"What am I supposed to say?" Reflections on Working in Major Trauma Psychology as a Psychological Wellbeing Assistant (PWA)

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This article presents reflections on the experience of carrying out clinical work while on placement in a Major Trauma psychology team from a psychology undergraduate student (AMDS) perspective. The aim is to highlight challenges and lessons learnt from gaining experience in clinical work at an early career stage.

For the past year, I worked as a Psychological Wellbeing Assistant (PWA) in the Department of Neuropsychology at the Manchester Centre for Clinical Neurosciences. This honorary role, offered to undergraduate students as a work placement year, was secured during my second year of undergraduate psychology studies at the University of Manchester. I was assigned to the Major Trauma (MT) inpatient psychology team, which provides input for acute and rehabilitation wards in a specialist MT Centre.

My responsibilities included delivering level one psychological work (Kneebone, 2016) with patients on a one-to-one basis, including befriending, active listening, behavioural activation, relaxation strategies, guided mindfulness, values-based exercises, and supporting cognitive rehabilitation. This also involved tasks such as taking patients outside for fresh air and befriending, particularly when they could not mobilise independently or when ward staff were too busy. Additionally, I supported therapy colleagues during group sessions in a rehabilitation ward. The clinical workload was dynamic and variable, while non-clinical responsibilities included administrative tasks, supporting colleagues with literature searches, and attending training courses for my professional development.

Throughout my placement, I reflected on my experience in MT and the lessons it taught me regarding my present and future professional growth.

Lesson 1: Learning How to Sit with Discomfort

Throughout my studies in psychology at A-level and University, I primarily encountered Cognitive Behavioural Therapy (CBT) as an intervention model, which tends to encourage the reappraisal and restructuring of unhelpful or unrealistic thoughts. But what if an individual's thoughts are not unrealistic? What if one's distress is due to memory impairment following a traumatic brain injury (TBI)? Or difficulties adjusting to the loss of mobility after a spinal cord injury (SCI)?

Early in my placement, I was introduced to a patient who had sustained an SCI with likely lifelong consequences. The severity of the situation made me feel powerless and insecure about my abilities, because no textbook or lecture had prepared me for this. This left me with the uncomfortable feeling that some problems seemed insurmountable. As a result, I noticed an urge in myself to fit into a 'staff' role by offering what I believed were the best solutions and providing

'professional' advice to patients, assuming that this was what I would want in their position. However, being able-bodied and minded, as well as clinically inexperienced, I often questioned my credentials to discuss traumatic injuries with patients. I recall thinking "I feel so silly; I'm a random 20-year-old walking into one of the hardest recoveries of someone's life - what am I supposed to say?".

Unsure of how to help, I took this to my supervisor, a Clinical Psychologist in MT, and expressed my discomfort and uncertainty. I felt that had I been in the patient's shoes, I would have been devastated. My supervisor's response shocked me. I expected a solution, but instead, she validated my discomfort, acknowledging the devastation of experiencing a MT and hospitalisation. I was encouraged to sit with that discomfort, leading me to realise it was a natural, sometimes unavoidable consequence of trauma. This helped me understand the significant value of validating, normalising, and empathising with a person's feelings without attempting to 'help' or 'fix' them, since grief is a natural part of the psychological adjustment process (Savas, 2024). Just as you would not rush someone to stop crying after a bereavement, or to run on a broken leg, natural reactions need time to play out. Understanding the importance of being present and sitting with someone through their pain proved seminal in improving my interpersonal skills and comfort in my role.

Lesson 2: Building My Understanding of an Underrepresented Field

Prior to beginning my placement, I had not yet encountered psychology in the context of MT, so I was apprehensive when I learnt that this was my assigned team. Moreover, when the service lead recommended that I review the current psychological literature in this field, I soon realised the scarcity of research specific to MT. In fact, a recent publication has highlighted how psychosocial aspects of MT care, albeit vital, are largely underrepresented in research (Olive et al., 2022).

As I came to understand, MT is a relatively new field, with the first regional MT networks launched in 2010 (Cole, 2022). An NHS Commissioning Board report (2013) outlined that more than one in four of the 20,000 annual MT cases in England resulted in death, making MT the leading cause of death for individuals under the age of 45. By 2020, MT networks had been implemented across the whole of the UK, including the MT Centre where I completed my placement. These networks have improved survival rates over time (Cole, 2022).

However, around 30-40% of all MT survivors experience serious, long-term psychological difficulties (Teager et al., 2023), which prompted me to question if this increase in survival rates would be matched by increased MT psychological research and support. I noticed a huge gap in the literature around psychological care for MT – one which made me feel concern for our

patients. For example, if I were to lose my ability to walk due to a car crash and subsequently developed post-traumatic stress disorder (PTSD), I would expect someone to recognise and address my needs.

Thus, I sought to improve my knowledge on the psychology of MT through multidisciplinary team (MDT) discussions, weekly supervision, and attending events such as a Spinal Injuries Rehabilitation Study Day. Additionally, I engaged in NHS-funded courses and other free online resources from organisations such as the Spinal Injury Association. These efforts not only enhanced my clinical confidence but also my awareness of the importance of continuous education in this area. Given the complexity and diverse nature of MT injuries, I soon came to understand that there would always be more to learn.

Lesson 3: Navigating Dynamics of Power

Given the complexity of MT and the aforementioned challenges, I frequently questioned what I was doing. I often felt as though I was fitting a tiny plaster to a massive open wound, which exacerbated my imposter syndrome. Reflecting on the Social Graces model (Burnham & Nolte, 2019), I realised my sense of disempowerment was influenced by my identity. For example, being the youngest and least qualified person on my team, I felt small, but eager to prove and develop myself. This reflection helped me notice power dynamics, common within MDTs as well as between staff and patients (Odero et al., 2020). I realised that my initial discomfort stemmed partly from the apparent dependency of patients on staff, which can create an imbalance in the therapeutic relationship.

In response to this, I tried to engage in therapeutic relationships characterised by mutual respect and dignity, adopting a person-centred approach focused on empowering patients as experts by experience. At times, this involved inviting patients to collaborate on activity plans, which seemed particularly helpful for those struggling with reduced independence – for instance, due to loss of mobility. In this regard, I also found that values-based conversations were especially effective in increasing a sense of control and self-efficacy.

Within the MDT, I sought to address power dynamics by increasing my knowledge and sharing my views, despite perceived barriers due to my status as a student. I realised that MDT work was the perfect environment to contribute with ideas, since, while each team member understood each patient differently, the sharing of observations and suggestions enabled a collective understanding of an individual's circumstances. Additionally, I learnt the importance of asking for support and acknowledging my need for growth, which strengthened my relationships with colleagues, who were always willing to help me learn.

These experiences highlighted the importance of addressing power dynamics in healthcare to create a more empowering environment for both patients and staff by balancing confidence and assertiveness with a readiness to learn.

Lesson 4: Using Clinical and Peer Supervision

Receiving supervision during my placement provided me with valuable protected time for reflection and feedback, helping me to identify strengths as well as areas for improvement. More specifically, supervision was crucial when starting my placement with no prior experience of MT psychology. Alongside learning new approaches to supporting clients/service users/patient, it helped develop my understanding of key concepts in the field, such as clinical formulation. For example, while working with an SCI patient previously diagnosed with depression, I found it difficult to engage them in psychological wellbeing sessions, despite them saying that they wanted support. During supervision, I was encouraged to consider factors such as attachment styles and past experiences which may maintain this behaviour. This shifted my perspective of psychology in practice from intervention-focused to a more holistic approach, seeing the person as a whole rather than a textbook case and allowing for critical thinking. Using this new perspective, I was mindful of this patient's avoidant attachment style by respecting autonomy while subtly and consistently encouraging social engagement.

Supervision was also essential for navigating ethical dilemmas, such as whether to disclose personal information to patients when asked personal questions. My supervisor's contextual advice, based on her personal experiences, normalised common dilemmas and provided a template for good clinical practice. This guidance was vital for maintaining professional boundaries in an empathic role during my early clinical experience.

Additionally, I engaged in peer supervision with a Senior Assistant Psychologist. This proved crucial in helping me understand the various pathways into Assistant Psychologist roles and the unique challenges and benefits of a career in clinical psychology. By validating and normalising my feelings of 'not knowing enough', I found reassurance in knowing such feelings are common in a new role - all of which helped reduce my imposter syndrome. As the Assistant had also just started their role in MT, we dynamically adapted our approaches together in response to evolving circumstances, such as adjusting to new routines, staff, and workflows in the MT Centre.

Conclusions

My year as a Psychological Wellbeing Assistant has been transformative, not only highlighting the impact of early clinical experience on personal and professional development in psychology but

also enhancing my gratitude for being part of the field. The dynamic and complex nature of MT presented unique challenges and learning opportunities. Direct patient care, MDT work, and supervision with qualified clinicians and Assistant Psychologists significantly contributed to my growth. This placement deepened my understanding of holistic treatment, an underrepresented field and taught me the value of empathy, patience, and continuous learning. Ultimately, it has been instrumental in guiding the early stage of my clinical psychology journey and instilled a profound appreciation for the importance of psychological approaches in medical settings.

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