Received: 24 February 2023 | Revised: 15 September 2023 | Accepted: 3 November 2023

DOI: 10.1002/smi.3353

WILEY

RESEARCH ARTICLE

Listening to other people's traumatic experiences: What makes it hard and what could protect professionals from developing related distress? A qualitative investigation

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Abstract

Listening to people talk about their trauma experiences involves indirect exposure to trauma (IET) and can trigger emotional distress. Existing studies about the risk factors for post-IET distress have methodological limitations and reported inconsistent results, making their findings difficult to meaningfully synthesise. Also, most of them did not focus explicitly on trauma narratives and did not explore qualitatively the opinions and experiences of professionals who work closely with trauma survivors. The present study involved 36 professionals who worked with trauma survivors and used a qualitative design to investigate: (a) the perceived impact of the survivors' accounts, (b) the factors they deemed as important to be psychologically prepared for trauma accounts, and (c) their strategies for coping with IET. The semi-structured interviews conducted yielded rich data that was analysed thematically and organised in 13 subordinate themes, and 4 master themes. Listening to trauma narratives was thought to lead to emotional distress when it challenges the listener's 'basic assumptions' of safety and justice, when the listener has reduced sense of control and operates outside their 'window of tolerance', when empathic responses are too strong, and psychological preparedness for trauma-narratives is perceived as insufficient. Recommendations for future research and implications for practice are discussed.

KEYWORDS
compassion fatigue, preparedness, qualitative, secondary-traumatic stress, trauma

1 | INTRODUCTION

Listening to people talk about their traumatic experiences involves indirect exposure to trauma (IET) which can lead to significant emotional distress (Butler et al., 2017; Michelson & Kluger, 2021). Those who work closely with trauma survivors (e.g., mental health (MH) professionals, emergency service staff, etc.) are especially at risk (American Psychiatric Association, 2013). Systematic reviews that examined vulnerability factors for post-IET distress, did not exclusively focus on the experience of listening to trauma survivors talk about their experiences, but included studies based on people with a broad range of IET (e.g., witnessing severely injured people). The studies included in these reviews highlighted various risk factors for post-IET distress, including but not limited to, personal history of

trauma, blurred boundaries, poor physical health, inadequate training, fewer years or professional experience, high peri-traumatic stress or stress levels at work (reflected through inadequate staffing or resources, working nightshifts, having a heavier caseload, etc.), personality traits (e.g., empathic aptitude, lower levels of dispositional optimism or mindfulness), poor self-care, lack of social support and unhelpful use of alcohol and tobacco (Baird & Kracen, 2006; Greinacher et al., 2019; Hensel et al., 2015; McGrath et al., 2022; Page & Robertson, 2022; Rhineberger-Dunn et al., 2016; Rivera-Kloeppel & Mendenhall, 2021; Sinclair et al., 2017; Turgoose et al., 2017). Nevertheless, the results of these reviews are sometimes inconsistent and thus difficult to meaningfully synthesise. For example, in some studies personal history of trauma increased the risk for post-IET distress, whereas in others it did not (Baird & Kracen, 2006). Similarly, in some studies having had more IET was protective, whereas in other studies it was a risk factor (Baird & Kracen, 2006). Also, studies examining the role of empathy, a staple skill of helping professionals, produced inconsistent results (Crumpei & Dafinoiu, 2012; MacRitchie & Leibowitz, 2010; Robins et al., 2009), with some suggesting that empathic bonds could be harmful (MacRitchie & Leibowitz, 2010). These inconsistencies may be due to the methodological differences of the existing studies (e.g., the use of different instruments to assess post-IET distress, including participants from different occupational groups, etc.) (Greinacher et al., 2019; Rauvola et al., 2019). Moreover, different terms have been commonly used in various studies (Greinacher et al., 2019; Page & Robertson, 2022; Sinclair et al., 2017; Turgoose et al., 2017) to describe post-IET distress, for example, 'compassion fatigue', 'compassion stress', 'vicarious traumatisation' or 'secondary traumatic stress'. Although these terms refer to similar emotional states, they are not entirely synonymous (Ting et al., 2005).

In addition to these methodological differences, some of the studies based their results only on one relatively homogenous group of professionals, for example, correction officers (Page & Robertson, 2022), MH professionals (Turgoose et al., 2017) or first responders (Greinacher et al., 2019), whereas relatively few were based on mixed groups of professionals (Manning-Jones et al., 2016; Molnar et al., 2017).

Qualitative studies can help further our understanding of complex psychological responses (Ritchie et al., 2013). However, most of the available qualitative research regarding IET focuses on its emotional aftermath, post traumatic growth and coping strategies (e.g., self-care, peer support and personal therapy) (Cohen & Collens, 2013; Pellegrini et al., 2022), but does not specifically explore when or why listening to other people's trauma experiences can lead to adverse emotional reactions (Pellegrini et al., 2022).

Also, to date little is known about factors that could potentially increase a professional's psychological preparedness for IET. The concept of psychological preparedness for trauma (PPT), was guided by evidence from the animal literature that predictable and uncontrollable stressors generally have more deleterious effects than do predictable and controllable ones (Başoğlu & Mineka, 1992). The concept was further developed through research involving survivors of torture (Başoğlu et al., 1997) and observations in the field of natural disasters (Reser & Morrissey, 2009). Başoğlu et al. (1997) conceptualised it as a psychological state, characterised by readiness for trauma, knowledge about what it involves, experience of having coped with similar trauma events in the past and a particular mindset, that reflects less endorsement of basic assumptions of justice and benevolence in the world (Janoff-Bulman, 1992). Psychological preparedness for trauma played a protective role in people exposed directly to political violence and torture (Başoğlu et al., 1997) and may be as protective for professionals with IET, especially to novices (e.g., new therapists, new recruits in the police, etc.) who might be more vulnerable (Brooks et al., 2020).

1.1 | Purpose of the present study

The present study used a qualitative approach to address some of the gaps in the literature discussed above. We focused on the opinions and experiences of professionals who have IET as part of their jobs and aimed at answering three key research questions: (a) When is it harder to listen to other people's trauma accounts? (b) What could psychologically prepare a person before they listen to a trauma account? and (c) What does effective coping involve and what could hinder it or promote it? For the purposes of the present study, since our focus is not directly on definitional issues or symptomatology, the term 'post-IET distress' will be used as an umbrella term, covering all the terms that describe adverse emotional responses to IET.

2 | METHOD

2.1 | Participants and procedures

Data was collected between January and September 2021 by the second author (Kate Whittenbury) and three post-graduate students of psychology at Manchester Metropolitan University (UK), who had been trained in qualitative methods at Master's level, and were supervised by the first (Dr Maria Livanou) and third (Dr Daniela DiBasilio) authors. Participants were recruited using a purposive sampling technique (Robinson, 2014). In detail, an advert was posted on the professional Twitter and LinkedIn accounts of the data collectors and information about the study was shared with their professional contacts, who included key professionals within the fields or networks of interest (e.g., therapists, fire-fighters, etc.). To be included in the study participants had to (a) be older than 18, (b) be fluent in English, (c) work as a first responder (e.g., police, fire-fighter, etc.), psychologist practitioner, therapist, prison officer, child-protection officer or social worker for at least 6 months, (d) have access to a computer and enough privacy for the interview, and (e) have experienced IET as part of their job through listening to people who have faced one or more traumatic events. Our original aim was to recruit 20 to 40 participants, as previous qualitative studies reported that this number was required to achieve data saturation (Green & Thorogood, 2018; Hagaman & Wutich, 2017).

Professionals self-identified as eligible for participation, after seeing an advertisement for the study that invited for participation professionals who "often listen to other people's traumatic experiences" and listed the study's inclusion criteria. Interested participants contacted the research team, who responded by sending them an information sheet with details about the aims of the study and participation. Professionals who chose to participate were offered an online semi-structured interview via Microsoft Teams, at the start of which we obtained their consent. Whilst obtaining consent, all participants confirmed that they had carefully read the information that was sent to them about the study (which also listed the inclusion criteria). No participant had a previous relationship with the researcher who conducted their interview. Interviews lasted on average 40 min and included questions directly addressing the key research questions mentioned above (e.g., "Would you like to tell me about times when you were affected by stories of your clients or the people you worked with?"). The interview schedule is available by the first author (Dr Maria Livanou) upon request. Recorded interview data was pseudo-anonymised and verbatim transcribed. The study was reviewed and ethically approved by the Faculty of Health and Social Care Research Ethics Committee at Manchester Metropolitan University.

2.2 | Data analysis

The authors, whose epistemological position is pragmatism (Allemang et al., 2022; Goldkuhl, 2012), analysed the data with hybrid thematic analysis (TA) (Fereday & Muir-Cochrane, 2006; King, 2004; Swain, 2018) using both inductive (data-driven) and deductive (theory-driven) coding. The inductive TA process involved first reading and re-reading carefully the transcripts, identifying meaningful units of text, and encoding them prior to interpretation. Deductive TA was subsequently used, scanning a subset of the transcripts to evaluate the applicability of a priori codes (Boyatzis, 1998). Some of these were based on the preliminary scanning of the transcripts and others guided by previous literature on IET and the main research questions (Fereday & Muir-Cochrane, 2006; King, 2004). Next, codes were connected and initial themes identified. Finally, coded themes were confirmed (Crabtree & Miller, 2022). The software package NVivo (QSR International Pty Ltd, 2018) was used to assist the process of coding.

2.3 | Rigour and trustworthiness

To strengthen the credibility of the analytic process and counterbalance individual influences on coding (Barker & Pistrang, 2005; Flick, 2004; Hill et al., 1997), KW who took a leading role in analyses, and ML who analysed a subset of the transcripts, met often to compare the codes each of them generated and discuss potential themes. Towards the end of analyses, no new codes or themes were added to the data set, suggesting that saturation was reached and all major themes had been identified. Using a consensus approach (Hill et al., 1997), all authors met to discuss different ways of conceptualising and presenting the results and an agreement was reached on the final set of superordinate and subordinate themes. Finally, these themes were reviewed and discussed by all authors, to ensure theme distinctiveness and accurate reflection of the data.

To strengthen transparency and rigour (de Jong et al., 2021), the Consolidated Criteria for Reporting Qualitative Research (COREQ; Tong et al., 2007) were used in reporting methods, results and discussion.

3 | RESULTS

Participants included 22 MH professionals (5 clinical psychologists, 2 trainee clinical psychologists, 4 assistant psychologists, 4 counsellors, 6 therapists, and one MH nurse), 6 police officers, 3 social workers, 3 paramedics (1 final year trainee, 2 fully qualified), one prison officer and one child exploitation specialist. Their ages ranged from 18 to 57 and the majority (n = 28, 78%) were female. Although information about the participants' years of professional experience was not systematically obtained, some spontaneously offered this information: eleven (31%) reported years of experience that ranged from 2 to "more than 10" years, whereas 5 (14%) implied they had relatively little experience (e.g., "newly qualified", "trainee psychologist"). The remaining 20 participants (56%) did not offer any information on their years of professional experience.

The analytic process resulted in the development of 13 subordinate themes that were subsequently organised into four master themes (see Table 1).

3.1 | Master theme 1: A new awareness of danger and malice

3.1.1 | Challenged assumptions of safety and justice

Indirect exposure to trauma can challenge the participants' pre-existing assumptions and beliefs, especially those relating to the world being a safe and just place. Some developed a new awareness of the dangerousness of the world, and the magnitude and frequency of adverse events.

> I think you just become overwhelmed by the horror of what you've listened to and the knowledge that this stuff goes on and … your concerns for that child (for) the future and how they impact them… It's just not nice. It's just not the sort of stuff you want to be hearing on a daily basis, really.
>
> (Anna, Police Officer)

For some, working with certain groups (e.g., children and elderly people) was more stressful, as they perceived these groups to be more vulnerable or "harmless", implying the assumption that innocent or vulnerable people do not deserve to be traumatised.

TABLE 1 Master themes and related subordinate themes.

	Master themes	Subordinate themes
1.	New awareness of danger and malice	Challenged assumptions of safety and justice
		Trauma too dark or severe
2.	Lack of control and narrowing windows of tolerance	The struggle to control and contain
		Survivors' overt expression of distress or dissociation
		IET triggers own traumas
		Stress and difficulty in self-regulating
3.	Empathy: The double-edged sword	Emotional immersion
		Maintaining boundaries
4	The prepared mindset	Prior knowledge, training, and expectedness
		Commitment to professional ethos
		Self-awareness and acceptance of limitations
		Scission between professional- and personal-self
		Knowing that it's not over when it's over

> … there are (predominantly) young people at risk … young people who have been in the care system, erm young people who are LGBTQ, young people who have got MH struggles. So, for me it would be hearing how vulnerable they are and how a perpetrator can exploit that vulnerability.
>
> (Jessica, Child Exploitation Specialist)

Relating to the survivor seems to intensify the reality of the trauma when it challenges the professional's assumptions of personal invulnerability or safety.

> If you're working with someone that's experienced childhood trauma and you've got a child, that's probably gonna make you more affected, because … you kind of put your children in that scenario.
>
> (Lucy, Trainee Clinical Psychologist)

3.1.2 | Trauma too dark or severe

Some participants were affected more by IET which involved events or situations that they considered particularly evil, dark or severe (in terms of magnitude, nature and chronicity).

> …it is the degree of sadism. You know, the more sadistic someone's abuser has been, the more it gets to you because it is just so difficult to hear. You do have moments where you think 'I don't know how you are still alive, I don't know how you have managed to keep your mind alive through all of this'.
>
> (Sophie, Psychotherapist)

Making sense of traumatic events that are particularly severe may be difficult. Some professionals described difficulty in performing professional duties when first learning about a clients' traumatic experience.

> I couldn't get this story out of my mind… I remember, I actually couldn't write my notes after the session… I couldn't process it in my mind…I thought there is no point writing notes at the moment because it is all a bit of a blur
>
> (Eleanor, Counsellor)

3.2 | Master theme 2: Lack of control and narrowing 'windows of tolerance'

3.2.1 | The struggle to control and contain

The participants often referred to the importance of controlling own thoughts, behaviour, and emotions during IET. A commonly held view was that they also need to control the broader context in which IET takes place, and particularly the survivors' emotions. One of them expressed the view that the professionals' lack of control can have a detrimental effect on the survivor, letting their emotions 'spiral out of control' (Amanda, Counsellor). Another used a metaphor to explain how self-control is a necessary precondition for containing the survivors' distress.

> … sitting in the room … you've got to not only contain your emotions, but you've got to contain theirs as well. I always like to use the metaphor about being on a plane and if the … air masks come down you need to

> put on yours before you put on someone else's because if you're not stable and not able to contain your own emotions, there's no way that you're gonna be able to do that to other people.
>
> (Lucy, Trainee Clinical Psychologist)

Some participants felt that lack of self-control during IET limits the professional's ability to conduct good quality work and be useful.

> Everybody is hysterical and crying and if I don't go in and deal with it, well… and I'm just joining the hysterical …see what I mean? I need to be the person who keeps it at one level and brings everyone else down, otherwise it'd just be carnage. It's knowing that if I don't cope with it well, then the situation is not going to be dealt with and not going to be controlled, because that's my job, really, to sort of control situations.
>
> (Tilly, Police Officer)

3.2.2 | Survivor's overt expression of distress or dissociation

The survivors' overt expressions of severe distress can make listening to their trauma-accounts harder, triggering in the listener intense emotional reactions.

> We did a reliving of that event and it is the most harrowing horrendous story I have ever heard in my life and I, along with him, we both just cried our eyes out while he told me this story and he relived it, in the way that we do in trauma-informed CBT. He was back there, he had his eyes closed, he was visibly, I can't even describe, it was almost like he was dissociating. … It broke my heart for him.
>
> (Jack, Clinical Psychologist)

Conversely, emotional numbness was considered to be a sign of trauma that was so painful that the survivor could not talk about it without emotionally disconnecting from it.

> … no pitch and tone and no reaction to the trauma… I think it's almost that disconnection that makes it harder. Maybe almost like a transference… I'm taking on those feelings that perhaps they do feel somewhere about it, but can't express… that flatness of not having any connection to it. I think it affects me more.
>
> (Monday, Clinical Psychologist)

3.2.3 | Indirect exposure to trauma triggers own traumas

Indirect exposure to trauma can trigger memories and emotions of personal trauma, making the professional feel defenceless and unable to control own thoughts and feelings while working with a survivor.

> I was working with someone that had similar experiences to me and I think I hadn't quite processed everything that had gone on, myself. So, I think within the session… I just didn't have any defences up. I was just …imagining myself fully as this person. I was not active in the room. I was quite passive.
>
> (Lucy, Trainee Clinical Psychologist)

Some professionals acknowledged how the triggering of their own past trauma can be challenging but highlighted how it had been useful, increasing their empathy for the survivors.

> Just makes me feel slightly more connected to the person, though when I go home it's harder to step away from it because you can get consumed by it… Like I said, it triggers things for you. It triggers what I went through in the past …things you've boxed off in your head and not really thought about in a while. It can resurface things… which is obviously going to be more traumatic…
>
> (Tilly, Police Officer)

3.2.4 | Stress and difficulty in self-regulating

Indirect exposure to trauma was thought to have a more negative emotional impact when it coincided with periods during which the professionals are stressed for other reasons.

> …if you're having difficulties in your emotional relationships in your personal life, it becomes more difficult because it's just harder to emotionally regulate yourself. The more emotionally calm you are going to work, the easier is to regulate yourself in response to emotional stimulus you're getting from the children.
>
> (Anna, Police Officer)

Stress was seen as influencing the professional's ability to self-regulate effectively, but both stress tolerance and ability to self-regulate were sometimes portrayed as fluctuating, depending on the professional's personality and life circumstances.

> …call it 'the bucket'… The bucket …can only get so full… before it starts to spill out, and these things manifest in

> ways that aren't normal for the individual… You will slowly begin to see a decline in personality, appearance, weight loss…
>
> (Charlie, Student Paramedic)

3.3 | Master theme 3: Empathy: The double-edged sword

3.3.1 | Emotional immersion

All participants stressed the importance of being empathetic when working with survivors of trauma, but their understanding of what is empathy varied. For some empathy was about perspective-taking, even though some questioned whether it is ever possible to achieve it:

> We are working with humans. There has to be that ability to empathise and to try and see the world from their perspective. Obviously, you're never going to be able to do that, 'cause you can't see inside another person's mind, you know. You can't fully feel what they're feeling… Your interpretation of what they're feeling is based on your own experiences and how you might react to a situation.
>
> (Lucy, Trainee Clinical Psychologist)

> For others, it is about being immersed into the clients' world and feelings.
>
> We try and get into the world of the other person and we start to feel what they feel or felt.
>
> (Amanda, Counsellor)

Some participants, especially MH professionals, highlighted the potential risks connected to a deep 'empathic immersion' in survivors' experiences.

> I think if you step into somebody's shoes you are, it's a dangerous sort of territory. If you are stepping into somebody's shoes constantly and if you think that is what empathy is then you are going to cross the boundary and it could be very detrimental to counsellor and to client.
>
> (Eleanor, Counsellor)

This concept was also described by another participant using the 'ditch metaphor', which describes the need for the 'listener' to connect empathically but maintain a separation between their own and the survivors' feelings and mental states, to protect both the client and the therapist.

> Don't jump in the ditch with the client, because then you're not empathising. You're in there with them. And I think, if you're doing what I described before, you're kind of going beyond that and you're getting in there with the person. You're not saying 'That's their experiences. This is my experience'.
>
> (Kelly, Counsellor)

3.3.2 | Maintaining boundaries

Some participants expressed the view that professional boundaries protect the professional's psychological wellbeing, but also work for the advantage of the survivors, because the emotionally composed or "uninvolved" helper can offer more assistance.

> …for me, that's about the boundaries. What's theirs, what's mine? … You can see that they are metaphorically swimming in their trauma and it's about not jumping in with them and trying to save them whilst drowning in it. It's about throwing them a rope to pull them out, but you are not going to do any good if you drown in that sea with them.
>
> (Amanda, Counsellor)

Yet, professionals may experience the urge to over-step professional boundaries. This can make them too emotionally involved with the trauma survivors and less able to deal effectively with IET.

> It is very hard to be with a young person when they are visibly upset crying …because then… for me, an instant reaction is to give that young person a hug and obviously there are professional boundaries there…I find, in that moment, it is very difficult. But it probably affects me more after. I find it very hard to switch off and say 'right, the laptops shut at 5pm' because if we are being honest, we absolutely care and love these kids … so we do have to set those boundaries in place.
>
> (Jessica, Child Exploitation Specialist)

3.4 | Master theme 4: The prepared mindset

3.4.1 | Prior knowledge, training and expectedness

Prior generic knowledge about what is trauma and about its emotional consequences was considered protective. Many suggested that prior knowledge and training helps people understand better the trauma survivors but also helps to understand their own reactions to IET.

> Being trauma informed. Learning about trauma. What trauma is. How trauma affects the person they are going to be working with. … And understanding the actual psychology behind that and your reactions is really helpful
>
> (Jessica, Child Exploitation Specialist)

Expecting to have IET at work was also considered important in preparing psychologically and managing better personal resources.

> If I know if I've got a difficult interview coming, I'll try and keep my day as calm as possible in the lead up to it. I'll be as organised. I think organisation as well helps your resilience … So, I'd say self-regulation, organisation, and just being clear about what it is you need to do when you're having an interaction with someone who's got quite a lot of trauma.
>
> (Anna, Police Officer)

3.4.2 | Commitment to professional ethos

A strong sense of commitment to one's professional duties can buffer the adverse effects of IET, through distraction, that is, by helping the listener to stay focused on professional tasks.

> When something's ongoing, and you're having to deal with (it)… your duty and your (ethics), the reason that you do the job kind of kicks in. And as a product of that… I personally find that easier to deal with. Because it's almost process-driven. That's a horrible way to describe it, but in terms of dealing with emotion, if you're task-focused… it helps direct your emotional input…
>
> (Charlie, Student Paramedic)

One participant described how strong commitment can empower the professionals, fuelling further their motivation to help the survivors.

> We all hear a lot of s**t. People off load it to each other, but we also channel it in to 'okay, how can we get the best outcome for this person?' … if we effectively get together and go 'right, but what can we do to help?' It really helps, because we can direct it somewhere positive.
>
> (Jack, Clinical Psychologist)

3.4.3 | Self-awareness and acceptance of limitations

Participants who were MH professionals valued self-awareness, proposing that it can help one better predict which situations may be particularly challenging for them and take preventive action when possible.

> We have supervision and we unpack that, and say that "This client has started to invoke things in me. Yeah. It's really starting to stir me up". I think, you have to be mindful, know ourselves well, what clients we want to take on and who we don't want to take on, because of how it could trigger us too.
>
> (Amanda, Psychotherapeutic Counsellor)

Being conscious of one's own weaknesses and past traumas and of the value of personal therapy to help increase self-awareness were highlighted as attributes that psychologically prepare a professional to face IET.

> It's about awareness of our past. It always amazes me that some counsellors, therapists, psychologists, psychiatrists come to this kind of work without having their own therapy… I think we have all had (trauma) in our lives and it is about understanding what has happened to us and what impact it has on us. I think that can be really harmful to ourselves as clinicians and also to our clients as well.
>
> (Amanda, Psychotherapeutic Counsellor)

For some, increased self-awareness meant knowing how much IET you can take and finding a balance between professional tasks that involve contact with trauma survivors and other tasks.

> I have colleagues that would be keen to … work more full-time, working with trauma. I'm not entirely convinced that that's necessarily a sensible approach … My feeling is there needs to be some level of balance, so that you're not always listening to the horrors of what has happened to people in their life.
>
> (Tomato, Clinical Psychologist)

Self-awareness and in particular acceptance of own limitations was also seen as protective against post-IET distress.

> No matter what work we can come in and do, and we do incredible work with young people, unfortunately sometimes no amount of work is going to be enough to completely wipe out that trauma. I think that is impossible.
>
> (Jessica, Child Exploitation Specialist)

3.4.4 | Scission between professional- and personal-self

Many participants described a consciously desired and sought-after scission between their 'professional self' and their 'personal self', which helped them protect their psychological wellbeing.

> For example, if my sister told me something very traumatic, that would be a different story because I imagine I would be feeling different things. I would be very heavily emotionally involved. But because it is a client and it is a professional relationship, it's not a friendship, is it? It's a professional relationship and there are boundaries and I am bound by my ethical guidelines to work within those boundaries, so I think that helps.
>
> (Eleanor, Counsellor)

This intentional separation between professional- and personal-self, was considered helpful in containing work-related feelings and experiences, without letting them spill over and affect other areas of their lives. For example, Mary, who is a psychotherapist, described being better prepared for IET when they had their 'therapist hat' on. For them, the impact of traumatic information was lessened by being conscious of one's professional role. Similarly, others also reflected awareness of a work-personal life division, when explaining that feelings can be contained within a particular environment and not transported beyond that.

> I do try and keep work and home quite separate. I kind of walk into work and leave home at home, and then leave work and leave work at work. I think because if not, if you don't have something like that, it can just eat you up and take over your life.
>
> (Francesca, Assistant Psychologist)

3.4.5 | Knowing that it's not over when it's over

Participants stressed the importance of self-care, discussing the value of various activities (e.g., exercise, personal therapy, reading, meditation, etc.). Some suggested that self-care has to be individually-tailored to maximise benefit. Others stressed that a self-care plan is useful when it is in place before IET or forms part of training.

> So, for me, it's a walk. For some of my students, it will be a run or yoga or, you know, sometimes a hot bath or whatever it is. … So, I would recommend that we get people to reflect on what could you do to look after yourself. What can you do? Can you make sure you don't see clients back-to-back and that you have space to go for a walk around the block or whatever it is…?
>
> (Kelly, Counsellor)

Receiving emotional support was also considered important in the context of after-care and was linked with resilience. Support from family or friends however was often considered less useful or inaccessible. Outsiders to the profession may be less able to understand the complexity of the work and the personal impact of it. Some might be unwilling to listen to the stressful experiences of the professionals. Also, the professionals may be unable or unwilling to share their experiences.

> I don't wanna tell people. Of course, everything is through data protection, so you can't share everything, anyway, and you anonymise the prisoners. But I don't want to share that with everybody, because people don't understand the same, whereas …the guys at work are like I said going through the same stuff. Or not even that they don't understand; I don't wanna shock people all the time, you know, and I don't want to burden anybody else …
>
> (Ashley, Prison Officer)

'Bottling up' one's emotions and thoughts provoked by IET, was seen as an unhelpful coping strategy which can lead to emotional distress. Finding the courage to speak up when one is struggling was considered vital in one's self-protection against the adverse effects IET.

> When I first began this role, I probably wasn't as assertive as I could have been and you know sort of "I'm fine, I'm fine". And then, when you get further down, you are sort of like 'actually this is how I am feeling. I'm not fine, I could actually do with some help. Could you guide me through this?"' … I think just being open and honest with your feelings is very helpful and just getting over that barrier.
>
> (Francesca, Assistant Psychologist)

Supervision was also viewed as a useful protective practice, providing a safe place to share experience of IET and process it as well as their own associated reactions. The usefulness of supervision was predominantly brought up by MH professionals and social workers, but not by police officers or emergency workers.

> What makes you less vulnerable is good supervision, so if you've got somewhere you can debrief, where you can speak about what's happening, what's processing, why you feel a particular way towards this case … you can kind of know what your values are and your own belief systems and have that self-awareness and reflexivity. I think that helps you manage those situations better.
>
> (James, Clinical Psychologist)

4 | DISCUSSION

Our results suggest that listening to trauma accounts may be more distressing when it makes professionals aware of a dark, dangerous, malicious and unfair world, where misfortune strikes vulnerable people. These findings support previous suggestions by Janoff-Bulman (1992), about exposure to trauma shattering people's assumptions of others being benevolent and the world being a just, meaningful and safe place. The shattering of such beliefs (henceforth referred to as 'basic assumptions') is thought to trigger emotional turmoil (Janoff-Bulman, 1992). Professionals who work with trauma survivors may be more trauma-informed, yet our results suggest that they too can foster 'basic assumptions', which in the course of their work get shattered. This may be even more likely when they can relate personally to the survivor, thus becoming more conscious of danger and their own vulnerability. The possibly predictive role of

basic assumptions has not yet been adequately examined. A prospective study based on trainee police officers (Yuan et al., 2011) reported a negative association between basic assumptions and Post-Traumatic Stress Disorder (PTSD), but in that study social desirability effects were not considered, thus the trainees might have under-reported negative or pessimistic world-views, to avoid seeming misanthropic. However, others (Başoğlu et al., 1996) reported that a lack of beliefs concerning a "benevolent state" may have protected political activists from the effects of state-perpetrated torture, thus suggesting that a more negative or cynical view of the world before trauma-exposure, or before joining a profession that involves IET, may be protective. Future prospective studies need to examine this issue further.

The participants also connected post-IET distress with situations that reduced their perceived control and made them less able to self-regulate and/or contain the survivors' emotions. What they described is in line with the notion of operating outside one's 'window of tolerance'. The latter, a paradigm first proposed by Siegel (1999), describes the zone of 'arousal' (emotional zone) where one functions optimally and is able to regulate emotions and practice self-control. When a person is forced out of their 'window of tolerance', they have difficulty in self-regulating (Siegel, 1999). Accordingly, when the survivors' accounts triggered memories (and related feelings) of personal trauma, and when overall perceived stress increased, our participants' windows of tolerance might have shrunk, making it hard to contain own or other's distress (Risan et al., 2016).

Furthermore, in the context of counselling or psychotherapy, 'holding' and 'containing', that is, providing an emotionally caring and protective space, allowing emotional expression and exploration (Finlay, 2016, p. 73), is considered very important. For participants who were MH professionals, inability to self-regulate and contain (or 'hold') the survivors' feelings, could be particularly stressful, signifying failure to perform an important professional role. For first responders, the need to regulate the survivors' emotions was sometimes presented as part of their work-related duties. On a less conscious level, however, trying to control the survivor's distress might have been an act of self-protection, given that exerting control over stressors reduces their emotional impact (Başoğlu & Mineka, 1992; Foa et al., 1992). It may be useful or essential to regulate the survivors' emotions in some professional contexts (e.g., a police officer at the site of a crime tries to obtain information) but not in others (e.g., when offering emotional support or counselling to survivors). Expressing trauma-related emotions in a safe environment is considered extremely helpful in trauma-recovery (Craske et al., 2014; Foa & Kozak, 1986). Thus, a helpful stance may be to not block trauma-related distress when working with survivors.

Previous studies also associated post-IET distress with work-related (Creamer & Liddle, 2005) or general stress (Arvay & Uhlemann, 1996) or with a personal history of trauma (Baird & Kracen, 2006), but none of them considered the mediating or moderating role that loss of control may play during IET. Loss of control can also be experienced when the survivors express overtly severe distress. Exposure to other peoples' distress can trigger strong empathic reactions, especially if the person who witnesses it is very perceptive of emotions (Batson et al., 1987; Batson et al., 1994; Preston & de Waal, 2002). Individual differences in emotion perception and recognition (Chikovani et al., 2015) could make some more vulnerable than others. Moreover, simply the presence of distress-related visual or auditory cues (e.g., tears, voice cracking, etc.) could intensify the impact of trauma-related information, by facilitating or augmenting empathic distress. If so, compared to people whose IET is limited to learning the survivors' trauma accounts (e.g., judges or psychology students exposed to case studies, etc.), people who have also face-to-face contact with survivors may be more at risk. In spite of these considerations, most of the existing studies of risk factors for IET did not consider adequately emotion recognition. Future studies need to address this gap and examine whether the presence of audio-visual emotion-laden stimuli augments the impact of IET.

Empathy was also implicated in the development of post-IET distress, especially when it led to blurred boundaries. However, even within the same profession, participants did not share a common understanding of empathy. For some it was about perspective-taking; for others it involved emotional immersion into the survivors' experiences. Sometimes that immersion was considered desirable or necessary in establishing trusting relationships with the survivors, but other times it was described as accidental, resulting from loss of control. Participants often contrasted empathy with sympathy and considered the latter to be poor practice. Yet sometimes their understanding of empathy overlapped with existing definitions of sympathy, that is, with having a heightened awareness of the survivors' suffering, accompanied by a feeling of care and concern, and a wish to see them freed from their suffering (Wispé, 1986). In contrast with empathy, a shared perspective is not central in sympathy (Burton, 2015), but some participants perceived the two concepts as being on a continuum, where too much empathy becomes sympathy. These findings support previous suggestions that 'empathy' is used to express various concepts or phenomena, including sympathy (Batson, 2009). Also, our participants' experiences were accordant with other evidence-based suggestions (Breithaupt, 2012) that people cannot help but empathise with others and that empathic reactions can be very powerful, involving the sharing of other people's feelings and potentially self-loss.

To our knowledge, ours is the first study to explore qualitatively components of PPT in the context of IET. Our results supported previous suggestions (Başoğlu et al., 1997) about PPT consisting of prior knowledge, training and readiness for trauma, and a 'mind-set' that reflects commitment to a (professional) cause and less endorsement of basic assumptions. Evidence about the association between these factors and lower levels of distress has been previously supported in the context of direct trauma exposure (Başoğlu et al., 1996, 1997; Perrin et al., 2007; Pietrzak et al., 2014), and thus our study provides preliminary evidence that the same factors may be protective also in the context of IET. The participants' opinions added to what has been described as a prepared mind-set (Başoğlu et al., 1996, 1997), the ability to mentally separate work from personal life, containing work-related feelings to the work environment

and vice versa. Whether this ability is a cause or a by-product of resilience is difficult to know, without results from prospective studies. The participants also stressed the importance of being aware of one's own triggers and weaknesses in advance of IET and accepting personal limitations (e.g., not expecting that every trauma survivor will be helped). The association among these additional factors and post-IET adjustment also needs to be examined prospectively. Furthermore, future studies need to examine whether differences in training within different professions lead to some groups of professionals having a more 'prepared' mind-set.

Also, our findings are accordant with previous studies that linked better coping with peer-support (Duffy et al., 2015) and self-care (Owens-King, 2019). However, in stressing the importance of self-care and of being able to speak-up when help is needed, our participants revealed viewing post-IET care by-and-large as dependent on the professional's own actions, resourcefulness and foresight. Some of the MH professionals who participated in our study underlined the value of supervision, thus supporting the findings of previous studies (Slattery & Goodman, 2009), but for other participants post-IET self-care was not conceptualised in the context of their employers' responsibilities.

The present study had certain limitations. Our participants were recruited for their experience of listening to trauma accounts, but they might have also experienced direct trauma exposure or other types of IET. Therefore, their insights might have been influenced by their other trauma experiences and be less relevant to listening to trauma accounts. Also, by deliberately expanding our recruitment to gain insights from more than one professional context, we reduced our sample's homogeneity. Heterogeneity of sample in qualitative research could hinder the development of meaningful cross-case themes or lead to findings that are relatively removed from real-life settings (Robinson, 2014). Nevertheless, our analyses identified some thematic commonalities across our relatively diverse group of participants, making it thus more likely that these could be reflecting generalisable experiences and views (Robinson, 2014). Even so, our qualitative design precludes generalisations and this is our study's most important weakness. Paradoxically, this is also the study's main strength, as the qualitative design allowed us to yield rich contextualised data from people with first-hand experience. Furthermore, the relatively large sample size was a strength, boosting the study's fidelity (Levitt et al., 2017) and enabling the exploration of new and richly textured understandings of core aspects of IET (Sandelowski, 2001).

4.1 | Conclusions and recommendations for practice and policy

In conclusion, our results suggest that listening to trauma stories can be harder when the person who listens (i) has basic assumptions about the world being safe and just (Rossberg et al., 2010), (ii) has less perceived control over their own thoughts, emotions and behaviour and operates out of their 'window of tolerance' before or during IET, (iii) misunderstands empathy and has difficulty in controlling empathic responses, and (iv) has an 'unprepared' mindset (i.e., does not have enough knowledge about what IET involves, does not expect it to happen, has low professional commitment, limited self-awareness and awareness of own limitations, and inadequate training in how to cope during IET or self-care after it). Existing studies of risk factors of post-IET distress have neglected to consider adequately the above factors and their possibly mediating role in the development of post-IET distress.

The participants did not conceptualise post-IET care as being primarily the responsibility of the organisation for which one works. Their perceptions could be at least partly reflecting their personal experiences in working in organisations that provide inadequate or ineffective support for mental difficulties health after IET. Similar findings have been also reported by others (Gittoes, 2014; Handran, 2015). Expecting those whose jobs put them at risk of post-IET distress to fend for themselves, with little or absent organisational support, raises obvious ethical concerns. So, our first recommendation is to ensure that organisational support is always in place. Sometimes, however, organisations do offer support, but the professionals are unwilling or unable to access it. People with traumatic stress tend to avoid thinking and talking about trauma-related experiences (American Psychiatric Association, 2013) and can be reluctant to seek help for MH difficulties (Wang et al., 2005). Therefore, organisations need to be proactive in offering help to staff. For example, routine psychological wellbeing sessions (PWS) embedded in the workload could include psychoeducation, which might be useful in increasing preparedness for IET, and peer-led support, which our participants favoured. The combination of psychoeducation and peer-led group sessions can help to reduce stigma and remove barriers to help-seeking (Greenberg et al., 2010; Watson & Andrews, 2018). Such PWS can also inform newcomers into professions that involve IET about the connection between basic assumptions and post-IET distress and even involve self-assessment of such assumptions, using the relevant self-report instrument (Janoff-Bulman, 1989). Also, peer-led group sessions could include discussions about controlling empathic responses. Previous suggestions about training people to consciously limit and control empathy (Breithaupt, 2012) need to be considered in this context. Moreover, the feasibility and effectiveness of the implementation of these suggestions needs to be examined. Furthermore, PWS could also offer professionals information about when efforts to control the escalation of emotions might be useful and when instead it may be more helpful to allow survivors to express their inner feelings with fewer restraints.

In addition to peer-led components, our results suggest that PWS need to also include routine one-to-one sessions with trained trauma-focused psychology practitioners. Professionals may be uncomfortable or unwilling to share with their co-workers some of their work-related MH challenges (e.g., their own past trauma's being triggered). Employers need to ensure that staff can freely access such specialist help from independent services based outside the organisation/service in which they work. This will be of particular value to

those who have concerns about being stigmatised by their colleagues, or do not trust those in their organisation who provide MH support (French et al., 2004). The one-to-one sessions could focus on different issues, depending on the stage of the professionals' career or their personal needs. For example, for new staff they might focus on helping them explore their own strengths and vulnerabilities, finding their own 'window of tolerance', offering support when past traumas are triggered, or on helping them to engage in self-care. For others, the sessions may involve supportive discussions about work-related challenges (e.g., limiting empathy or boundary-blurring) and how to overcome difficulties in applying a self-care plan. Finally, for those experiencing symptoms of PTSD, the sessions could involve trauma-focused therapy. This combination of peer-led in-house group sessions and external independent one-to-one sessions could be especially useful in settings where MH difficulties and emotional vulnerability are stigmatised, such as that of the police (Drew & Martin, 2021; Stuart, 2017).

Finally, given the importance the participants' ascribed to sense of control, policies for the well-being of the professionals need to consider ways of increasing their effectiveness in regulating emotions, both theirs and their clients', when working on trauma. This could include developing strategies to help them manage better their workloads or incorporating flexible shifts, to allow staff to take breaks and self-care when it is most needed.

ACKNOWLEDGEMENTS

Sophie Jaber, Myriam Scully and Adrienne Dean assisted in data collection and transcription.

CONFLICT OF INTEREST STATEMENT

The authors report there are no competing interests to declare.

DATA AVAILABILITY STATEMENT

The participants of this study did not give written consent for their data to be shared publicly, so data is not available.

ETHICS STATEMENT

The study was ethically approved by the Faculty of Health and Social Care Research Ethics Committee at Manchester Metropolitan University (Ref: 2021-32301-26072).

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How to cite this article: Livanou, M., Whittenbury, K., & Di Basilio, D. (2024). Listening to other people's traumatic experiences: What makes it hard and what could protect professionals from developing related distress? A qualitative investigation. *Stress and Health*, *40*(3), e3353. https://doi.org/10.1002/smi.3353