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## **Research Ethics, Trauma and Self-care: reflections on disaster geographies**

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## Research Ethics, Trauma and Self-care: reflections on disaster geographies

### Abstract

In this Research Note, I reflect on researcher trauma in the discipline of geography, and explore ways to build a framework for researcher self-care by facilitating conversations about mental health in collaboration with Human Research Ethics Committees, Professional and Organisational Development Services and Workplace Health and Safety units.

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RESEARCH NOTE

## Research Ethics, Trauma and Self-care: reflections on disaster geographies

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Researcher self-care; human research ethics; trauma; workplace health and safety; disaster; Australia

Bushfire is a topic that most Australians have an (often strong) opinion about, as the role of bushfires in Australian landscapes is tied to a range of emotions and experiences that are deeply embedded in traditions and everyday life (Eriksen and Gill 2010; Rickards 2016). The intensity of public and policy debates on bushfire provides an incentive for academic researchers to use the university ethics approval process as a means to ensure that each step of the research has been considered—from participant recruitment, interview structure, timing, locations and safety, to potential outcomes and ensuing debates. In my research on social dimensions of disasters (Eriksen 2014), the Human Research Ethics Committee (HREC) has played an important role in ensuring that the researcher's unbiased attention can be granted to all individuals and their particular stories. In this capacity, the HREC provides a buffer between the researcher and the passionate 'less constructive' participant voices that occasionally make demands of the university that a particular issue be raised or ignored. It is also comforting to know that the HREC's stamp of approval, at least in my case, ensures support when opinionated individuals voice their dislike of the research.

Despite this constructive partnership, an unforeseen problem has emerged that, in part, stems from a disciplinary loophole in the ethics process. The HREC at the University of Wollongong (UOW)<sup>1</sup> from the outset emphasised that reliving a bushfire, as part of an ethnographic interview, can potentially be emotionally distressing for participants. A mutually agreed upon statement therefore forms a standard part of the Participant Information Sheet provided in advance of interviews:

Reliving a bushfire experience can be emotionally distressing. You will not be pressured for details you feel uncomfortable talking about. Your involvement in the study is voluntary and you may withdraw your participation from the study at any time and withdraw any data that you have provided to that point. Refusal to participate in the study will not affect your relationship with the UOW. Should you require emotional support, Lifeline Australia provides 24 hours a day telephone crisis support during and after natural disasters: call 13 11 14 or see <https://www.lifeline.org.au/Get-Help/Facts---Information/Community-recovery>.

This statement testifies to the emphasis that university HRECs rightly place on ensuring the emotional well-being of research participants. In comparison, the mental health of researchers in social science disciplines such as human geography is rarely given much, if any, consideration. This is despite the National Statement on Ethical Conduct in Human Research stressing that 'Each institution needs to be satisfied that ... those conducting its human research ... understand the need to assess risks to their own safety and that of participants' (NHMRC 2014, 68). Risk assessments, first aid training, and teamwork all form a standard part of 'safe research practice'. However, the ethical side of such practice has little scope for assessing, protecting or detecting symptoms of mental distress that can result from, for example, exposure to the emotionally and politically charged narratives of disaster survivors. At present, the ethics approval process does not address this problem either. As UOW's Research Ethics Manager explained:

The problem for the HREC is that it has no authority to require any action in this area. There are governance questions in all of this that are not easily addressed. That doesn't mean HRECs couldn't ask more questions and make more suggestions in this space though. (Pers. comm., 18 February 2016)

Adding to this problem, few geographers are equipped as part of their education with the skills to process narratives in a way that prevents vicarious trauma.

### *Understanding vicarious trauma in geographical research*

Vicarious traumatisation is defined as 'the response of those persons who have witnessed, been subject to explicit knowledge of or, had the responsibility to intervene in a seriously distressing or tragic event' (Lerias and Byrne 2003, 130). It is an individual's psycho-emotional reactions caused by exposure to the traumatic experiences of others (Berceli and Napoli 2006). Similar to the clinical symptoms associated with secondary traumatic stress, its symptomology includes: re-experiencing the event, persistent avoidance (emotionally and behaviourally), increased anxiety and anger arousal, and impairment of optimal levels of functioning. Factors identified as predictors of the occurrence of trauma symptoms are: previous trauma history, prolonged

exposure, psychological well-being, social support networks, age (resilience increases with time/life experience), gender (women are more susceptible), greater education and socioeconomic status (increase access to and understanding of support networks), and coping styles (negative coping response increases anxiety symptoms) (Lerias and Byrne 2003). The lower intensity at which vicarious traumatisation can occur (compared with direct trauma) means many do not realise they are being affected:

Victims may still be able to function relatively well in their life while still suffering its symptoms ... [they] are often overlooked because their level of distress may not be significant enough to come to the attention of clinicians ... [they often] suffer in silence until their distress escalates to visible levels. (Lerias and Byrne 2003, 136–137)

My journey towards recognising vicarious trauma amongst disaster researchers started with an observation of a growing personal inability to manage seemingly inconsequential tasks in professional and private life after 6 years of ethnographic-style research with bush-fire survivors, firefighters, and residents fearful of the potential threat of bushfire. The pain was intangible, the causes subliminal—undercurrents in what was otherwise a busy everyday life. The thought of vicarious traumatisation seemed alien, as the pervading feeling during interviews had always been a profound sense of calm rooted in gratitude towards the participants for sharing their intensely personal experiences and emotions. Analysing and writing about these experiences seemed a suitable way to simultaneously process any internal reaction to these (often horror-filled) stories. This, it appears, was a vast underestimation of the potential accumulative effect of years of indirect exposure to high-impact events (see also Kiyimba and O'Reilly 2016). Instead, a growing sense of helplessness set in:

The role of a researcher is different from that of a clinician or counsellor and potentially more traumatizing because of an inability to 'help' the victim. Researchers identify problems and needs, but may feel unable to provide any assistance that helps survivors cope with the experience of ... violence. (Coles et al. 2014, 96)

The stories narrated by disaster survivors are often elaborate, filled with suspense and emotionally charged. It should therefore come as no surprise that researchers with whom these stories are shared could become vicariously traumatised. Yet, while there are extensive accounts and analysis of vicarious trauma amongst, for example, mental health professionals (Hafkenscheid 2005; Berceci and Napoli 2006; Caruana 2010) and emergency service personnel (McFarlane and Raphael 1984; Weiss et al. 1995; Beaton et al. 1998; Beaton et al. 1999; Chopko and Schwartz 2009), there are few studies to date which deal explicitly with vicarious trauma amongst academic researchers who work specifically with individuals and communities impacted directly by natural disasters. This is with the notable exception of recent work by researchers in Australia and New Zealand (Calgaro 2015; Dominey-Howes 2015; Eriksen and Dittrich 2015;

McLennan et al. 2016; Adams- Hutcheson *in press*). This problem was similarly identified for research psychologists in the aftermath of the 9/11 terrorist attacks in the USA in 2001 (Greenall and Marselle 2007), media personnel covering the 2009 Black Saturday bushfires in Australia (Muller 2010), as well as for researchers investigating sexual violence (Coles et al. 2014).

### *Building a framework for researcher self-care*

To work towards an ethical framework attentive to researcher mental health, HRECs seemingly have to negotiate a fine line between assessing the potential traumatic parts of extensive research projects, forcefully policing researcher skills and exposure (to known unknowns), and trusting the researchers to monitor signs of distress. However, equipping researchers to skilfully detect signs of distress (within themselves and in participants), and incorporating psychological feedback sessions (face-to-face) as part of the ethics approval process could provide an effective way to detect warning signs, and the need to procure professional help. The offer of impartial professional help is important, given the feeling of vulnerability that comes from disclosing research-related emotional distress to an employer who has the power to prevent the researcher from continuing work on a particular project. This issue became evident in the examination of why few media people vicariously traumatised in the wake of the 2009 Black Saturday bushfires confided in their employers or accepted the counselling offered to them:

Some went off and obtained professional help at their own expense rather than do it through the company for fear that, despite assurances to the contrary, their cards would be marked and they might not be assigned to similar big stories in future. (Muller 2010, 10)

The key lessons drawn from Muller's (2010) study are equally relevant to universities: separating personal from operational/organisational debriefing, creating a culture of acceptance where managers and staff talk about vicarious trauma, the importance of couching the offer of help in the right way and offering the right kind of help, and the imperative of management to promote access to help (see also Bober and Regehr 2006; Coles et al. 2014).

The missing link in the university system is arguably the current disconnect between the HREC and universities' respective Professional and Organisational Development Services (PODS) and Workplace Health and Safety (WHS) units. I enquired in late 2013 about the possibility of a training session on 'researcher mental health', as part of the 'Mental Health in the Workplace' series offered to managers and students by PODS. This request resulted in a circular, 4-week run-around where baffled staff suggested contacting someone else, who referred to someone else, ad infinitum. Months later, the WHS unit became involved only after the physiotherapist treating the physical pain caused by my unrecognised trauma made a referral for worker's compensation.

This triggered an automatic referral to a professional and independent Injury and Occupational Health body, who immediately pointed to the likelihood of a psychological rather than a physical cause. There is no individual point of blame in the links that form a part of this chain of events. Rather, the picture that emerges is of a system that is ill equipped for detecting, supporting and addressing the warning signs of vicarious trauma and researcher mental health at an early stage before more severe clinical conditions develop. Linking PODS training, HREC approval processes, and WHS monitoring and support would go a long way towards closing this loophole, by providing greater awareness within the ethics approval process of the potential short- and long-term mental health consequences of researcher trauma.

One area where the scope of ‘ethics creep’ has the potential to benefit researchers is in an area of academia that needs more support, namely researcher mental health. ‘Ethics creep’ refers to the ‘dual process whereby the regulatory structure of the ethics bureaucracy is expanding outward...while intensifying the regulation of practices deemed to fall within its official ambit’ (Haggerty 2004, 394). Participant well-being, including mental health, is already high on the list of concerns of the HREC. HRECs could take the cognitive and progressive leap towards a similar concern for the mental health of researchers by creating a support system closely linked with PODS and WHS. There is clearly scope within the National Statement on Ethical Conduct in Human Research (NHMRC 2014) to achieve this, and at the UOW change is afoot. Revisions to the ethics approval form, which includes a question on researcher self-care, are underway. PODS introduced a ‘Managing Mental Health for Managers’ training module in 2015 that raises awareness of the psychological risks of working in academia. However, at the time of writing, the module does not mention researcher trauma or promote researcher self-care. Rather, emphasis is placed on the generic duty of care that managers, supervisors and heads of unit have for their staff and students, and workplace conversations are encouraged about potential impacts, risk mitigation and resources available if aid is needed. The role that the HREC could play in encouraging or policing such conversations with research academics is debatable. UOW’s Research Ethics Manager, when asked to comment, suggested that

We could look at more active identification of risks for researchers by the HREC, a process where the HREC notifies their managers, and resources available that the HREC and/or manager can direct people to for support/training. Where I differ from your paper<sup>2</sup> is in the role of the managers/heads of unit. I think it is their responsibility to look after their staff, and if they are failing in this duty of care you need to look at why and address it ... There is a body of thought that the HREC should require evidence that staff welfare has been addressed before approving a project. I am not convinced that this shift in responsibility for determining whether welfare issues have been addressed would be in the researchers’ interests though. The heads of unit are much closer to the researchers than the HREC, and so better placed to act where needed; it is important that they remain responsible and accountable for the welfare of their staff. (Pers. comm., 8 March 2016)

What is clear from my case is the detrimental effects of not taking researcher self-care and emotional well-being into account—suppressing signs of trauma for want of institutional support. Opening a conversation about mental health support facilitated collaboratively by the HREC, PODS and WHS units, as discussed above, provides a tangible first step. Furthermore, students and academics, including human geographers, could be trained on a regular basis on researcher self-care, just as, for example, research methods, critical data analysis skills, risk assessments, and protocols for safe travel are part and parcel of their education and career development. In this way, ethical research and research ethics become distinct yet intimately entwined aspects of sound geographical research.

### *Notes*

1. <http://www.uow.edu.au/research/ethics/UOW009378.html>
2. Referring to an earlier draft of this Research Note.

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