Troubling/trouble in the academy: posttraumatic stress disorder and sexual abuse research

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Abstract

The potential and actual impact of traumatic research work on researchers has been of focus in academic literature for at least the past 30 years (Alexander et al., *Violence and Victims*, 4(1), 57–62, 1989; Bahn and Weatherill, *Qualitative Research*, 13(1), 19–35, 2012; Coles et al., *Violence Against Women*, 20(1), 95–117, 2014; Coles and Mudaly, *Child Abuse Review*, 19, 56–69, 2010; Connolly and Reilly, *Qualitative Inquiry*, 13(4): 522–540, 2007; McCosker et al., *Forum: Qualitative Social Research*, 2(1): 1–13, 2001). This period of time—over 30 years ago—is approximately same age I was when I commenced writing this paper as a result of my direct experience with posttraumatic stress disorder (PTSD) as a consequence of academic research. For the entirety of my life, researchers have been writing their accounts of trauma, and yet it is an experience that I, and many others, still endure. In this piece, an autoethnographic account is used to explore my diagnosis of PTSD as a consequence of involvement on an academic project examining particular aspects of sexual abuse. In doing so, I examine how PTSD is approached and addressed within the academy, the serious impact that working with traumatic material can have, and suggest a number of approaches that can be considered to address this. These include outlining how we can plan for trauma in research, how considerations of trauma should be built into institutional review boards and ethics applications, and how we can best understand and address the unfair impact that trauma has on fixed-term and casual staff members.

Keywords Posttraumatic stress disorder · Sexual abuse · Sexual violence · Secondary traumatic stress · Qualitative research

Introduction

Eighteen months into my first professional academic role post-PhD, I was diagnosed with PTSD. This diagnosis was directly attributed to my work as a researcher, in which I had

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undertaken dozens of interviews with survivors of sexual abuse, and then analysed and coded these same interviews. A further six months after my diagnosis, I chose to resign from my fixed-term role, and return to tenuous casual teaching work. My diagnosis also meant that I undertook over a year of therapy, with a subsequent medical bill totalling thousands of dollars. This paper acts as a description of my experience pre- and post-diagnosis, the professional hurdles I faced in seeking support, and as a critical examination of the wider institutional failings that have led to the vulnerability of fixed-term and casual staff in shouldering the cost of trauma.

In recording something deeply personal, I do not wish for this piece to be seen as an act of self-pity. Rather, in the spirit of other researchers who have documented similar experiences (Nikischer 2019; Smith 2021), this piece was written to encourage reflection and to instigate change. It draws together a series of recommendations and critical examinations of power within higher education that have been published across an array of disciplinary journals (Fenge et al. 2019; Nikischer 2019; Smith 2021; van der Merwe and Hunt 2019; Woods 2010). In uniting these perspectives, I seek to highlight the impact of ongoing trauma as a consequence of research, and the role of institutions in changing this. In publishing this in *Higher Education*, I intend this article to reach individual researchers, wider research teams, PhD supervisors, institutional review board members, and university managers. This piece is designed to initiate those sometimes uncomfortable discussions of power in higher education, and how institutions can better support fixed-term and casual staff members employed on research projects who are exposed to traumatic material.

In obscuring the specifics of this research project, I wish to highlight how common my experience is. The exploitation of fixed-term and casual staff members when working on a research project is one that many others have drawn attention to (Reay 2004; White 2012). In this respect, *many* research teams and *many* universities may see themselves in my account in a general sense, as the issue of trauma as a consequence of academic research is increasingly discussed (Nikischer 2019; Smith 2021; Williamson et al. 2020). The changes suggested herein are designed to assist researchers in planning for trauma, and support staff members in understanding appropriate levels of psychological support when encountering trauma in the field. Without changes like those suggested being instigated, we will continue to see articles such as this published, with the recommendations and experiences remaining the same.

Writing for recovery

Before examining the impacts of my exposure to traumatic material, it is important to situate myself, and my role as a researcher, within this piece. When I commenced work on the project that eventually led to my diagnosis, I was in my late 20s, and several months from completing my PhD. I had begun work on a part-time, fixed-term contract at an Australian university, and was attached to a project examining specific aspects of sexual abuse. In particular, my role involved gathering and analysing qualitative data in the form of interviews with people who had been victim/survivors of this aspect of sexual abuse.

This situatedness is included here as a part of the methodological approach of this paper: one of autoethnography. Defined as an approach “that acknowledges and accommodates subjectivity” (Ellis et al. (2011, p. 273), autoethnography is commonly understood as a researcher drawing upon tenets of autobiography and ethnography to write a personal account of their research. Denzin (2003) notes that autoethnographic accounts also allow for

a disruption of power politics, and a democratisation of research, whilst Okely (1992, p. 3) argues that “autobiography dismantles the positivist machine”. In using autoethnography in this article, I recognise that my intentions sit within both of these definitions: the account given is personal in nature, but also seeks to disrupt and question the relations of power that surround academic research. Similarly, the structure of this piece is somewhat non-traditional: in documenting an experience of trauma, it also considers and outlines relevant literature, research, and recommendations.

As a method, autoethnography can be deeply personal. Bochner (2007) notes that it is a suffering of the remembered experience, and an attempt to capture this experience in language. This same level of personalisation and closeness to the topic can lead to one of autoethnography’s most common critiques: that there is a lack of distance in the account provided, as the researcher and subject are the same person (Lapadat 2017). Autoethnographers have also faced accounts of being navel gazers (Soyini Madison 2006), with these accusations typically resting on an assumption of a failure to “fulfil scholarly obligations of hypothesizing, analysing, and theorizing” (Ellis et al. 2011, p. 283). However, others have contended that autoethnography is useful for its therapeutic ability for authors; the ability to write personal stories can allow a person to make sense of themselves, and their experience (Kiesinger 2002). Ellis (2002, p. 401) argues that good autoethnography “can stimulate the beginning of recovery... [and] invites others to express how they feel”. In this sense, this article is no exception: it was a specific goal suggested by my therapist as a part of my recovery process, and was undertaken by myself as a way to highlight the uneven relations of power that surround academic research.

This paper joins similar accounts of trauma as a consequence of academic research (Bloor et al. 2010; Coles and Mudaly 2010; Coles, Astbury, Dartnell, and Limjerwala 2014; McCosker et al. 2001; Nikischer 2019; Smith 2021; Williamson et al. 2020). In doing so, this study also contributes to an underexplored area of higher education scholarship: that of how we approach and address PTSD as a potential consequence of academic research. Despite multiple accounts of trauma more generally as a result of research, the understanding that these experiences can cause PTSD is relatively recent. As I will outline, owing to the change within the 2013 edition of the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (more commonly known as the DSM-5) of what constitutes PTSD, very few accounts exist of this experience. Berger (2021, p. 2) notes that even when employing broader search terms related to trauma practice and trauma research, “only a handful of studies examined the possible effects...on those who study trauma”. This is reflective of my own review in framing this article: despite over 30 years of publications focused on the impacts of trauma, there is a dearth of relevant knowledge regarding the subsequent wellbeing of researchers.

In discussing my own account, I intend to emphasise the serious impact that working with traumatic material can have. The below is therefore structured in a way that outlines an autoethnographic account of PTSD as caused by academic research, and examines the difficulties faced in receiving effective support and assistance. Finally, the paper draws on the work of fellow researchers in this area to make a series of institutional-based suggestions for change in overcoming these hurdles.

The terminology of trauma

In documenting an experience of trauma and PTSD, it is important to clarify the terminology attached to the term, and its misconceptions and development within the wider research.

Although PTSD is often associated with those in frontline services (such as ambulance workers, police officers, and psychologists) (Bell et al. 2003; Peled-Avram 2017; Schauben and Frazier 1995; Slattery and Goodman 2009), work has also been undertaken to examine the experiences of researchers (Alexander et al. 1989; Coles, Astbury, Dartnell, and Limjervala 2014; Nikischer 2019; Smith 2021; Stoler 2002; Williamson et al. 2020). In examining these impacts both on researchers and more broadly, a variety of terms have been suggested to give shape to the experiences of those effected. These terms have changed over time, with researchers identifying these traumatic experiences as forms of vicarious trauma (Pearlman and Saakvitne 1995), burnout (Figley 1995), compassion fatigue (Coles and Mudaly 2010), secondary traumatic stress (STS) (Jenkins and Baird 2002), and more recently, posttraumatic stress disorder (PTSD).

In understanding the impact of trauma on researchers, it is important to comprehend the differences in these terms, as their sheer variety can lead to confusion and misunderstanding within institutions. STS has been described by Jenkins and Baird (2002, p. 424) as “the sudden adverse reactions people can have to trauma survivors when they are helping or wanting to help”. The main difference between STS and PTSD, Jenkins and Baird argue (2002), is in the *secondary* nature of STS—the traumatised person develops PTSD, whereas the person who learns of the trauma develops STS. However, the 2013 edition of the DSM-5 updated its diagnostic criteria for PTSD, subsuming the definition of STS into its definition of PTSD. As the DSM-5 acts as the professional handbook used by health care professionals to diagnose mental disorders, this seemingly minor change in the wording of the diagnostic criteria for PTSD (outlined in Table 1) consequently results in researchers, alongside others who have experienced “repeated or extreme exposure to aversive details of... traumatic events” (American Psychiatric Association 2013) being diagnosed with PTSD.

I stress the particular importance of this point—that of the variety, confusion, and changing terminology surrounding these diagnoses—because of my experience in attempting to seek support from my university. Had I not independently sought external psychological support, my diagnosis of PTSD could well have been missed. Within the university, the only support available to me was the Employee Assistance Program (EAP), which provided access to two sessions with a psychologist. Upon meeting this psychologist for my first session, I was told by them that they lacked the expertise to assist me and I should instead seek specialised care from a therapist trained in trauma. The variety of terms and associated experiences can lead to confusion in institutions, and appropriate steps for support and care. When the definition of an experience is unclear, the wider implications and impact of trauma also remain difficult to articulate.

Table 1. Diagnostic criteria of PTSD (American Psychiatric Association 2013)

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- A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:
1. Directly experiencing the traumatic event(s).
 2. Witnessing, in person, the event(s) as it occurred to others.
 3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
 4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g. first responders collecting human remains; police officers repeatedly exposed to details of child abuse).
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Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

Emotion work in qualitative research

As outlined above, my exposure to traumatic material came about as a result of my work as a researcher into sexual abuse: in particular, as a consequence of my interviews with a number of victim/survivors and the subsequent data analysis. Initially, the interviews were expected to gather information regarding a person's experience of the abuse alone. However, following the completion of the first few interviews, it became clear that these instances of the particular aspect of sexual abuse being investigated were often indicative of a wider context of physical and emotional abuse. On a number of occasions, I found myself interviewing victim/survivors who had experienced physical violence, sexual assault, or stalking—but had chosen to participate in an interview because of their additional experiences of abuse being investigated by the research team.

In order to hear, record, and then analyse these interviews, I was required to establish a level of trust with the participants, and delve into their “intimate world” (Bahn and Weatherill 2012, p. 21). In doing so, I heard multiple and graphic accounts of physical abuse and violence, emotional abuse, threats of extreme violence, and accounts of child abuse. Some of these disclosures by victim/survivors had not been told to a single other person, and multiple participants noted that they had undertaken the interview in the hope of obtaining a form of closure. This is in line with the work done by both Connolly and Reilly (2007) and McCosker (1995): Connolly and Reilly (2007) remark that researchers can be placed in the position of being the sole person to hear another's account of trauma; McCosker, meanwhile, observes that her interviewees were inclined to treat the interview process as a counselling session (1995). This empathy, or emotion work, is noted as an important tool for undertaking “good” qualitative research (Bahn and Weatherill 2012; Coles and Mudaly 2010; Rothschild and Rand 2006). The more sensitive the topic and the more vulnerable the participant, the harder this emotion work can be (Whitt-Woosley and Sprang 2018), and the more at risk a researcher is of “becoming a repository of the participant's emotions and feelings” (Connolly and Reilly 2007, p. 529).

Acting as a repository for a person's trauma is not without risk—as others have noted, trauma is often “sticky” in nature. Both Etherington (2007) and Kiyimba and O'Reilly (2016) provide accounts of the experience of transcribing potentially traumatic material, and the impacts of these experience on the transcribers. Kiyimba and O'Reilly (2016) note that the process of listening and re-listening to traumatic material can have a cumulative effect on the transcriptionist; this is despite the transcriptionist often being at least two steps removed from the site of the trauma as they are neither the person who has directly experienced the trauma, nor the researcher who undertook the interview. Figley (1989) further characterises trauma as contagious: it does not sit safely within one person's experience, but can instead move between participants, researchers, and those working indirectly with the resultant data.

This “stickiness” may also prove more challenging for qualitative researchers. Whitt-Woosley and Sprang (2018) confirm the potential for STS associated with researching trauma-exposed populations, with a particular risk factor being the engagement of qualitative research methods. A number of researchers have noted that the “distance” they were expected to keep from their participants left them feeling powerless, and unable to effect change in the way a clinician or frontline professional could (Coles, Astbury, Dartnell, and Limjerwala 2014; Connolly and Reilly 2007; Etherington 2007). It is this inability to *help* the participant beyond the scope of the wider research goals that has been identified as leaving a researcher feeling powerless (Coles, Astbury, Dartnell, and Limjerwala 2014). Of course, there is the chance that the research will eventually contribute to larger structural changes that will benefit society; but

as Nikischer (2019, p. 911) argues, “the promise of the potential for positive change years down the road does little to help a researcher sleep at night”.

Encountering trauma in the field

In order to compare and contrast my experiences of trauma with those described within the literature, this section outlines a summary and timeline of my work across the 24 months I spent as a researcher, my initial symptoms of trauma, and the steps I took to try and receive professional support. This summary is also provided in the interest of considering the wider institutional failings that occurred, and how these were linked to relations of power within academia.

One of my primary responsibilities within the research project was the recruitment of participants, and the gathering and analysis of data. Inside of 12 months, I undertook over 20 separate interviews with adult survivors of sexual abuse. At my busiest, I undertook three interviews in one day, with 15 interviews being completed by myself across a 12-day period. To contrast this with recommendations made by other researchers, McCosker (1995) advocates for no more than one interview per week, whilst Coles and Mudaly (2010) state that one interview per day best suited their work.

Alongside the work of participant interviews, I also undertook the subsequent coding of interview data. Fortunately, I was not responsible for directly transcribing interviews—a further risk factor Etherington (2007) summarises—but I did undertake analysis of over 40 interviews. The coding process was revised and reworked on at least five separate occasions, and each time the codes were revised, it resulted in me recoding and revising each separate transcript. Although developing and finessing coding categories across the coding process is considered advantageous and responsive (Miles and Huberman 1994), it was this consistent revisiting of the data that was, at the time, the most traumatic: I felt there was no clear end in sight, and I could not move away from the data itself. At the time, I wrote the following:

It feels like I will be here forever, and yet I don’t want to be. I want to stop looking. I want to catch my breath. I haven’t been able to take a full, deep, lasting breath for months.

The impact of coding and recoding traumatic material has been observed by others: Woodby et al. (2011), p. 833) argue that the “linear sequences of exposures [to the interview data] ... exerted a cumulative effect and increased the overall risk of distress”. My experience of coding interview data followed a similar pattern; the consistent reliving and replaying of the interviews through the audio files and interview transcripts brought on personal feelings of concern and distress for each interview participant.

Twelve months into my role, I began to experience what I later realised were symptoms of PTSD. I developed a week-long tension headache that resulted in a visit to my doctor; alongside this, I had trouble falling and staying asleep. When I did sleep, I had vivid nightmares of being chased, attacked, and raped. At work, I often visited the toilets to cry for reasons I could not explain. My journal entries from the time document this:

I’m so tired, and yet the irony is that I can’t sleep... [I have] a headache that won’t leave... My body is physically and mentally rebelling against the work I submit it to day after day.

After raising my concerns with the senior leaders of the research project, I contacted the university's human resources (HR) department. I was advised to book an appointment with the external employee assistance program—a limited number of these appointments are provided free of charge to university employees every 12 months. I attended two of these interviews with the psychologist provided by this service; however, as outlined earlier, I was advised by this psychologist that they could not provide me with the care needed for someone experiencing trauma received due to research. Furthermore, the psychologist also outlined that I would need ongoing care—a fact reflected in the research, which notes that a one-off session following exposure to trauma should not be offered for the prevention or treatment of PTSD (Phoenix Australia 2013).

Finally, I secured an appointment with a clinical psychologist experienced in treating vicarious and complex trauma, and was eventually diagnosed with posttraumatic stress disorder (PTSD). The subsequent appointments with my clinical psychologist would eventually span more than 12 months—resulting in a significant amount of money spent¹ addressing my PTSD. Of the four sets of exposure to trauma that fall within PTSD, it was the last that was deemed applicable to me: repeated or extreme exposure to aversive details of a traumatic event (Pai et al. 2017). The diagnosis of PTSD was unchanged for the next year as I continued to receive psychological support.

Difficulties with the data

Following my formal diagnosis, I took steps to adjust and regulate my workload, in line with advice provided from my clinical psychologist. Initially, this advice took the form of a letter sent from my psychologist to the senior leaders of the research project, and the university's HR department. The letter outlined a number of steps that could be taken to help adjust my workload, including ensuring I only coded a maximum of two interviews per day, took regular breaks from my work, and organised additional debriefing support.

In approaching colleagues for support following my diagnosis, the responses I received were somewhat disappointing. The senior leaders of the research project referred to my diagnosis of PTSD as my difficulties with the data, and concerns were raised about my ability to continue working on the project in any capacity. Financially, I had little choice: as an early career researcher (ECR), I was fortunate to secure work in the sector, and was not prepared to leave my role due to my diagnosis. This is mirrored in the work of “The Lost Voices” series (London Postdocs 2021): in writing about their negative experiences as postdoctoral students and ECRs, many participants note that they were reluctant to speak up because they felt their roles were precarious.

Subsequent advice from the university's HR department proved equally fruitless. Representatives from HR suggested to me that I obtain a professional mentor if I felt inadequately supported by the wider research team. When I questioned the ability of a mentor to assist me in addressing my PTSD, I was told I could attend a workshop on how to best respond to disclosures of sexual abuse. Needless to say, I did not attend this workshop; it was the issue of disclosure that had led to my initial diagnosis.

In attempting to readjust my workload, the university implemented a return to work plan for me. These plans are often built for those who have sustained a physical injury in the course of

¹ In total, the cost of these sessions was approximately \$2,000 Australian dollars.

their work. In my case, I completed an initial incident report form that requested me to answer questions such as “what part of the body was the most affected?”, and the “location of the incident”; in my case, I had to resort to stating that the incident had taken place “at my desk”. Needless to say, this approach is inappropriate when the injury is not singular or discrete, but instead both cumulative, and concerning a person’s mental health.

In the space of three months, very little had shifted in terms of my mental health. I was receiving ongoing care from my own psychologist, but was continuing to experience symptoms of PTSD. A diary entry from this time reflects this:

I try, and work, and grunt and sweat and cry and lift...I climb the long flight of stairs to work. I carry myself through it. I cajole myself, I reward myself, I bribe myself... I am a combination of nurse and patient, simultaneously seeking to put the pieces back together and distressed about the breakage. I wonder when it ends, and worry that it won’t.

Six months after my initial report and diagnosis—and six months before my contract was due to expire—I left my role on the research project, and returned to casual teaching. A journal entry written two weeks before I resigned documents my decision to leave:

I would gnaw off a limb to escape [this workplace] ...I am afraid of feeling like this forever, [and] being damaged and scared forever. I would like to resign tomorrow.

My experience with PTSD as a result of academic research holds several consistent themes, and raises significant questions regarding how to best address and ensure researcher safety in undertaking potentially traumatic work. These themes include an ineffectiveness in planning and addressing trauma resulting from research at each stage of the research project; an uninformed and impassive systematic response from the wider university; and the vulnerability of casual and fixed-term researchers to exploitation. Each of these themes is discussed further below.

Planning for trauma in research

As the role I was employed within was explicitly research-based in nature, my subsequent analysis considers how these environments can best respond to and plan for trauma. This section considers how principles such as those within the trauma-informed care (TIC) model can be employed in academic research spaces, and compares these principles to the current processes and guidelines used to undertake qualitative, “sensitive” research (Lee 1993).

Trauma-informed practices are defined as those that “realize the impact of trauma and potential paths for recovery, recognize the signs and symptoms of trauma, respond by integrating knowledge about trauma into their approach, and resist retraumatization” (SAMHSA 2014 as cited in Campbell et al. 2019, p. 4767). Previous literature (Campbell et al. 2019) has focused on the use of the TIC model for researchers, rather than within higher education institutions more broadly. But, as demonstrated, researchers themselves are vulnerable to confronting traumatic material: consequently, universities need to consider how they can best support their employees engaged in traumatic research work.

As researchers commencing a new project, academics are typically required to undertake approval from an institutional review board (IRB) (also known as an ethics committee). The

main function of an IRB is to anticipate and minimise potential risk to participants (McCosker, Barnard, and Gerbner 2001)—but an IRB should also play a role in protecting the safety of a research team (Kiyimba and O'Reilly 2016). Currently, this role is typically not one considered by IRBs. In my case, the research project I had worked on had noted in its application what Bahn and Weatherill (2012, p. 26) deem as a “throw away line...saying that ongoing support and counselling being made available to research participants”. Significantly, this offer was not extended to research staff. In looking to develop a TIC model for integration into IRB approval, an opportunity to review and consider the wellbeing of research staff is presented. Currently, TIC models emphasise the importance of self-protection, and the need to integrate knowledge about trauma into broader institutional responses. However, universities—and in particular, IRBs—consistently fail in their reliance on “heads of school, PhD supervisors and grant holders to make subjective decisions as to the level of risk... to protect field researchers” (Bahn and Weatherill 2019, p. 25). In moving to a TIC model, these subjective decisions could be removed. Instead, researchers would be asked to “plan” for trauma. As Coles and Mudaly (2010, p. 58) argue, “it is probably inevitable that [researchers who are engaged in studies with vulnerable populations] would be affected” by their exposure.

The Sexual Violence Research Initiative (SVRI 2015, p. 15) guidelines recommend that, in order to prevent harm to researchers investigating sexual violence, it should be an essential requirement in research protocols “that researchers reflect on how they will protect themselves and the research team from trauma”. As Nikischer (2019) further notes, the SVRI guidelines (2015, p. 15) add that researchers should also outline the measures and strategies that will be implemented to ensure this protection is in place, and supply a budget accordingly. I would further argue that this should be a standard process for researchers applying for ethics clearance, in order to embed a level of reflection on the nature of harm to researchers within the submission process.

In understanding the adverse psychological impact of research as a form of risk, it is worth bearing in mind the role of workplace safety, and the legislative requirements operating within a university’s “duty of care”. In Australia, mental health is classed as a subdivision of health more generally (Victorian Occupational Health and Safety Act 2004)—meaning that a risk to mental health is considered as severe as a risk to one’s physical health. In embedding a standardised process of reflection regarding how researchers can be protected, universities can move closer to building a trauma-informed workforce: an environment that supports the health and wellbeing of workers, alongside those experiencing trauma directly (Hoge et al. 2007).

In considering my own experience, it is clear that none of the measures proposed in this section were in place. The research project I worked on had no direct funds allocated for professional psychological support of staff (nor any flexibility in being able to reallocate these funds), or professional guidelines for addressing researcher exposure to traumatic material. The failures were therefore quite clear: an initial lack of foresight within the research team in not considering the impact and risk of the work, and a wider failure by the university’s IRB in not comprehending the impact of this work on researchers. More broadly, it is also clear that any changes implemented within IRBs related to implementing a model of TIC also need to be actively supported and applied by researchers: well-intentioned changes made by a committee mean nothing if research teams do not engage with the underlying principles of the change. This was mirrored in my own experience: in the final six months of work prior to my resignation, I was tasked with completing an annual risk assessment report for my university’s IRB. In finalising this form, I was instructed by the senior leaders of the research project to indicate that there were no adverse events that had taken place over the lifetime of the research.

These adverse events were defined as those that had impacted participant welfare, or unexpected outcomes that changed the ethical acceptability of the project. At no stage was my diagnosis of PTSD mentioned in this report; nor was it flagged as something the IRB *should* have known—something that I would argue was, at the very least, an “unexpected outcome” of the research.

The suggestion in this instance is to introduce a TIC model into IRB approvals in order to ensure clearly articulated plans to protect and address trauma in researchers. The introduction of a TIC model is not all-encompassing, and there are many other suggestions made by researchers that are designed to be enacted on a more personal level, within smaller research teams. However, even these suggestions are not equally attainable to all researchers. The following section considers the particular vulnerabilities of fixed-term and sessional staff to trauma as a consequence of research, and how the current suggestions within the literature to address trauma are not always appropriate or applicable for these researchers.

Vulnerable researchers

This section examines an area not always considered in the body of work on trauma as a consequence of research: that of the particular vulnerability of fixed-term and casual staff members. The research into trauma as an effect of academic research makes a number of suggestions not always achievable for fixed-term and casual researchers, and subsequently, this section considers how and why these suggestions need to be reconsidered.

The “temporary” academic workforce is made up of those employees on fixed-term or casual contracts. These employees have often been characterised as an expendable underclass, despite making up a sizable section of the higher education workforce (White 2012). Within Australia, it is estimated that 27 of its 42 universities have casualisation rates above 40% (Long 2018), with universities in Victoria reporting rates of 68.74% (Duffy 2020). Reay (2004) argues that, like housework, contracted research is severely undervalued and under-supported in relation to its actual importance. Furthermore, research has demonstrated that there is a disproportionate number of women concentrated in lower levels of the academic “hierarchy” (Courtois and O’Keefe 2015; Fitzgerald 2012).

In understanding the true limitations of fixed-term or casual work, the suggestions made to address trauma in the literature are thrown into sharp relief. Alongside their accounts of trauma, researchers have also published their own practices and recommendations used to lessen the impact of their work. These suggestions include allowing researchers to halt data collection if necessary to reduce anxiety (Alexander et al. 1989), spacing interviews out over longer periods of time (Connolly and Reilly 2007), reorganising workloads and delaying data analysis and subsequent interviews (Coles and Mudaly 2010), and presenting opportunities for members of the research team to opt out of the sexual violence aspect of the research without risk to the researcher’s future career or job opportunities (Coles, Astbury, Dartnell, and Limjerwala 2014). Researchers have also advocated for debriefing amongst colleagues (Driscoll et al. 1997; McCosker 1995), whilst others have recommended specific, regular access to crisis counselling (Coles and Mudaly 2010). Finally, the SVRI guidelines (2015, pp. 9–10) also advise that interviewers be able to take breaks “from listening to victim or perpetrator stories”, temporarily shift between interviews and other tasks, cap the number of interviews undertaken each day, and ensure adequate breaks are taken between interviews.

Although the above recommendations are useful, none can be easily enacted by fixed-term or casual staff members. Often, researchers in this position are unable to authorise or organise any of these practises—they do not steer the overall project, and may instead enter or exit the research across different points in time. To return to my own experience, my attempts to reorganise my workload took over a month to be formally approved; I could not access any support from abuse counsellors or trained professionals with the particular expertise needed as provided through the university; and there was never a suggestion that data collection should be temporarily halted in order to alleviate my symptoms. Indeed, instead of pausing the project, other inexperienced RAs were hired to assist with coding the interviews I had deemed to be too upsetting to revisit. The RAs were untrained in data analysis, being post-graduate students who had not before undertaken any research with sensitive subjects, or had experience coding interview data. Nonetheless, they were asked to code these interviews within a short period of time in order to ensure we remained within our deadlines.

Although senior leaders within the research project did offer to debrief with me, I felt uncomfortable in discussing my experiences of trauma and the impact of the work with them. In large part, this was due to their lack of knowledge in being able to appropriately and efficiently support me—as my diagnosis of PTSD had previously been referred to as my difficulties with the data, I felt that any attempt at debriefing with them would not be given an adequate level of seriousness or care. As Coles, Astbury, Dartnell, and Limjerwala (2014, p. 112) observe, “given the power dynamics at play between supervisor and supervisee, it may be useful for the researcher to access additional support outside of the supervisory relationship... it is essential for this person to have relevant skills to assist the researcher through [their] experience”. Further speaking to power relations within a research project, the SVRI (2015, p. 12) guidelines assert that “supervisors and managers should not be tasked with project team/researcher debriefing unless trained to do so”.

The impact of trauma can hold a significantly higher price for fixed-term and casual staff. This is not to suggest that the psychological impacts are any different: but rather that ongoing staff have the option of sick leave, a guaranteed and secure wage, and an established support network, whilst fixed-term and casual staff may not. An ongoing academic has the ability to negotiate their work deadlines, whilst a fixed-term or casual staff member of work deadlines often means directly who attempts to negotiate the same deadlines is required to report the reason for the leave to the person responsible for the research. As Coles, Astbury, Dartnell, and Limjerwala (2014) noted earlier, the power dynamics at work mean that researchers who are reliant on variable and uncertain work may be reticent to report their experiences of trauma to their manager, for fear of being taken off the research project and losing income.

The strategies outlined in these sections—those of planning for trauma through TIC models—are done so in order to protect all researchers, but in particular those in fixed-term or casual roles. The current measures in place to support researchers at universities may not be sufficient in addressing and supporting fixed-term or casual staff members who have experienced trauma as a result of their work. Furthermore, debriefing between colleagues may not be effective for those experiencing PTSD. Serious consideration by research teams is therefore needed if they are to effectively and successfully support their fixed-term and casual research staff who encounter potentially traumatic experiences as a part of their work.

Final notes

When I commenced this article, I anticipated the majority of the research to be oriented towards trauma as experienced by those within frontline roles—psychologists, counsellors, and social workers. However, a number of researchers have documented experiences of trauma as a consequence of their work, with the literature spanning at least 30 years. The accounts and recommendations made by these researchers hold a number of similarities: that debriefing is significant, professional psychological support is necessary, and researcher trauma is a common side effect of qualitative research in sensitive areas.

We know where the gaps are. As a profession, the areas within academic research that need improvement are clear. In higher education, there is an ongoing trend towards casualisation and a lack of risk management when overseeing research projects (Bahn and Weatherill 2012; Bloor et al. 2010), whilst the long-term impact of COVID-19 on universities in Australia has been described as “grim” (Marshman and Larkins 2020). These facts further highlight the need to introduce concrete and tangible measures to protect researchers—both ongoing, fixed-term, and casual—from harm. These include planning for trauma in an ethics application; factoring professional debriefing and counselling services into a project’s budget; and understanding, acknowledging, and avoiding the exploitation of fixed-term and casual staff for the benefit of a wider project.

Those in senior positions within university management, IRBs, and ongoing research positions hold obligations to those employed around and below them. Most importantly, the obligation is moral: that researchers do not emerge from their projects with PTSD as a consequence of their work. Alongside this sit professional and ethical obligations: how can we as a community promote and sanction research that has done no harm to interview participants, but has simultaneously led to the research interviewer to resign from their role, and undergo over a year of professional therapy?

I argue that the needs of researchers should be clearly considered by their immediate employers, colleagues, peers, and others within wider university systems to safe-guard them against harm. These needs should be prioritised in equal measure to those of the research participants themselves. Alongside this, potentially uncomfortable discussions of power need to also be had within institutional review boards, research teams, funding councils, and university management. As outlined in this paper, there was a failure at each of these levels to protect an employee against harm. The consequences were, for me, immense and multiple. I eventually resigned from my role, returned to casual teaching, endured over a year of therapy, and suffered a number of psychological and physical impacts as a result of my PTSD.

As I noted in the introduction to this article, I do not wish for my reflections to be seen as self-pity. Instead, this piece was written to encourage reflection, and to instigate change: as the literature demonstrates, this is an issue that has endured for over 30 years. The suggestions outlined above are not always easily enacted: in many cases, the wider support of supervisors, managers, and institutional review boards is needed. But without these changes, we will continue to see articles such as this published, with the recommendations remaining the same. It is my hope that we can begin to reckon with the true effects of trauma as a consequence of academic research, and seek to address these effects without another 30 years slipping by.

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