195 *The problem is I can't allow my sympathy to come into that room. So maybe in a*
196 *situation like that, the battle is between sympathy and empathy, irritability towards*
197 *the other and empathy; why is he this way, what was his dad like, what was his*
198 *grandfather like, how does he turn into this man? That's also sad.*

200 In contrast to feeling sorry for the patient, Allen empathises with their perpetrator by
201 wondering about their life challenges and how these may have contributed to them becoming
202 the abusive person they are. Due to the context in which he works, he holds himself back
203 from feeling sympathy. Instead, he tries to make sense of the perpetrator through his patients'

experiences, and perhaps thinks that he can help the patient by understanding the perpetrator. He engages with this encounter as he also tries to make sense of his patient's first-hand experience with the perpetrator. This leads to him feeling frustrated and empathetic as he chooses to be concerned about the perpetrator too.

Lack of closure

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

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

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

into water and maintain his vegetables, to reap the rewards of the end product, rewards he does not always get to see with his patients.

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

Theme 2: The presence of gender

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

Treating female patients

In witnessing a female victim’s early termination in therapy due to her traumatic experience with a male, Allen found this relationship difficult to address:

251 *So I was in front of a lot of young Coloured¹ girls from 17 and going up into the 30s*
252 *and 40s who'd been raped by a man, and here they are sitting in front of a man and*
253 *there not being anybody else. And first of all, needing to talk about that and on some*
254 *level, apologising for the fact that I'm it. The sad thing is, for many of them that was*
255 *too much, and there'd be some kind of inauthentic goodbye at the end of the first*
256 *session and they wouldn't return.*

257
258 He describes a situation where there are no other female psychologists to attend to the
259 victims. He refers to a sense of helplessness experienced by both himself and the patients.
260 Perhaps he feels that they are stuck with him in the room as their therapist, alluding to a
261 process they feel somewhat forced into, where “choice” is denied them. The difficulty in
262 treating trauma is that there is an aspect of each woman’s trauma narrative that is linked to
263 him, thus he refers to himself in an emotionless manner as “it”. The unspoken “it” is
264 understood to be the uncomfortable experience in the room, unsure of how it should be
265 addressed but easy to avoid. This creates an uncomfortable atmosphere for him, knowing that
266 being a male is the reason for the patient’s early termination. By receiving an inauthentic
267 goodbye, it makes him feel devalued in a context which he is unable to control. In trying to
268 manage his own feelings of discomfort, he is unable to address the patient’s needs as she
269 distances herself from the process, robbing him of the opportunity to draw her back in.

270 Allen dances between understanding the patients’ fears and the reason they do not
271 want to return to therapy, choreographed by the perceived need to apologise for being a man.
272 Something he found tough was being a man and a clinical psychologist, as he later stated,
273 *“the awareness of the discomfort, the gently coaxing them into something that’s difficult to*

¹ The term “Coloured” was used as a racial classification category under the Population Registration Act of the Apartheid dispensation and is still commonly used in South Africa today to refer to individuals who are of mixed race [20].

274 *talk about, you know?”*. Allen describes the early stage of therapy where patients have a
275 preconceived perception of men, not yet comfortable and trusting of the therapist. As a White
276 man, there is also stigma associated with the former system of Apartheid, causing her to feel
277 intimidated and scared. With this acknowledgement, Allen feels unsettled by his attempt,
278 guided by his therapeutic skills, to persuade the patient to see a different side of a male when
279 they are not yet ready for this shift. He is aware of his own positionality in relation to his
280 patient, and his role as therapist is troubled by the characteristics he brings into the room
281 while trying to create a safe space for the trauma survivor.

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

288 Allen elaborates on his experience of treating women who have been sexually
289 assaulted and raped. In this instance, he found it difficult to hold the therapeutic frame while
290 exploring safety measures and helping her process the trauma:

291 *When a man does a terrible thing like that to a woman, so many things can be*
292 *misinterpreted by a male therapist, not the male therapist doing the misinterpreting,*
293 *but the client misinterpreting. It’s hard. It’s very hard, because that’s not what you’re*
294 *saying; you’re not saying it’s their fault.*

295
296 As a male therapist, conscious of his male presence in the room and aware of the
297 emotional turmoil the patient is sitting with, Allen provides a safe and steady professional
298 structure for therapeutic work to take place. Despite this, he ultimately feels misjudged,

perhaps causing him to feel a sense of disappointment. Allen recognises that patients have their own perceptions based on their experiences, and these impair the honest interpretations he makes in therapy. He finds himself walking the fine line between helping them and acknowledging that an abusive event may occur again, while also trying not to blame the victim. A delicate engagement is roped between them as the patient does not, maybe cannot, feel understood or supported by someone who resembles the perpetrator. While he tries to be engaged and hold the patient's distrust, an uncomfortable tension is present because the patient sees him as a threat, projecting her unresolved fears onto him.

Theme 3: Conscious of the effect on his personal life

Allen referred to how treating trauma influenced his personal life.

Personal experiences

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

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

Although, when listening to the trauma narratives of his patients, Allen formed an appreciation for his life:

It makes me realise that irrespective of whatever has happened to me in my life, there are other people out there that have had it much worse than I. So, actually, it doesn't make me down on life, it makes me appreciate it more and my history.

Allen learns from his patients' difficult life experiences and feels grateful for his life journey when comparing himself to them. Existentialism emphasises Allen's capacity to use the world and his experiences to make decisions and develop views centred on himself, rather than on the fear which society generates. This experience seems to have formed his personal view of life, appreciating and focusing on the little things that are pleasurable. Being a male who was called to the military for national compulsory service, working in townships and other communities, he feels empathy towards others for their struggles. He has encountered and witnessed first-hand trauma injustices being committed, and, in this way, has been exposed to the darkness of the world. His current profession enables him to make a difference, while valuing his life and the opportunities afforded to him.

Participant 2: "Annie"

Table 2

Summary of themes for Annie

Themes	Sub-themes
Strong emotional reaction	Anger
	Confused when treating the perpetrator

Balancing roles

Balancing maternal and professional
roles

Experience as a female clinical
psychologist

Faced with the topic of initiation

341

342 *Theme 1: Strong emotional reaction*

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

345

346 Anger

347 Annie described an experience of treating child rape victims, particularly cases of incest:

348 *And I suppose that's inherent with child work in a way, that they're more vulnerable,*
349 *and it just dials up certain responses in me; a lot of anger.*

350

351 Here, she expresses anger in response to cases where children are betrayed by their
352 family members and are unable to defend themselves. With cases of incest, this sentiment
353 may have left her in disbelief by how a father or other male family figure has the capability to
354 inflict pain on a minor. As a married woman and a mother coming from a close family
355 setting, her natural expectation of the male figure in the home is of a protector and nurturer.
356 When confronted with a situation contrary to her perception of safety, where the male figure
357 is the perpetrator, it becomes appalling to her as her perceived idea of a safe family home is
358 shattered. This interpretation is supported by a similar reflection where she expresses
359 disbelief, "*So that's a bit disheartening, like, how could someone do this to someone else?*"
360 Annie struggles to sit with how someone could be so disconnected from someone else's
361 suffering.

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

Confused when treating the perpetrator

Annie explained that she read an inpatient's file before seeing him and was dismayed by horrific details of his criminal charges:

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

Her response to the case marked a rollercoaster of emotions as she was shocked by the nature of the crime the patient had committed. After reading the file, she felt conflicted by how she would treat the inpatient knowing what he had done. Thoughts regarding whether he was deserving of her treatment and care emerged, and fear of being present in a room with

him. Annie reflects on her thoughts of being able to tolerate horrific narratives, referring to the fact that she is still able to do her job. Here, she uses her own insight to navigate the negative outcomes present in the workplace like a compass, seeking direction in order to feel less affected and more available to her patients. She is able to distance herself from cases through the use of her own coping strategies, these being self-awareness, personal supervision, and mindfulness, while also learning to apply “*acceptance and trust with the use of collegial support*”.

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

Theme 2: Balancing roles

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

Balancing maternal and professional roles

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

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

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

"So it's interesting how I have different fears for my son than I do for my daughter."

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

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

She grapples with issues of trust in others due to her experience of treating both victims and perpetrators. She is aware that being in her profession comes with a price to pay,

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

Theme 3: Experience as a female clinical psychologist

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

Faced with the topic of initiation

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

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

The above extract describes a specific trauma which caused Annie to feel uncomfortable and overwhelmed, knowing that, within an historical-cultural understanding, it is strictly out of the domain of a female's topic of conversation. Being a White English female herself, she would not engage in the topic voluntarily, and experienced the space to be disconcerting to her as if she were tiptoeing on hot coals in a context where male patients are vulnerable. Annie acknowledged the sensitivity of the topic by being respectful of the traditions of the patient's culture, and perhaps also distressed that such a sacred ritual could perpetuate trauma.

Participant 3: "Ruby"

Table 3

Summary of themes for Ruby

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

Theme 1: Responses in dangerous settings

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

Delayed response to trauma and danger

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

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

I saw the pictures, including that of the little girl. And it took me by surprise; it really shocked me. I had a little girl, and I was like, woah, and I started feeling ...not panicky, but I started trembling and shaking, like, oh my word, I'd sat with this guy so relaxed and so chilled, and this is what he's capable of doing?

The pictures and details of the patient's crime became real, as she internalised the seriousness of the case. In this instance, Ruby was reminded of her own daughter and experienced shock after realising how dangerous the patient was. Based on her preconditioned way of responding, being informed by her training, she reacts with an automatic response at first. As a mother, she is reflecting on how she would have felt had that

502 been her daughter in the picture. She felt threatened and scared, as if she were standing in a
503 dark passage, in the presence of a strange figure, feeling physiological symptoms which can
504 only be understood to be secondary traumatic stress. A feeling of terror arises later in the
505 form of panic as she is faced with the reality of the dangers and the fragility of life, and the
506 knowledge that this dangerous man could have harmed her in the open room in which they
507 sat.

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

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

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

524
525 Here, a sense of fear illuminates as there is always a present threat. Ruby finds that
526 she is not always safe, even with a security guard. In order to protect herself, and alleviate her

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

Wondered about patients

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

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

As a clinical psychologist, she understands the psychological functioning of a perpetrator who is unwell. Although, it appears that she was so shocked by the horrific crime the patient committed in a normal state of mind, she wondered what drove him to do it. She expressed interest in seeking answers to understand him, and her distorted view of humanity caused her to feel curious about the perpetrator’s motives for his actions. She reminds herself

of her professional role, not allowing her personal curiosity to cross the bridge into her professionalism and she does this by maintaining her boundaries.

Theme 2: Strong reactions in secure settings

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

Hopelessness

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

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

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

Theme 3: Motherhood vs career

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

Managing roles

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

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

Trauma treatment is demanding, and she found herself juggling her role as a psychologist and as a mother. Each role carries its own emotional demands, and it appears her professional role became too overwhelming. In her experience of treating trauma, making the patient relive details of their experience, she views this process as inhumane, cold and disconnected from the patient’s suffering characterised by a therapeutic technique, *“And it’s hard and painful to*

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

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

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

control, “*with therapy I started realising there’s only so much I can do*”, bringing her some relief.

Discussion

This study found that the lived experiences of clinical psychologists working with trauma in a psychiatric context is complex. In the existing literature, little is known about the nature and prevalence of traumatic stress in psychiatric hospitals, however, the findings of the current study have brought much needed attention to the notion that treating trauma comes with both risks and benefits. From the interpretive analysis, findings depict that trauma work evoked psychological distress within participants in response to the trauma narratives of their patients [8, 15, 21].

When talking about psychological distress, the findings identified shared feelings of shock, sadness, and frustration amongst all participants in response to trauma narratives. Allen’s brief feeling of shock speaks to his resilience which allows him to recover quickly, thereby experiencing a normal reaction to an abnormal event [22, 23]. Ruby and Annie differed from Allen in terms of feeling anger and fear. These experiences put clinical psychologists at risk for vicarious trauma [1, 24]. Each emotional reaction was triggered by the participants’ experiences. For example, Ruby experienced physiological symptoms in response to a dangerous patient she interviewed, evident in her trembling, fearful reaction, and this adds emphasis to her experience in a setting which she perceived as threatening. In support of this finding, Sui and Padmanabhanunni [8] similarly found that somatic complaints of physical exhaustion are common with trauma work.

Both Annie and Ruby reflected on treating victims and perpetrators. Annie experienced feeling confused at having to treat someone who inflicted pain on another, whereas Ruby described being hyper-vigilant sitting in the presence of a dangerous patient.

However, Allen differed in this regard, as he was rather curious about the perpetrator's presentation as opposed to fearful of it. A study by Olashore et al. [25], similar to the current study, explored the prevalence and predictors of PTSD in a psychiatric setting in Botswana, where findings depicted that mental health practitioners who were physically harmed by patients were at risk for PTSD. Recently, Booysen and Kagee [1] supported this finding in the Eastern Cape and Western Cape by highlighting that the context in which mental health practitioners work can perpetuate the burdens of traumatic stress. In corroboration with the findings of the current study, McCann and Pearlman [24], as well as Sui and Padmanabhanunni [8], identified that feeling unsafe and experiencing mistrust were common amongst psychologists working with trauma. In contrast, treating child victims of trauma reflected a converging sense of helplessness for Annie and Ruby and, although the literature is limited, the theme of helplessness is also present in Allen's narrative and existing literature [1, 8, 26].

Furthermore, in the findings, participants highlighted powerful complex meanings related to a socio-political context while treating trauma in a psychiatric hospital. This finding speaks to the overall message that one cannot treat trauma devoid of its social context [1]. The experiences of the participants made reference to gender and culture, suggesting that socio-demographic factors perpetuate challenges when treating trauma in a psychiatric hospital. The existing literature does not point to these findings directly, however, Booysen and Kagee [1] found that socio-demographic factors do in fact precipitate traumatic stress, but in low-resource communities. Issues of gender, race, culture, and politics are not readily referred to in the treatment of trauma, yet there is an awareness of the interplay between trauma and the social context from which it stems. For example, Allen referred to his role as a White male clinical psychologist treating "Coloured" trauma victims in post-Apartheid South Africa, reflecting on how his presence affected the therapeutic process. Annie, in

contrast to Allen, struggled with the topic of initiation as a White English female psychologist. These reflections refer to this overlooked dimension in understanding and treating traumatic stress.

The female participants reflected distinctly on family and work. Specifically, motherhood emerged prominently as Annie and Ruby's experiences of treating trauma influenced how they parented their children and how they themselves felt about the safety of the world around them. Annie and Ruby's experiences reflected suspicious and hyper-vigilant behaviours in their personal lives, which influenced their protective roles as mothers. Vicarious symptoms of hyper-vigilance seem to be more common for Annie and Ruby, whilst Allen had no noticeable concerns for safety. Arguably, the difference in experiences alludes to how men and women might experience treating trauma, especially in a psychiatric hospital, diverse in terms of gender. This finding concurs with the existing literature that women are more at risk to traumatic stress than men [27, 28]. The impact of treating traumatic stress experienced in the personal and professional lives of clinical psychologists in a psychiatric hospital illustrates the importance of navigating ways to maintain their mental well-being [29, 30].

All three participants expressed using supervision and peer supervision as a means for support, whilst reflecting on the psychiatric hospital as a supportive environment. This suggests that a supportive collegial environment is helpful and can mitigate the effects of vicarious trauma [31]. In addition, they expressed trauma work to be "taxing but rewarding", feeling hopeful and grateful to be part of a patient's process and progress, despite the process being tumultuous at times [32, 33]. All three participants also reflected on upholding their boundaries, developing successful coping strategies, and trusting the process with years of experience. Zaccari [34] supports this finding on boundaries and self-care as a way to create balance and maintain healthy lifestyle choices.

This study has a number of limitations. The first author was known to two participants, having previously briefly collaborated with them in a professional capacity. This prior contact was seen as an advantage in obtaining honest reflections, although it is possible that the participants may have felt an obligation to participate. Generalisability of this study needs to be considered with caution as the sample size was relatively small with only three interested psychologists. There was also a concern that the results may generate a negative impression of clinical psychologists in practice, however, by paying attention to the participants' coping strategies, the study's results have in fact enriched the understanding of their lived experiences. The study was conducted during the eased lockdown restrictions of the Corona Virus pandemic, which may have captured added burdens of the impact of traumatic stress during this trying time.

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

Conclusion

It is evident that experiences do arise, when clinical psychologists treat trauma survivors at a psychiatric hospital, which can lead to vicarious trauma and traumatic stress. This study observed an added element of danger whilst treating high-risk state patients, exposing psychologists to traumatic stress. However, the participants highlighted that trauma work can

also be rewarding and creates vicarious post-traumatic growth. With the use of unique coping strategies, participants showed themselves to be resilient, and as a result, are less likely to experience debilitating symptoms of trauma. This shows conclusively that clinical psychologists who engage in self-care and supportive strategies protect themselves from long-term risks. Furthermore, a socio-political aspect to treating trauma that was not found extensively in previous research was found in the current study. Psychologists recognised culture, their gender, race, and the impact this has on their roles in their personal and professional lives while working within the field of trauma.

Acknowledgements

We want to acknowledge the participants for participating and sharing their unique experiences.

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