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**Exploring the effects of vicarious trauma
in New Zealand practitioners**

A thesis
submitted in fulfilment
of the requirements for the degree
of
Masters of Social Sciences
at
The University of Waikato

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THE UNIVERSITY OF
WAIKATO
Te Whare Wānanga o Waikato

2016

Abstract

Vicarious trauma is an occupational stress reaction that affects health professionals on different levels. This is caused from empathic engagements with clients and being exposed to traumatic material on a regular basis. In this study it was clear that practitioner's experience negative as well as positive shifts in their world views and sense of self. Eleven health practitioners were interviewed to explore what led them into their desired helping profession and how they have managed to practice effectively. Related concepts of psychological impacts are discussed describing the relationship between posttraumatic stress type features and vicarious trauma that are experienced by health professionals. Information collected from interviews explored the themes between the shared stories and the literature on vicarious trauma effects. Four sections explore: *motives for helping, personal experiences of vicarious trauma, identifying it in others and various ways of coping with effects*. Various sub-themes are explored from each major theme using the constructivist self-development theory. In conclusion with the findings from the data collected and previous research, this study shares lived experiences of the effects of vicarious trauma.

Keywords: qualitative research, thematic analysis, stress, acute stress disorder, posttraumatic stress disorder, transmissions of trauma, secondary traumatic stress, vicarious trauma, Constructive Self Development Theory (CSDT)

Acknowledgements

I would like to express my deepest appreciation to a number of people who have made this research project possible. Firstly, I would like to acknowledge Dr Armon Tamatea for his time and perseverance with me on this journey. It has been instrumental for its completion. The time you gave, the guidance and patience you displayed is sincerely appreciated. I value your teachings, wisdom, and support throughout the duration of this study. Thank you for always being truthful and giving me the feedback I need to hear and allowing me the space to improve. In addition to this I would like to thank my second supervisor Dr Carrie Barber, without your backing this would not be possible, I am deeply grateful for your support and patience. This is a special plead of thank you for being part of this project. Nga mihinui tena korua, engari, tena koutou, tena koutou, tena koutou katoa.

On that note, I would also like to thank the University of Waikato's School of Psychology and Maori and Pacific Research Unit (MPRU) for its continual support and acknowledgement of my achievements and progress thus far. The support is amazing and always valued. Nga mihi, nga mihi, nga mihinui kia koutou.

I would also like this opportunity to thank my participants without them this would not be complete. This project was special because of your contribution. The negative and positive experiences over the years have added to your expertise and passion for helping others. I am truly grateful for your kindness and generosity in the information that you shared. I am hopeful for the future, knowing that there are wise and caring people out there like you guys, making a quiet contribution to the health and wellbeing of others.

For all those who have openly expressed their support and acknowledgement of this thesis. I humbly appreciate the genuine interest and support it has been influential and important. My team at Hauora Waikato, Te Aka Kura your support has also been noted. I would like to extend my deepest appreciation for the support and belief in me, arohanui koutou.

Lastly, to my family and friends thanks for loving me unconditionally and supporting my journey. The late night chocolate and lolly runs to keep me going were priceless, I am grateful. A special mention to my kid's who continue to be my inspiration and joy, thank you for being there and always making me laugh. I am the luckiest mum, love you guys endlessly. Thanks everyone!

He aha te mea nui o te ao? He tangata, he tangata, he tangata!

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Glossary of Terms

Karakia - prayer

Kaupapa – topic

Kaumatua - elders

Kawa - protocol

Maumau - waste

Nga tohu - signs

Tapu – sacred

Tikanga – customs

Tohunga – expert/chiefs/priests

Wahine - female

Whakapapa - ancestry

Whanau – family

He aha mea nui o te ao? He tangata he tangata he tangata

What is the most important thing in the world? The people the people the people

Appendices

Appendix A – Ethics approval

Appendix B – School of Psychology cover letter

Appendix C – Information sheet

Appendix D – Consent forms

Appendix E – Demographics form

Appendix F – Interview schedule

Appendix G – Secondary traumatic stress scale

Appendix H – Professional quality of life scale

Chapter One: Introduction

Purpose of study

This study explored occupational stress and trauma in a specific context, namely that of the helping professions. Occupational stress is a long-term concern in the healthcare industry where higher rates of substance abuse and suicide are reported more than any other professions (Kenna & Lewis, 2008). The complex interaction between traumatised clients, stressed staff, organisational issues and challenging social, economic and political environments create an atmosphere for vicarious trauma and burnout (Warshaw & Pease, 2010).

Vicarious trauma is commonly referred to as compassion fatigue, this occurs in professionals as a direct result from wanting to help other people who are suffering, in distress or have been hurt. If the compassion causes negative changes, in the psychological, emotional, physical or spiritual wellbeing then professionals may be suffering from Vicarious Trauma (Figley, 2002; Pearlman & Saakvitne, 1995; Warshaw & Pease, 2010). Practitioners who are exposed consistently to traumatic material and work-related stress are vulnerable to the effects of vicarious trauma and burnout-related impacts (McCann & Pearlman, 1990).

The literature identified serious conditions that place helping professionals at risk of harmful effects from psychological impacts specific to their work (Bride, Robinson, Yegidis, & Figley, 2004; Figley, 1995; McCann & Pearlman, 1990; Pearlman, 2014). The literature suggests a better understanding of these impacts, increase self-care practices and reduces negative stress effects, subsequently improving the system of healthcare (Meurs & Perrewe, 2011). In the past vicarious trauma effects were commonly referred to as burnout or countertransference. However, over the last four decades more extensive studies

have conceptualised those effects into distinct categories (Bride, Robinson, Yegidis, & Figley, 2004; Figley, 1995; McCann & Pearlman, 1990; Pearlman, 2014).

The terms vicarious trauma, compassion fatigue, burnout and secondary traumatic stress are still used interchangeably, knowing these concepts help reinforce self-care practices to ameliorate the effects of these work hazards (McCann and Pearlman 1990; Figley, 1995; Puckey 2001; Alarcon 2009; Davies 2009). This study attempts to contribute to our understanding of stress-related psychological conditions that arise in the workplace for health professionals in New Zealand. The research explored the lived-experiences of practitioners across various health settings, such as counselling, nursing, social services, psychological and cultural with the aim to gain an insight into how they manage VT effects.

Researcher Perspective

The purpose of this study was developed for educational purposes that arose out of concerns for my own personal safety as a Māori psychology student wanting to help others. Are there any risks, if so, what are the risks involved? Are there people more vulnerable than others, if so, why? How do they manage? Because of my interest in this area I was given the opportunity to research the costs of caring on health professionals.

I currently work in the mental health sector in a non-clinical role and can see firsthand the importance of self-care strategies and professional supports that encourage help-seeking interventions. I started this research project before I began my role so I was theoretically aware of the psychological impacts that I may face

from repeated exposure to others pain and suffering. This study sets out to answer the many questions that arose out of researching this topic.

It was important that the approach used was culturally sensitive to my own cultural values and those of the participants. The underlying foundations of VT reflect the same principles and structure as the cultural framework of Mason Durie's (1994) Te whare tapa wha model. Durie's (1994) holistic model of health and wellbeing, assesses four specific areas; emotional (taha hinengaro), physical (taha tinana), social (taha whanau) and spirituality (taha wairua). The cultural similarities were acknowledged and the VT framework (Constructivist Self-Development Theory) was chosen based on these holistic foundations aligning with the literature and research aims.

Definitions

It is useful to understand the keywords for helpers that are used interchangeably in this study, depending on the context it is pertaining to. The key terms are used extensively throughout this study and defined below.

Helping professionals refer to a profession that nurtures the growth of or addresses the problems of a person's physical, psychological, intellectual, emotional or spiritual wellbeing. A *health professional* is an individual who provides systematic ways to help people, families or communities through preventative, curative, promotional or rehabilitative health care services. A *practitioner* is a person who actively engages in an art, discipline, or profession, especially medicine. A *therapist* is a person skilled in a particular kind of therapy. A *participant* is a person who takes part in something (Oxford University Press, 2016). These key terms in the context of this study are used interchangeably to

describe the targeted population and the participants who are also referred to as practitioner-participants at times.

The terms clients or patients have been used interchangeably throughout this study. A *client* is referred to as a person or company using the services of a professional person or organisation, including medical or social services. A *patient* is a person who is about to receive or registering to receive medical treatment (Oxford University Press, 2016). At times these may be used interchangeably depending on context.

Research Objectives

Vicarious trauma explains the psychological effects on health professionals specific to their occupational stress. The researches goals aim is to increase the knowledge base by sharing the lived experiences of helping professionals in New Zealand using the VT framework. Exploring effects in various health professional across settings ultimately to find out how VT concepts are understood and managed? These became important areas of focus. The specific research goals were to:

1. Explore helping professionals motives for helping including knowledge of psychological impacts prior to employment in health care
2. Explore effects of VT in helping professionals through their own lived experiences and perspectives
3. Identify factors from witnessing VT effects in other colleagues
4. Gain insight into self-care practices that manage and prevent effects of VT effectively from experienced health professionals

Thesis Outline

This chapter provides the reader with a foundation of the thesis. It describes key terms used throughout this study, and the research goals and objectives of this project. This thesis is structured into five chapters. The following chapter reviews the overlap and differences between VT and other related concepts, an overview in psychological theories of stress, the diagnostic features associated with VT, an overview of the constructivist self-development theory (CSDT) and lastly New Zealand studies of VT. The third chapter outlines the research methodology describing methods and procedures used to collect information and analyse it. Chapter four reports the key findings, from self-report measures and the interview schedule, exploring themes and subthemes derived from this research additionally, linking the findings to the research. Chapter six concludes the thesis and emphasises the small contribution made by this research.

Chapter Two: Vicarious Trauma

This chapter covers a wide range of topics it attempts to describe VT, its related concepts, early theories of stress, the current diagnostic features related to VT, the psychological impacts on helping professionals including the CSDT framework and New Zealand studies on VT.

The contribution since the conceptualisation of vicarious trauma and other related concepts have been met with relief and validation from many health practitioners (Figley, 1995; Kenna & Lewis, 2008; Pearlman, 2014). VT is still a relatively new field of study and most studies on this topic are outside of New Zealand. The importance of knowing these work hazards for helping professionals in New Zealand highlight a knowledge gap that this study can attempt to contribute to the literature in this field.

VT was developed by McCann and Pearlman (1990) in reference to their own personal experiences from working with sexual abuse survivors. It is a specific process of change resulting from empathic engagements with trauma survivors. Listening to the graphic accounts of horrific events in great description, even participating in traumatic re-enactments and listening to the cruelty of others are part of the empathic engagements (Pearlman & Saakvitne, 1995). The result for “people who work with trauma survivors on a regular basis tend to feel isolated, overworked and powerless” (Berceli & Napoli, 2006, p. 153) thus increasing the possibility of mass trauma on health professionals. An increase in mental and physical diseases including death and suicide are considered high among health professionals (Berceli & Napoli, 2006; McCann & Pearlman, 1990). In an attempt to describe this mass trauma on health professionals McCann & Pearlman (1990)

created the term ‘vicarious traumatisation’ which they formulated through the framework of constructivist self-development theory (CSDT).

Vicarious traumatisation is a result from working with trauma survivors. It is the emotional residue that continues, well after the empathic engagement has ended. It is described as the professional’s trauma reactions, resulting from the regular exposure to clients traumatic experiences (Figley, 1995; Figley, 2002; Munroe, Shay, Fisher, Makary, Rapperport, & Zimmering, 1995). Since the conceptualisation of VT other researchers (Baird, 1999; Bride, Robinson, Yegidis, & Figley, 2004; Davis, 2009; Follete, Poulsny, & Milbeck, 1994; Hudnall-Stamm, 1995) have expanded on its application in a wider range of occupations that have high human contact including those connected to people who have endured psychological trauma.

Related Concepts

The importance of the 1990’s produced key works that introduced the term caring-induced trauma models and Figley’s (1995) transmission of trauma model which suggests that the “members of systems require identification with victims and their suffering” (Figley, 1995, p.248). Caring-induced trauma is a broad term associated with working professions that have high human contact (Davis, 2009) and transmissions of trauma are referred to as secondary traumatic stress disorders (STSD). Secondary traumatic stress (STS) is typically used interchangeably with compassion fatigue and vicarious trauma (Figley, 2002). These models and authors are leaders in the research of; psychological impacts on helping professionals, compassion fatigue (CF) (Figley, 1995), secondary traumatic stress (STS), (Hudnall-Stamm, 1995) and vicarious trauma (VT) (McCann & Pearlman,

1990). This study explored the effects of VT in the practitioner's personal and professional perceptions (Pearlman & Saakvitne, 1995).

It is important to identify the differences between these occupational hazards in order to inform recovery and treatment interventions (Figley, 1995; Hudnall-Stamm, 1995; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). Figley (1995) argued that there existed an inadvertently overlooked sample of traumatised people, individuals who become impaired as an outcome of their compassion for those in harm's way. In the past helping professionals' reactions to client traumas were referred to as burnout or countertransference. The ongoing research has recognised the consequences of working with trauma survivors additionally identifying various ways of coping that help alleviate the effects (Figley, 2002).

Compassion fatigue.

Compassion fatigue is considered a consequential outcome from working with traumatised clients (Huggard & Nimmo, 2013). It reflects the high level of exposure to suffering, sorrow or sympathy to the point of exhaustion, parallel this with the deep desire to alleviate the trauma inflicted upon others is known as the 'cost of caring' or compassion fatigue (Figley, 1995; Huggard & Nimmo, 2013; Tabor, 2011). Compassion fatigue in comparison to vicarious trauma is argued to have a faster onset and recovery period (Tabor, 2011) and is not just associated with victims of trauma or violence. For example, any health professional that witnesses chronic illnesses in patients may become distressed gradually over time.

Two theoretical models were constructed from the research in an attempt to capture the developmental pathways of compassion fatigue (Huggard & Nimmo, 2013). The first was Figley's (1995) Compassion Stress and Fatigue or

Compassion Fatigue/ Satisfaction Self-Test (CFST) model followed by the newer version the Professional Quality of Life version 5 (ProQOL) model (Hudnall-Stamm, 1995; Figley, 1995; Stamm, 2010). This model emphasises that empathy is the major resource used when working with traumatised clients. The term compassion fatigue (CF) can be used interchangeably with secondary traumatic stress (STS) (Figley, 1995).

Secondary traumatic stress.

Hudnall-Stamm (1995) first introduced secondary traumatic stress (STS) in the mid-nineties and is regarded as a caring induced trauma. The conceptual dimensions of STS parallel those of posttraumatic stress disorder (PTSD) this includes; re-experiencing, numbing, emotional withdrawal and avoidant symptoms the distinction between the two concepts is the transmission of stress (Wang, Strosky, & Fletes, 2014). Huggard, Stamm, & Pearlman (2013) recently recognised STS arises when the fear of a person's safety is threatened including a form of revictimization of repeated exposure to details of a traumatic event (Huggard & Nimmo, 2013; Tabor, 2011).

STS can be experienced by describing the single traumatic event to others or testifying in court while having to recall specific details (Tabor, 2011). STS is defined by Figley (1995) as “the natural consequent of behaviours and emotions resulting from knowing about a traumatising event experienced by a significant other” and the stress then results from wanting to help the traumatised person (p.7). Even though VT may present with STSD-like symptoms the main difference is VT occurs without having to experience or witnesses the traumatic event (Tabor, 2011).

Burnout.

Burnout is a result of psychological strain, it can also happen as a consequence of high expectations not being met (McCann & Pearlman, 1990) and is often the end result of ongoing caring induced trauma (Tabor, 2011). It can be described as “emotional and physical exhaustion” (p.204) accounting for delayed performance, tardiness and absenteeism. Another distinction is that it can occur in any job situation, not just those working with victims. Factors that can contribute to this, is professional isolation, emotional and physical drain of always being empathetic, cynicism and over ambitious with no acknowledgment or reward (Tabor, 2011), lack of therapeutic success, nonreciprocal encounters, feelings of inadequacy and incompetence (McCann & Pearlman, 1990). Other symptoms include depression, loss of compassion, increased boredom and discouragement (McCann & Pearlman, 1990). VT that is left unaddressed becomes a potential predictor of burnout (Martin, 2006).

Countertransference.

Transference represents the feelings experienced by the patient in regards to the therapist, where countertransference is the feelings of the therapist's in regards to their patient. In the past countertransference referred to the “activation of the therapist's unresolved or unconscious conflicts or concerns” (McCann & Pearlman, 1990, p. 134). Originating from Freud in 1910 it is referred to as “the reciprocal impact that the patient and the therapist have on each other during the course of psychotherapy” (as cited in Jankoski, 2010, p. 106). Overall exposure to traumatic experiences of victims is detrimental to the health of people close to the victim including those involved with the healing process (McCann & Pearlman, 1990). McCann & Pearlman (1990) believe that those working with trauma

survivors will experience alterations in their cognitive schemas, affecting their “feelings, relationships and life” (p.136). Herman (2001) recognised trauma as contagious and introduced the term traumatic counter-transference referring to helpers reactions mimicking the same rage, terror and despair as their client’s. These pervasive alterations to helper’s feelings (Baird, 1999, p. 23) are a result of working with survivor’s trauma material.

Posttraumatic growth.

The previous key terms and concepts have primarily focused on negative effects for helping professionals. However helping professionals also experience positive effects from empathic engagements. The literature on posttraumatic growth is a new concept used to describe positive changes after trauma. The concept of growth following adversity is a common topic discussed throughout history among philosophers, major religions and recently is a theme in contemporary Western culture, addressed by empirical research (Gibbons, Murphy, & Joseph, 2011). For many years the focus has been on the harmful effects of adversity, however since the conceptualisation of caring induced trauma models, positive growth outcomes are just as favourable and conceivable. Due to the extensive research on harmful effects researchers are now able to identify these effects more constructively, as processes for healing and recovery through self-awareness. The related concepts associated with VT describe pathways to burnout that can be prevented by early detection. Early theories of stress can provide a greater understanding of stress reactions psychologically, emotionally and physically.

Psychological Theories of Stress

The James-Lange theory (1884-1887) of emotion proposed, an event/experience happens; our autonomic nervous system creates physiological reactions that can increase heart rate, perspiration, muscular tension, and dry mouth. The bodily sensations prepare us for action, and then emotions follow, rather than cause. For example, I see a bear, my muscles tense, my heart races, I feel afraid. The event = arousal = interpretation = emotion (Cannon, 1927; Prinz, 2004).

The Cannon-Bard theory of emotion developed in the 1920's refuted the James-Lange theory proposing an event/experience happens, we feel emotions and physiological sensations occur together (Cannon, 1927; Friedman, 2010). The sequence is; event = simultaneous arousal and emotion, for example, I see a bear, I feel afraid and I tense ready to run away. The phrase 'fight or flight' still refers to the automatic physiological reaction of organs, nerves and hormones which prepare the body for action to potentially dangerous situations and reacts in order to survive (Cannon, 1915). It was suggested by Cannon (1927) initially the bodies endurance to low levels of stressors as necessary but prolonged or intense stressors can result in a biological breakdown.

The articulation of the stress experience by Selye (1936) believed it was a process of adaptation and developed the term general adaptation syndrome. According to Selye (1936) there were three stages of the stress process that progress from the; (1) *alarm stage* reaction to the situation, (2) the *resistance stage* of the stressor, and (3) the *exhaustion stage*. Like Cannon, Selye (1974) agreed that stress is important and not necessarily negative, therefore endorsing stress as a necessary experience rather than something to avoid. Stress can be

recognised through negative events that can result in distress and positive events that can result in eustress. These two terms were first differentiated by Selye (1974) who argued the body cannot physically differentiate between positive and negative stress.

In the 1950's Lazarus and colleagues discovered that stressful conditions did not always produce the same effect in some people, noticing that under stress conditions, for some it was great and for others it was small. Lazarus's work on cognitive appraisal began developing (Lazarus & Erickson, 1952). Cognitive appraisal relates to how individual's view a situation, the appraisal is the direct evaluation of the surroundings in reference to personal well-being (Lazarus & Folkman, 1984).

The appraisal process identified two stages; primary and secondary: (1) *primary appraisal* is the initial evaluation of the present situation, *positive*, *dangerous* or *irrelevant*, if the event is perceived as *dangerous* then the process progresses to the next stage (2) *secondary appraisal* which evaluates people's ability to cope with the situation and determines the level of stress and emotional reaction to the event, is it a *challenge*, a *threat* or *harm/loss*. It is then evaluated by sufficient or insufficient resources of overcoming the stress. Two types of coping processes were identified (1) problem-focused (where the focus is on managing the encounter), and (2) emotion-focused coping (where the focus is on regulating the emotion). Then reappraisal occurs (Lazarus & Folkman, 1984). This theoretical base framework informed the development of current work place stress theories. Lazarus's *Transactional model* argues that stress is a product of the transaction between the individual and the environment and is based on the cognitive appraisal process (Cooper, Dewe, & O'Driscoll, 2012).

This next model focuses on how it views behaviour as a predisposition open to vulnerability from life stress experiences; the *diathesis-stress model* makes these connections. These predispositions can be genetic, psychological, biological or situational factors these individual differences that interact with subsequent stress events lead to developing disorders (Ormel, Jeronimus, Kotov, Riese, Bos, & Hankin, 2013; Ingram & Luxton, 2005). The term diathesis is derived from a Greek term meaning disposition or vulnerability the diathesis-stress model is a correlation between biological or genetic traits (diathesis) interacting with environmental influences and life events (stressors) which produce depression, anxiety or schizophrenic disorders (Oatley, Keltner, & Jenkins, 2006).

It is these factors *predisposition* and *stressors* that the diathesis-stress model declares that if the stress exceeds a threshold the person will develop a disorder. The individual's threshold is determined by the interaction of the diathesis and stress (Oatley, Keltner et al. 2006). This model is used specifically for studying the development of psychopathology and used in many fields of psychology (Sigelman and Rider 2009). It accounts for the interplay between nature and nurture in understanding the susceptibility of psychological disorders and can assist in determining who will develop a disorder and who will not (Oatley, Keltner et al. 2006). For example, in the context of depression, a person with a family history of depression is vulnerable to the risk of developing a depression themselves.

However people who have a family history of depression and have experienced exclusion or rejection from peers would be at higher risk of developing depression than a child with a family history of depression that has a positive supportive social network (Barlow & Durand, 2009; Gazelle & Ladd,

2003). The diathesis-stress model was further extended to explain a vulnerability to positive environments and why someone could have a better outcome than someone else this is termed the *differential susceptibility hypothesis* (Belsky & Pluess 2009).

The diathesis-stress model defines stress as a conceptualised life event that disrupts a person's equilibrium (a calm state of mind) in life (Oatley, Keltner et al. 2006). As mentioned in the previous example of depression it is not until the exposure of a specific stress can the depressive disorder be triggered (Nolen-Hoeksema 2008). Stress is recognised for its significant role in individuals developing psychopathology (Sigelman and Rider 2009). The importance of including this model is that it explains how some people are more vulnerable than others.

A critical role in human emotion is cognition, the interpretation of a situation can determine what emotion we will associate with the experience (Ellsworth & Scherer, 2003; Siemer, Mauss, & Gross, 2007). Therefore it is important to understand how to regulate emotions through our appraisal and information processes as individuals can be prone to cognitive biases (Joormann, Waugh et al. 2015). These cognitive biases in interpretation or memory tend to interpret vague material in a negative manner and recall negative events more often, impairing emotional regulation and increasing vulnerability to emotional disorders (Joormann, Waugh, & Gotlib, 2015; Joorman, Yoon, & Siemer, 2010).

Individuals at risk of developing emotional disorders posit that depressed or anxious individuals exhibit cognitive biases in various stages (interpretation and memory) of information processing (Matthews & Macleod 2005). Clinical features of psychological distress point to a state of emotional suffering key

features resemble symptoms of depressions, such as loss of interest, sadness, hopelessness and anxiety symptoms such as restlessness and tension (Mirowsky & Ross, 2002). Somatic symptoms including insomnia, lack of energy and headaches may also be connected to these symptoms and will vary across cultures (Alarcon, 2009).

The scientific literature describes “psychological distress” as a significant predictor for a number of disorders including but not limited to depression, posttraumatic stress disorder and other anxiety disorders, these symptoms combine with personality traits, functional disabilities and behavioural problems (Vrshek-Schallhorn, et al., 2015; Drapeau, Marchand, & Beaulieu-Prevost, 2012; Campeau, Liberzon, Morilak, & Ressler, 2011). The defining features of psychological distress becomes evident after the exposure of a stressful event that threatens the mental or physical health where there is ineffective coping with the stressor and emotional turmoil leading to serious mental health conditions (Drapeau, Marchand, & Beaulieu-Prevost, 2012; Horwitz, 2007; Ridner, 2004).

Pathology of Stress

Exposure to a traumatic event is often the prelude of psychological distress the duration in which an individual remains distressed determines the difference in diagnostic criteria. The DSM-5 (APA, 2013) explains under trauma and stressor-related disorders that trauma can cause clinically significant distress and impairment in important areas of functioning this is based on the medical model. Vicarious trauma in therapists tends to look like symptoms similar to those who have primarily experienced trauma (Bride, 2007; Davis, 2009; Drapeau, Marchand, & Beaulieu-Prevost, 2012; Figley, 2002; Pearlman, 2014). The

following clinical disorders represent the symptoms and severity of stress levels that can impact on health professionals practice as a result of caring for others.

Diagnostic Features

The diagnostic criterion informs health professionals of symptom durations and impacts, needing further reflection and self-awareness to understand the psychological impacts from their job. The transmissions of trauma from client to practitioner is the main theme of this study, knowing how to identify what is going on for health professionals can lead to a deeper understanding of self, others and the world they are in. Literature supports the belief that the significant others of health professionals who are not in the same industry would also benefit from knowing about these psychological impacts that affects their loved one (Pack, 2004). It is the transfer of stress from one person to another that interests researchers into identifying patterns and themes of this transference. These transferences of stress from client to health professional are referred to as transmissions of trauma (Figley, 2002).

The difference between stress and trauma can be confusing at times. The word *traumatic* can refer to *highly stressful* events and *trauma* narrowed down can refer to *extreme stress* (Allen, 2005). The significant effect of trauma is “the intrusion of the past into the present” often indicating the onset of developing psychological symptoms and psychiatric disorders (p.4). As a result of working with highly stressed and traumatised populations the common outcome for many practitioners developing secondary traumatic stress (STS) is between 6% to 26%, and those working with children are up to 50% at higher risk of developing it and/or other related conditions of posttraumatic stress disorder (PTSD) and vicarious trauma (NCTSN, 2015).

The following psychiatric classifications, acute stress and posttraumatic stress disorders describe overlapping vicarious trauma and secondary traumatic stress related symptoms that can become harmful to the helping professional. Vicarious trauma in therapists tends to look like symptoms similar to those who have primarily experienced trauma (Bride, 2007; Davis, 2009; Drapeau, Marchand, & Beaulieu-Prevost, 2012; Figley, 2002; Pearlman, 2014). The following clinical disorders represent the symptoms and severity of stress levels that can impact on health professionals practice as a result of caring for others.

Acute Stress Disorder.

A diagnosis of acute stress disorder (ASD) can only be given three days after a traumatic event has occurred (APA, 2013). It is referred to as the initial psychological reaction to witnessing or experiencing psychological trauma. If ongoing life stressors are present during the first month it can worsen symptoms. These symptoms include; “Intrusion (thoughts, images), Negative Mood, Dissociative symptoms, Avoidance symptoms, and Arousal symptoms” (p.283). If stress responses are transient but still occur within one month of trauma exposure it may not result in posttraumatic stress disorder (PTSD). Although it is estimated that around half of the individuals who initially present with ASD will potentially develop PTSD (APA, 2013). The DSM 5 (2013) characterizes ASD by the fulfilment of certain criteria, principally, if ASD exceeds four weeks, PTSD is diagnosed.

Posttraumatic Stress Disorder.

The development of Posttraumatic stress disorder (PTSD) is a set of symptoms that were not there prior to a traumatic event, it relates to disruptions in; social, occupational, physical disability and socioeconomics including medical

care (APA, 2013). It can eventuate after a traumatic experience from directly experiencing it, witnessing it or learning of the traumatic event, or exposed to repeated aversive details of the traumatic events (including emergency workers, police or mental health professionals) (APA, 2013). PTSD symptoms may ripple through important areas of one's life it connects to poor social and family relationships, absenteeism from work, low income, and education and occupational success (Figley, 2002).

PTSD has eight criterion that include lists of symptoms in most categories, that either need one, two or more of the symptoms, they include; the *Event*, Intrusion, Avoidance, Negative Moods, Arousal, duration of symptoms, clinically significant distress, and a requirement that the physiological effects are not attributed to any substance or medical condition (APA, 2013). The way in which a person reacts to their traumatic experience with fear and helplessness may result in sleep disturbances, hyperarousal and hypervigilance, reliving the experience, horrific flashbacks and intrusive thoughts (APA, 2013) and unsuccessful attempts at avoiding details of the traumatic event (Yeager & Roberts, 2015). According to the DSM-5 (2013), PTSD is often comorbid with several other disorders for a diagnosis of PTSD, duration of symptom's must last for more than a month and significantly impair function in important areas of one's life (APA, 2013).

Constructivist Self-Development Theory

Tragedy comes in many forms; it has no discrimination and can happen to anyone (Allen, 2005). The avenues in which people sought help in the past use to rest largely on extended families and communities for emotional and psychological support (Berceli & Napoli, 2006). The increase of traumatic experiences in recent times has increased the need for trauma survivors to seek

help placing a high demand on expert help and services (Berceli & Napoli, 2006). People who work with trauma survivors on a regular basis tend to “feel isolated, overworked and powerless” thus increasing the possibility of mass trauma on health professionals (Berceli & Napoli, 2006, p. 153). An increase in mental and physical diseases including death and suicide are considered high among health professionals (Berceli & Napoli, 2006). In an attempt to describe this mass trauma on health professionals McCann & Pearlman (1990) created the term ‘vicarious traumatisation’ which they formulated within the framework of constructivist self-development theory (CSDT).

CSDT interweaves psychological theory into a framework that identifies aspects of self that are affected by trauma for understanding and healing (Pearlman & Saakvitne, 1995b; Wang et al., 2014). This framework “suggests that individuals construct their own realities through the development of cognitive structures or schemas” (Cohen & Collens, 2013, p. 4). The cognitive structures (schemas) in context to CSDT include a person’s beliefs, assumptions and expectations about self, others and the world. These schemas “are then used to interpret events and make sense of experience” (p.4). New information is often assimilated into these existing schemas when possible (McCann & Pearlman, 1990), it is argued however that if new information challenges the original existing schema it becomes incompatible and cannot be assimilated.

The effects of trauma work on the original schemas about self, others and the world become invalidated or shattered (Cohen & Collens, 2013; McCann & Pearlman, 1990). The existing schemas need to be modified to integrate the new information into the belief system (Cohen & Collens, 2013). Vicarious trauma is experienced when these schemas are modified in a negative way. Typically, after

hearing about graphic accounts of rape and violence, the helping professional may no longer see the world as a safe place to live in. The cognitive bias supports the new information, of a potentially unsafe world, increasing distress overtime (Cohen & Collens, 2013; McCann & Pearlman, 1990).

CSDT was developed to identify these schema's closely affected by trauma and causing harm to self (Pearlman & Saakvitne, 1995). It explains the way in which people may interpret the experiences of trauma. There are five main components of self-affected by trauma that make up the framework of Constructivist Self Development Theory (Affleck, Saakvitne, & Tennen, 1998). These include, (1) frame of reference, (2) self-capacities, (3) ego resources, (4) central psychological needs and (5) perceptual and memory systems. These five areas “reflect both cognitive and experiential modes of organising experiences” (p.283).

Frame of reference.

Identity, world view and spirituality, contemplating, causality, why? Trauma survivors often reflect repeatedly, why did this happen to me? Pearlman & McCann (1990) find some therapists may try to understand why individuals experience such traumatic events. The authors argued that this type of thinking is thought to be destructive, if a form of victim blaming takes place. This often represents a searching for causality for the therapist rather than the client believing that people can influence the outcomes in their lives. Consequently a fascination in asking questions about the perpetrator to the victim can diminish the therapeutic alliance and can often lead clients to early termination of therapy (Way et al., 2004). The helper professional can become overwhelmed by reports of traumatic experiences the continuous challenge to their schema which can have

a disorientating effect with no room to process, this can leave an “unsettling sense of uneasiness” (Pearlman & McCann, 1990, p. 142), leaving practitioners with a sense of disrupted frame of reference if not worked through or addressed (Pearlman & Saakvitne, 1995).

Self-capacities.

This reflects the ability to maintain a continuous, relatively consistent positive sense of self across time and includes three components: (1) tolerating strong affect (2) maintaining a positive sense of self (3) maintaining an inner sense of connection with others (Pearlman & Saakvitne, 1995). According to Pearlman & Saakvitne (1995) these capacities develop in childhood provided they come from stable, loving parents or caregivers. A disruption in these capacities may include, “overextending, overindulging (overeating, substance abuse, binge shopping), frequent or intense self-criticism, self-loathing, difficulty modulating strong feelings, hypersensitivity, disconnection from loved ones and a sense of isolation” (Pearlman & Saakvitne, 1995, p.161). An adaptation to this includes, immersing oneself in work, numbing or minimisation to disguise the pain. The appearance of these can be difficult at first to recognise and are equally dangerous for both client and health professional (Pearlman & Saakvitne, 1995).

Ego resources.

Include our (1) intelligence and will power for personal growth, (2) the ability to foresee consequences and protect ourselves from harm and (3) the ability to establish mature relationships and maintaining boundaries. These can become disrupted by trauma which will make it difficult to achieve meeting our psychological needs (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995).

Psychological needs and cognitive schemas.

These include our needs, beliefs and relationships around certain basic psychological needs; (1) Safety, to feel secure from harm, (2) Trust, to have confidence in one's own perceptions, (3) Esteem, to feel valued by self and others, (4) Intimacy, the need to feel connected to self and others (5) Control, managing one's feelings and behaviours (6) Power, therapist's own sense of power or efficacy in the world (7) Independence, freedom of movement and personal autonomy (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). If these psychological needs are not being met it may indicate a disruption in our cognitive schemas.

Perceptual and memory system.

People who listen to others traumatic accounts can unintentionally internalise the other person's memories which temporarily or permanently alters their memory system. Traumatic memory is commonly fragmented and dissociated from the individual and has five aspects; (1) verbal, (2) Affect, (3) Imagery, (4) Somatic and (5) Interpersonal. A disturbing experience for helping professionals is to experience intrusions of their client's sexual or violent traumatic imagery often at inappropriate times. For example they may be experienced at intimate times with loved ones, which could be difficult to discuss at the time and may result in interpersonal conflicts increasing overtime. Continual exposure to trauma stories can have a profound and lasting effect that alters one's sense of self and frame of reference. CSDT is a framework that is used to examine the effects of trauma-work in therapeutic relationships between client and health professional (McCann & Pearlman, 1990).

The integration of life experiences operate from different levels, the context and consequences, existing beliefs, the intensity of somatic aspects, affect and interpersonal components determine the event for cognitive processing. It is necessary for one to incorporate these functions into one's frame of reference (sense of self, others and the world) and schema's regarding our central psychological needs. CSDT understands the adaptation process includes these factors; personality, personal history, the traumatic event and its context, within social and cultural contexts, and builds on the basis that individuals construct and construe their own realities (Affleck, Saakvitne, & Tennen, 1998; Figley C. R., 2002). CSDT identifies the patient in context of their experience and thus avoids labelling the client "as a collection of symptoms" (Pearlman & Saakvitne, 1995a, p.56). The philosophical underpinnings of CSDT provides an inclusive theory encapsulating effects from both client and carer, being less symptom driven than PTSD, it outlines the aspects of self that become affected by trauma over time (Davis, 2009).

NZ Studies of Vicarious Trauma

A review of NZ research on VT identified this term as an under-researched topic. However, NZ studies that can contribute to the research in this area add value to this relatively new concept. Puckey's (2001) study of vicarious trauma in psychiatric nurse's described the relevance and implications of VT for mental health nurses. The study explored the nature of vicarious traumatisation, and its contemporary conceptualisation of helping-induced trauma. It became evident through her findings that vicarious trauma is a real risk and is likely to impact on all areas of psychiatric mental health nursing practice. Puckey (2001) stressed that vicarious trauma in psychiatric mental health nurses is a safety risk and advocated

taking measures to engage in a process of risk management for both nurses and client.

In her doctoral research that included qualitative interviews of 36 ACC approved counsellors and their significant others, Pack (2004) explored the range of factors that impacted on sexual abuse counsellors, whose exposure to their client's trauma increased their risk of burnout and secondary traumatic stress. The aim of her study was to investigate if concepts of VT were relevant in New Zealand. Pack (2004) explored if these counsellors were more negatively affected by the intense material they are engaged in. She highlighted the importance for support from significant others to provide a threshold of space that enabled them to explore the impacts of living with a partner who is a health practitioner that is continually exposed to others traumatic material.

Pack (2004) described the discord as the hallmark of traumatic stress in context with sexual abuse counselling in New Zealand. It is this research paper that Pack (2004) presented a movement for theoretical frameworks that provides a context for establishing and maintaining connection on a variety of levels. This study highlighted important areas for growth both personally and professionally.

Another study by Pack (2007) reviewed the concept of Hope in gestalt therapy for ameliorating the effects of vicarious trauma. It was her idea to illustrate an approach in balancing hope and despair. Drawing upon a particular case Pack (2007) argued that staying present and in the moment with the client is key to recovery. A vital component on how well clinicians can work effectively and manage self-care when working therapeutically rests on the underlying optimism and courage of Gestalt theory. Pack (2007) believed that hope and an attitude of 'optimistic perseverance' as essential when working with clients who

present with complex trauma which raise existential themes and dilemmas for therapists. Acknowledging her own hope and despair, Pack (2007) felt she freed herself from over-identifying with her clients' and from re-experiencing vicarious trauma again. Pack (2004) argues "this path, once feared, is now well known, well-trod, and successfully traversed" (p.65).

Additionally another study by Pack (2008) reflected on her own background and experience of vicarious traumatisation through her practice. In this study she reflected on the negative impacts working with trauma survivors providing brief models of intervention. She disputed the constraints of the current medical model and provided a contextual alternative for client healing and collegial practice. In her practice the use of Gestalt and Narrative therapies offers other versions to her client's stories. These re-authored narratives offer a greater sense of personal organisation and a way forward for all involved in the healing process. What Pack (2008) recalls as "back from the edge of the world" in re-authoring her own personal narratives as a defining moment in her development as a psychotherapist" and she says "remains a work in progress" (p.42).

Davies (2009) explored mental health nurses knowledge and experience of VT. In her study she described the role of a mental health nurse as forming ongoing therapeutic relationships with patients to foster healing. She argues that it is these empathic engagement that leaves nurses vulnerable to VT. A qualitative study on mental health nurses using in-depth semi structured interviews was conducted using narrative enquiry. The outcome of this study revealed that mental health nurses learned of VT on the job and were unprepared of the negative impacts. Davies (2009) findings recommended education on identifying VT and

that self-care measures include clinical supervision to ameliorate the effects of VT and endorsed further research of VT in mental health nurses.

There are a small number of studies on vicarious trauma in New Zealand and although it is still a relatively new concept it is gradually growing in research. The New Zealand studies add to the richness of the literature and offer a perspective in context to New Zealand health professionals. This study highlights important cultural aspects unique to NZ.

Chapter Three: Research Methodology

Studies on vicarious traumatisation have usually included large scale research surveys with quantifiable techniques to analyse the information. This study however is focused on finding those stories that practitioners experienced in the field using a qualitative research approach of in-depth interviews and surveys to gather data. The information gathered from participants in the interviews help identify themes of vicarious trauma as a normal process and, stages in development as a “rite of passage” (Pack, 2008; 2013).

Research Focus

This particular study was interested in interviewing professionals who are referred to as experts in their field. Bogner, Littig, & Menz (2009) positions experts as professionals who have technical process oriented and interpretive knowledge to their specific professional scope. Because experts are typically bound by time restraints and pressures an interview schedule was developed to outline the specific process and given prior to the interview so one was familiar with the process and the objective of this study (Bogner, Littig, & Menz, 2009; Flick, 2014).

Qualitative research is instrumental in its ability to provide complex textual descriptions of how people experience a topic it provides the human side to an issue. It places emphasis on human existence and the complexities of how we shape, reshape and create our personal realities. The focus is on the lived realities and qualitative research methods explore people’s experiences of living and how it affects them in different areas of their lives (Hungler & Polit, 1992).

In this study narrative methods are used in order to understand the lived experiences of practitioners and the effects of their work. A big role of the

researcher was to create a setting that promoted 'trust and openness' so the practitioners felt safe enough to tell stories partly involving unsettling times in their lives. This type of qualitative research primarily positions narratives as a retrospective reflection of bringing order to disorder and for the narrator to organise the disorganised (Murray, 2008) and give it meaning.

Narratives position itself in everyday understanding of disruption, vicarious trauma can be very disruptive for a practitioner at work and at home. Using interviews as part of the data collection allowed practitioners to share their stories from a reflective standpoint they also shared what they must do to ameliorate such disruption. The interviewing process referred to as episodic interviewing focuses on telling stories about particular experiences of change or disruptive episodes in their lives (Murray, 2008, p.117).

In the event of telling our experiences to others we create a space that allows us to incorporate others feedback in a way that helps shape and structure our stories (Black, Lapsley, & Nikora, 2002). The process of constructing these experiences is evidently a part of everyday life and a key role for interactions with professionals and agencies. The practice of therapeutic story telling is relatively specific to mental health settings and referred to as a special type of narrating. This type of narration produces stories of guilt, shame, loss, failure, sadness, horror and abuse. Practitioners rely on the ability of individuals to relay their experiences emotionally as it comes to them (Black, Lapsley, & Nikora, 2002).

Kaupapa Māori Processes

Karakia, - prayer (Tauroa & Tauroa, 2009, p. 160). Kawa, - protocol (p.160). Tikanga, - custom; the way things are done (p.165). Tikanga is the implementation of kawa (p.153). Kawa is Māori protocol (p.146). There are

various differences of kawa between each tribal affiliation however there are basic principles that apply to all. Following the correct tikanga, kawa is an indication of respect to the local people; typically meetings of any type are opened and closed with karakia which is tikanga kawa. Karakia can also be conducted as a part of hospitality (Kai'ai, Morrfield, Rielly, Mosley, 2004). This process was used to begin and close the interview process led by two of the participants who practice this tikanga respectively (Tauroa & Tauroa, 2009). Although these cultural practises were used in this research the method is essentially a western one which is 'culturally informed'.

Data Analysis

Thematic analysis identifies, analyses and reports patterns within data (Braun & Clarke, 2006). This thematic analysis is theory driven where the data is previously derived from the framework constructivist self-development theory which identified five main themes. Thematic analysis provides a method that can both "reflect reality and unravel the surface of reality" (p.81). Informed by narrative psychology the following sections will briefly provide a description of the processes used in this research. Limitations in this process tend to be concerned with reliability due to the interpretation of defining data themes and applying codes to portions of text. Despite these issues it regarded thematic analysis as the most commonly used method of analysis in qualitative research (Braun & Clarke, 2006).

Ethical Considerations

This research project was approved by the University of Waikato School of Psychology Research and Ethics Committee (Appendix A). Approval was necessary before contact could be made with potential participants Ethical

considerations were discussed such as the *protection of participant's identification*; this was remedied with giving pseudonyms and the option of modifying or deleting anything that they may wish to exclude. The need for *informed consent* was essential and all participants were fully informed of their rights this was outlined in the information sheet (Appendix C) and consent form (Appendix D).

All participants were informed of their rights to withdraw within a set timeframe of four weeks preceding the interview with no explanation needed. *Confidentiality* is an extremely important to maintain the anonymity and confidentiality of the research participants. All information captured from participants were stored securely as a requirement by the University of Waikato regulations postgraduate research and will be archived for a minimum period of ten years. *Respect for Māori* was pivotal as five of the participants identified as being Māori and as a Māori researcher understanding Māori interests were interpreted and understood accordingly.

Recruitment of Participants

A participant information sheet was designed specifically for this study (Appendix B). The information sheet described the background and objectives of the study as well as participants' rights (e.g. the right to withdraw from the study under any circumstances). Participants were also informed that all information provided by them will be viewed only by those involved in conducting this study and will remain confidential.

Consent forms were used to ensure that participants understood fully their rights, and what was required of them. Consent forms included, the title, and a checklist of questions regarding the project, and their right to withdraw at any

time, declaration statement of agreement for both participant and researcher and a space for their signature and the date (Appendix D).

This study was open to individuals in the helping professions, adults only who worked/s specifically or routinely with a traumatised group. An interest in how practitioners are able to manage the effects of vicarious trauma and achieve a level of balance. A requirement for this study was that Practitioners are managing their work conditions and are currently well. The participants included a psychiatric nurse, practising counsellors, social workers, psychologists and those who work in the mental health field or who provide regular pastoral-care for people. A participant demographics form was developed to capture certain information including name, age, ethnicity, and their email contact, highest form of education, primary helping role, years of practice and what areas they specialise in, a repeat of withdrawal rights as well as the contact details of the researcher and supervisor (Appendix E).

All participants were assigned a pseudonym to protect their identity and keep their information confidential. The ethnicity revealed two main ethnic types (5) Māori and (6) European, nine of the participants were from New Zealand and two participants identified themselves as American, however exact places of origin were not discussed. The interviews were held in Hamilton with one via skype to Tauranga. The places the interviews took place were at different locations around Hamilton that was most convenient for the participants, such as work places, one was by the river at Wellington Beach, the University campus. Following is Table 1 an overview of the demographics for each of the participants who took part in this study.

Table 1
Demographics of Practitioner-Participants

| Name | Age | Ethnicity | Education | Primary Roles | Yrs | Fields |
|-------|-----|---------------------|-------------|---|-----|---|
| Mrs A | 59 | Māori | Masters | R.N(comp) NZ | 37 | Forensic-Specialised ID |
| Mr B | 40 | Māori | Degree | Practice Manager | 18 | Domestic Violence, Criminogenics |
| Mrs C | 50 | NZ Pakeha | Cert. & Dip | Senior Employment Consultant | 20 | Rehabilitation |
| Mr D | 48 | Māori | PGDip | AOD & Cultural Counsellor | 10 | Cultural, Addictions & Co-Existing |
| Mr E | 59 | European | PGDip | AOD Counsellor | 25 | Addiction, Mental Health |
| Mrs F | 38 | Māori/Fijian/Indian | Other | Youth & whanau worker | 5 | Youth Justice |
| Mrs G | 58 | European | Degree | ACC Counsellor | 13 | Sexual Trauma, Domestic Violence |
| Mrs H | 44 | Caucasian/American | PGDip | Clinical Psychologist | 16 | Axis 1 disorders, Community Mental Health |
| Mr I | 64 | Māori | College | Senior Co-ordinator/Cultural advisor/Kaumatua | 15 | Govt. Agencies vs. Whanau needs, Cultural teaching |
| Mrs J | 42 | European | PGDip/Mast. | Consultant Clinical Psychologist | 16 | Youth, PTSD, Sex Trauma, Suicide Prevention & Postvention |
| Mr K | 43 | Caucasian/American | PhD | Psychologist/Psychotherapist | 11 | Trauma (Physical, Sexual, Existential) |

A total of 13 practitioners took part in this study; all participants were sourced from known networks and from word of mouth, three of whom were referred from participants and friends. One participant requested their information be withdrawn due to work constraints. Another participant was sourced through social media their forms were incomplete and did not fit the criteria as initially thought.

Research Procedures

Interviewing was the main process of data collection in this research. It encompasses a mixed method using two surveys (Appendix G and Appendix H) and a four part questionnaire (Appendix F). The interview according to Breakwell (2000) “is a virtually infinitely flexible tool for research” (p.239). The interview schedules primary aim was to produce a coherent narrative of the experiences of practitioner’s and how they process effects of vicarious trauma. The interview process can provide greater detail and depth than the standard survey. This allows insight into how the individuals understand and have narrated specific aspects of their lives. It was important to find participants who were willingly open and honest to share their information (Creswell, 2007).

A comprehensive set of interview questions was developed to draw out the many experiences of the practitioners. The practitioners were free to share their experiences either briefly or as extensive as they felt necessary or relevant. The narrative-story-telling approach aimed to understand the experiences of vicarious trauma and the effects on practitioner’s wellbeing.

The interview began with three background questions (section one), as a place to start and proceed from. Section two, three and four comprised of three parts, Part, A, B and C (section, two, three and four). From here the questions were aligned with the specific areas the project planned to explore.

Section one; *Background questions*: Motives for helping, knowledge of psychological impacts and vicarious trauma. Section two; *Part A*: Personal experiences of vicarious trauma and what that looked like. Section three; *Part B*: Can practitioners notice it in other work colleagues - How they could tell if they saw it in others and what their reaction was? Section four; *Part C*: How do you

manage your work and take care of yourself? Any historical traumatic experiences and support systems used in the past and most importantly present.

The interview schedule aimed to elicit articulate narratives of experiences of vicarious trauma, its detection and reactions in self and others, initial engagement with health and support services, and pathways to recovery. The questions were structured and asked to each participant in the same order. The questions were forthright about impacts from trauma work and specific areas were covered. The length of each interview varied from thirty minutes to ninety minutes. All interviews were recorded using a Dictaphone and did not need to be transcribed verbatim. The next chapter provides a detailed presentation of the findings from the interviews.

Chapter Four: Findings

The practitioner-participants as part of the interview process each filled out two self-report measures. These were (1) Professional Quality Of Life scale (ProQOL) version 5 (2009) and (2) the Secondary Traumatic Stress Scale (STSS) (Bride, 2004). Both were completed prior to the interview schedule. The interest in using the self-report measures was to gain an overall look at other related concepts such as compassion fatigue, compassion satisfaction, secondary traumatic stress and burnout. A comment was made from one of the practitioner-participant's in regards to the timing, stating if he was interviewed a few months earlier then the answers would have been completely different. This feedback was valuable to note for the importance of recognising and addressing early warning signs of negative effects.

Professional Quality of Life

The ProQoL (Stamm, 2010) is a 30 item self-report measure comprising of three subscales; (1) compassion satisfaction, accruing pleasure from the capacity to help others (2); compassion fatigue/secondary traumatic stress, negative feelings driven by fear and work related trauma; (3) burnout – associated with difficulties at work, feelings of hopelessness. The scores on each subscale have the potential to range between 0-50, higher scores are indicative of job satisfaction, burnout or compassion fatigue (Gibbons, Murphy, & Joseph, 2011). This ProQOL is the current and third version of Figley's (1995) Compassion Fatigue Self Test (CFST). The transition of versions or upgrade has since corrected psychometric problems resulting in a reduction of items from 66 down to 30 items on a 5 point Likert-type scale and the name changed to incorporate a user friendlier term. It measures the quality one feels towards their work as a

helper incorporating both the positive (compassion satisfaction) and negative (compassion fatigue) aspects relative to their job influencing their professional quality of life.

Compassion fatigue

Compassion fatigue comprises of two parts. The first part relates to, exhaustion, frustration, anger and depression characteristic of burnout and the second part refers to secondary traumatic stress and the negative aspects driven by fear and work related trauma. It is important to note that work related trauma is a combination of both secondary and direct (primary) trauma at work. Please refer to figure 1 that illustrates the pathways. *Figure 1* depicts the positive and negative pathways (Stamm, 2010).

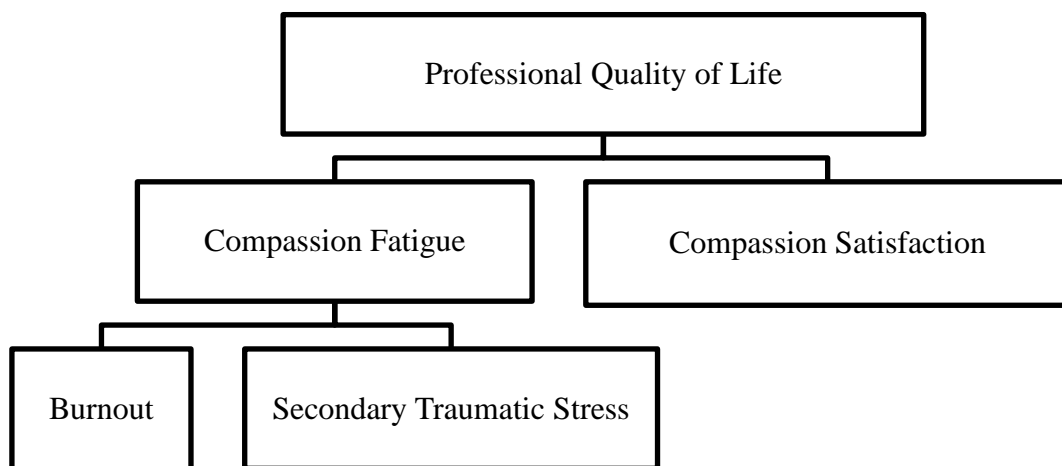


Figure 1. Diagram of Professional Quality of Life model and the pathways of compassion fatigue and compassion satisfaction.

Burnout is one aspect of the negative effects of caring and is referred to in this context as compassion fatigue (CF). Burnout is associated with feelings of hopelessness and difficulties with working effectively. The negative feelings have a gradual onset which tends to sneak up on individuals. Negative feelings can be

associated with high case-loads, non-supportive work environments and thinking that any efforts make no difference (Stamm, 2010).

The results from the ProQOL self report measure fell in the low range scores on the burnout subscale. The average score on this scale is 50 (SD10; alpha scale reliability .75). On the burnout scale an extra step was taken as some items were reverse scored. The sum of the burnout questions is divided into three levels; Low (22 or less), Average (between 23 - 41) and High (42 or more). The practitioner-participants lowest score was 17, the highest score was 30 and the average score overall was 21.

The scores individually fell between the low and average ranges, the overall results Low (22 or less), ($n = 6$) and Average (between 23 – 41), ($n = 5$). Typically about 25% of people score above 57 and about 25% score below 43. If the score is below 43, then this reflects positive feelings about the ability to work effectively. Any score above 57 then one is advised to contemplate on what at work makes you feel ineffective (Stamm, 2010). None of the practitioner- participants fell into the high category.

Secondary traumatic stress (STS) is the second component of compassion fatigue (CF). STS is work related and associated with secondary exposure to people who have experienced traumatically stressful events. The range of negative effects may include; intrusive images, fear, sleep difficulties and avoiding reminders of the client's traumatic experiences. STS share many similarities with vicarious trauma (Stamm, 2010). The results from the ProQOL on the secondary traumatic stress scale overall showed Low scores. The practitioner-participants lowest score was 15 and the highest was 25 with the overall average score of 21. The overall average result falls into the Low category; Low ($n = 7$) and Average

($n = 4$). About 25% of people score below 43 and about 25% score above 57, the higher score is indicative of reflecting, what at work is frightening or what other reason is effecting the score.

It is mentioned that high scores do not necessary mean there is a problem it could indicate perceptions of the work environment. If one does score highly on this scale it is advised to speak to a supervisor, colleague or healthcare professional (Stamm, 2010). None of the practitioner-participants fell into the High category. STS has its own section following compassion satisfaction and this is because the next self-report measure focused only on STS factors (excluding burnout, compassion fatigue and compassion satisfaction).

Compassion satisfaction.

Compassion satisfaction (CS) is about pleasurable feelings accrued from being effective at work. This is in context with the feeling of being able to help others through your work. Positive feelings about work, work colleagues and the ability to contribute at work and to the wider community (Stamm, 2010). The results on the CS scale showed Average to High scores. The practitioner-participants lowest score is 32 and the highest was 50 the overall average was 43. The average overall results fall into the High category; High ($n = 7$) and Average ($n = 4$). Typically about 25% of people score higher than 57 and about 25% score below 43. Higher scores are indicative of professional satisfaction in your role. If the score was below 40, it could indicate work-related problems or some other reason affecting the score, or one derives satisfaction from other tasks that are non-work related (Stamm, 2010). None of the practitioner-participants fell into the Low category.

Secondary Tramatic Stress Scale

The secondary traumatic stress scale (STSS) has 17 items on a 5 point likert-type scale, designed to measure the frequency of; intrusion, avoidance and arousal symptoms associated with work-related indirect exposure to traumatic events from traumatised clients in the last 7days (Devilly, Wright, & Varker, 2009). The STSS measures the symptoms congruent at that time with the Diagnostic and Statistical Manual of Mental Disorder's (DSM-IV) (American Psychiatric Association (APA), 1994) a conceptualisation of the characteristic symptoms of post traumatic stress disorder (PTSD).

STS is representative of PTSD diagnostic criterion B (intrusion), criteria C (avoidance) and criterion D (arousal) (APA, 1994). STS is a syndrome that is virtually identical to PTSD, the difference being PTSD is experienced by the sufferer and STS refers to the significant other's (or health professional) secondary exposure to knowledge about the traumatising event, the endless exposure of bearing witness to the suffering of others (Figley, 2002).

Like the ProQol the STSS has gone through rigorous testing resulting in the 17-item STSS reliability and validity coefficient alpha's of .94 intrusion subscale, .83 avoidance subscale and .89 arousal subscale (Bride, Robinson, Yegidis, & Figley, 2004). According to the American Psychiatric Association (APA) (2000), intrusion symptoms (or re-experiencing) include recurring and intrusive recollections of the event, consisting of, images, thoughts, or perceptions. These maybe through distressing dreams, illusions or halluciantions, flashbacks, a sense of reliving the experience and intense reactions when associating cues or reminders of the event (Bride, 2007).

Avoidance symptoms include a numbing responsiveness with a determined effort to avoid features associated with the trauma, such as thoughts, feelings or conversations, activities, places and people. Avoidance symptoms can also include detachment from others, a restricted range of affect, and impairments in recalling the traumatic event. Arousal symptoms include, anxiety or increased arousal that was not there before the trauma, “such as difficulty falling or staying asleep, irritability or outbursts of anger, difficulty concentrating, hypervigilance, or exaggerated startle response” (Bride, 2007, p. 64).

The STSS scores range from 17 (no symptoms) to 85 (severe symptoms) total score across all three subscales.

Intrusion subscale scores ranged between Lowest 5 and Maximum 25. The individual results from practitioner-participants scored between 5 and 13 with an overall average of 10.

The avoidance subscale scores range between Lowest 7 and Maximum 35, the individual results from practitioner-participants scored between 7 and 24 with an overall average of 15.

The arousal subscale scores ranged between Lowest 5 and Maximum 25, the results from practitioner-participants scored between 5 and 14 with an overall average of 10.

The practitioner-participant results ranged between lowest of 17 to a high score of 51 with an overall average of 35. Table 2 presents the overall scoring interpretation.

Table 2

Score Interpretation, Inclusive of the Three Subscales, Intrusion, Avoidance and Arousal.

| Little or no STS | Mild STS | Moderate STS | High STS | Severe STS |
|------------------|----------|--------------|----------|-------------|
| 27 or less | 28-37 | 38-43 | 44-48 | 49 and more |

The 50th percentile is 27 or less (Little of No STS). The 51st to the 75th percentile is between 28 and 37 (Mild STS). The scores at the 76th to 90th percentile is between 38-43 (Moderate STS). The 91st to 95th percentile is scored between 44-48 (High STS) and scores above the 95th percentile is 49 and above (Severe STS) (Bride, 2007). The overall results from the practitioner-participants are as follows; Little or No STS ($n=3$), Mild STS ($n=4$), Moderate STS ($n=3$), no High STS and Severe STS ($n=1$). It is important to note that one practitioner – participant scored Severe STS. Majority of the practitioner-participants results ranged between Little or No STS to Moderate STS, with one Severe STS. The Lowest score of 17 .

Interviews

This research explored the effects of vicarious trauma through the lived experiences of helper professional's from across various health services. These services include; three psychologist's, two clinical psychologists and one psychotherapist psychologist, three counsellor-clinican's, one sexual trauma, two AOD one of those is also a cultural counsellor, one psychiatric nurse, one disability employment consultant and three social services workers (one youth justice, one practice manager and lastly one senior co ordinator who is also a highly regarded cultural advisor/kaumatua). Each practitioner spoke openly about

their experiences of why they chose their careers, what vicarious trauma effects look like, the effects of how it looks in colleagues and their unique self-care processes that positively transforms the effects of vicarious trauma.

The key themes in the vicarious trauma framework CSDT is used to categorise the transcripts and explore the practitioner-participant's experiences. The framework provided a narrative sequence to the interview schedule by describing the practitioners experiences to explain the concepts. CSDT is referred to as a theory of personality which focuses upon the complex relation between traumatic life events, cognitive schemas about self and world and psychological adaptation (McCann & Pearlman, 1990). This enabled a theoretical approach to the outcomes of this research and explores four key sections which include;

- *motives for helping,*
- *personal experiences of vicarious trauma,*
- *noticing effects in others,*
- *ameliorating the effects of vicarious trauma.*

Section One: Motives for helping

- Professional development
- Spirituality
- Personal trauma history
- Knowledge of psychological impacts
- Knowledge of vicarious trauma

Section Two: Personally experienced effects of VT

- Impacts of listening to others pain
- Psychological needs
- Perceptions of profession, past vs., current
- Disruptions in self capacities

- Treatment of vicarious trauma
- Effects on interpersonal relationships
- Ego resources

Section Three: Noticing VT effects in colleagues

- Learning outcomes from noticing effects in others

Section Four: Ameliorating the effects of VT

- Help seeking patterns and key support
- Trauma history
- Learning outcomes

The question ‘how do NZ practitioners manage effects of vicarious trauma? Is sought to answer, through *acquiring* knowledge, ‘ if we understand the psychological impacts we can then try to ameliorate the effects’ so if we do this (understand psychological impacts), then more specific forms of healing may occur. This chapter discusses the four key sections using the CSDT framework and subsequent themes to answer the research question.

McCann & Pearlman (1990) identified trauma as disruptive in the context of helping professionals. It specifically affects a persons; frame of reference (identity, world view, and spirituality), disruptions in self capacity (affect, sense of self and connection to others), disruptions in psychological needs, beliefs and relations (safety, trust, esteem, control/power, independence and esteem), how these effect interpersonal relationships, impair ego resources, and alter individuals sensory memory systems.

In this section the areas are explored through the lived experiences of the practitioner-participants. The key findings and experiences reported by the practitioners are in the sequential order following the interview schedule.

Motives for helping

This section explores the practitioners career interests in the helping profession and how the cost of caring supports vicarious trauma factors experienced by the practitioner-participants, such as personal trauma history and professional development (McCann & Pearlman, 1990). Personal trauma history in the context of motivation to pursue a helping profession is found in the practitioner's narratives. Direct references to personal, or significant people, trauma experiences that influenced there pathway and profession. These events played a role that encouraged and guided them to develop personally and professionally in the helping profession. Professional development and personal trauma history produced sub-themes that were anchoring factors to the practioner-participants chosen careers, three interwoven aspects emerged; motives for helping others, cultural aspects and family history.

According to Pearlman & Mac Ian (1995) the literature stipulates there are specific therapist characteristics that will influence the risk of vicarious trauma. These include; "personal trauma history, the meaning of traumatic life events to the therapist, psychological style, interpersonal style, professional development and current stressors and support" (p. 558). Three themes found in section one are as follows, (1) professional development (2) spirituality and (3) personal trauma history.

Professional development.

All of the participants motives for helping others was clear from a young age, some progressed through educational and professional development to achieve these goals and others suggested they were guided spiritually to help others.

Well, I work with youth, and when I was growing up, I kind of could see that some of my mates were struggling, but there was nobody for them to

go and talk to or who was there for you, was dumb, and so I wanted to be there for my mates, in the future kind of thing...so thats kind of what led me.. (Mrs J)

Health professionals maybe drawn to this work “because of a deep belief in social justice” and a “personal objective to initiate social change” (Gerding, 2012, p. 4). Kruger (2003) cited work by Cialdini, Brown, Lewis, Luce, & Neuberg (1997) whom proposed it is the relationship that overlaps between self and others or ‘oneness’ “between the helper and the individual in need, that motivates helping, rather than empathy” (Kruger, 2003, p. 119). Kruger (2003) argues the association of helping others with whom one feels commonality is not a selfless act rather its one that promotes a more positive mental state.

When I was a kid I use to like helping my friends with giving them advice about stuff at home and when I was 10 (years old) I was editor of the news paper. It was a school newspaper, its nothing, it was a little tiny nothing, and they had a little column called ‘dear granny’ and it was like an advice column and I did that and it was anonymous they didnt know it was me, so ever since then, I’ve been bitten by the helping bug (Mrs H).

Being ‘bitten by the helping bug’ implies the notion of developing a passionate interest in a specific activity (Oxford Dictionaries, 2015). The urge to help others is evident in *all* of the practitioner-participants experiences and shared stories. An altruistic nature is a possible factor in the pursuit of job profession. Although altruism may influence motivation, a wider “range of motivations such as empathy, distress, personal and social rewards intertwine to influence altruistic motivation” (Burks & Youll, 2012, p. 396) The association between altruism and empathy is significantly positive it is relevant in health care professions to maintain efforts of empathy, to continually “motivate helping efforts” (p. 399).

Empathy for healthcare purposes is defined as a cognitive attribute that involves understanding patients negative concerns with the ability to comprehend this understanding and communicate it with the intent of helping (Hojat, Louis, Maio, & Gonnella, 2013). In contrast to sympathy which is an affective response which is activated by feelings, this can be detrimental for both patient and practitioner. The authors argue that “empathy because of its cognitive nature, even in excess, is always beneficial to patient care” (p. 6). The quality of empathic engagements leads to improved outcomes (Hojat, et. al., 2013) and empathic levels have been linked to trauma-growth in relating to others by moderating the relationships (Brockhouse, Msetfi, Cohen, & Joseph, 2011). Each participant at some stage in the interview mention empathy as an important component in their roles.

Spirituality.

The most fundamental disruption that helping professionals will experience is the disruption in the individuals sense of identity, central beliefs about the world and their spirituality (Pearlman & McCann, 1990; Pearlman & Mac Ian, 1995; Way, Van Deusen, Martin, Applegate, & Jandle, 2004; Brockhouse et al., 2011). Culture plays a major role in terms of spirituality, language, ethnic origin, and belief systems. Cultural values are expressed and acknowledged throughout the (5) Māori practitioner-participant’s experiences and included spiritual components such as tikanga (customs), karakia (prayers/blessings) and tohunga (chiefs/priests), as well as intrinsic involvement with the whenua, community, iwi (tribal) and marae affiliations.

It is argued that a strong sense of spirituality enhances therapist’s abilities to witness their clients suffering and remain strong (Brady, Guy, Poelstra, &

Brokaw, 1999), throughout their professions, the Māori participants claim that it is these factors that can keep them safe from harm and buffer effects. Vicarious trauma and spirituality are directly linked, by understanding the relationship between these two concepts is often essential for recovery work for both practitioner and client (Brady et al., 1999).

In order to help people, I didn't fall into it by accident but there was a calling, there was a tohu to say, 'hey you have some stuff that could be beneficial for others'. And the calling came in 1998 -1999 to say 'hey you're required here'. So it was from that point in time I've had a, I wouldn't say a good journey, I mean it's been a tough journey but yeah it was about self-exploration, self-realisation. It was about finding the purpose of my whakapapa, then me, so it was sought of a ...what would you call it? Synchronised or a multi-disciplinary path for me but helping that's what we do. (Mr D)

Themes that appeared through participants shared experiences were spiritually orientated for all (5) of the Māori practitioners. From the data it was clear that the Māori practitioners felt directed in a sense by their cultural heritage, their whanau (family), their whanau connections and their spirituality. The spiritual connections were mentioned as nga tohu (signs) and visions or apparitions from tohunga (chiefs/priests), kaumatua (elders), and respected members of the community who foresee the future wellbeing of their people, for the purpose of all people. All five Māori participants acknowledged their spirituality through culture, tikanga (customs) and commitment to caring for people.

It was the vision of our tohunga (name omitted for confidential reasons), and me not realising my potential I guess and my abilities, he pushed and actually directed that I take this position. Because he couldn't see a person with a background of clinical to be able to manage both family, clients and agencies together, to be neutral between the two, and he saw, he envisioned that in me and says 'I, need to be there, that person there'

but I didn't see it, I didn't see it till later on...and I say later on probably 6 months to 12 months later on. I started to realise what he was saying.. Yeah... because his apparition I guess, it was go in there and listen for the first 3-6 months, without asking questions, just sit there and listen (Mr I).

. Culture is ethically recognised as an important component to health services and providers can benefit from being aware of the specific cultural preferences (Mauri Ora Associates, 2008). A cultural element was first applied by one health service (Tokanui Psychiatric Hospital) in the mid 1980's within a clinical setting in New Zealand. The mental health sector became the first to practice and embrace culture as a therapeutic intervention (Kingi, 2006). In 2010 there were 275 Māori health providers who delivered frameworks distinctively Māori (Kirkman, 2012).

Improved healthcare has been associated with familiarity of cultural heritage in New Zealand for Māori and non-Māori, as a result in New Zealand cultural competence is a necessity in continuing education for healthcare professionals (Kingi, 2006). All registration bodies are required to establish standards of clinical and cultural competence under the Health Practitioners Competence Assurance Act (HPCAA), (2003).

I was kind of directed there because of my whanau members, not that I had, you know, close cousins, or brother, or mother in forensic...I felt I had a role there and then my son who was autistic was getting into a bit of trouble hitting people. Well, if you're gonna kill somebody I want to be there because they will put you in a place where nobody cares about you and I wanted to be there (Mrs A).

According to a study by Kumar, Ng, Simpson, Fischer, & Robinson, (2008) the results showed a slight disparity in how Māori mental health inpatients are treated. Consequently reporting Māori inpatients were less likely to be offered psychotherapy and more likely to be prescribed higher doses of antipsychotics

then non-Māori. This finding is common in other ethnic minorities from all over the world (Kumar et al., 2008).

Personal trauma history.

The data found that most participants had some personal trauma history experienced personally or through family members who were affected by trauma and mental illness. Rodrigo's (2005) paper on the conceptual dimensions of compassion fatigue and vicarious trauma refers to the personal trauma history as the 'wounded healer' and explores the connections between the 'wounded healer' and 'vicarious trauma'. The wounded healer was first introduced by Carl Jung a psychoanalysis in the 19th century his concept referred to the idea that analysts are compelled to treat patients because the analyst himself is wounded. A study by Barr (2006) reported that 73.9% of therapists had some form of wounding experience that led them to their career choice.

Rodrigo (2005) introduces the model, compassion fatigue and vicarious trauma/wounded healer model (CF&VT/WH). The way in which therapists choose to relate to and process their private and sometimes unresolved suffering will most likely impact their therapeutic work positively contributing (or not) "to their own healing, in parallel with their clients" (p. 70). Zerubavel & O'Dougherty Wright, (2012) researched the Jung's wounded healer archetype's and found the literature suggests that a "healer's own wounds can carry curative power for clients" and thus "embodies transformative qualities relevant to understanding the recovery processes" (p. 482). The authors argued that it is not the woundedness itself that produces healing rather the potential of healing is generated through the recovery process. Once one understands their own wounds and journey of

recovery the better they are in guiding others through such a process (Zerubave et al., 2012).

Well I kind of went through my own kind of crisis slash breakdown when I was about 29, in 2001.... well I guess it really kind of started pretty much when I was born into a pretty traumatic family and the foster system for awhile, so I kinda sort of maintained some resilience through that but it definitely scarred me pretty badly and then I sort of held on but by the time I was in my late 20's it all sort of came crashing to a head and so I went through my own process of healing. Fortunately I had mindfulness practice already established at that point so I was able to use that as a major resource for working through my own trauma and recovery and then after, experiencing tremendous healing and just the whole process was such a blessing in the end that I realised I really tried to enjoy my life that I decided that I'd like to support other people going through similar kinds of journies, there coming from there traumas and what not...(Mr K).

Rosenbloom, Pratt, & Pearlman, (1995) referred to the helper's own trauma history influencing the way in which they respond to their clients' trauma material. Thus deepening their understanding and sensitivity towards their clients reactions, further enriching the clients sense of being understood without judgement.

After completing treatment for drug and alcohol addiction, I went back to whangamata where I was living. I quickly realised my state around there, I wasn't going to last very long and I thought well, what can I do? what do I know? I know drug and alcohol I know mental health and I thought this would be a good way to keep me clean so that's where it started... (Mr E).

In the vicarious trauma literature referring to personal trauma history practitioners are at risk of reactivating early experiences and memories. Prior to the vicarious trauma model countertransference was referred to as this type of reaction however there is a difference between the concept of countertransference

and vicarious trauma. Countertransference is referred to as a therapists emotional reaction to their client activated by past unresolved personal life experiences (Neumann & Gamble, 1995; Pearlman & McCann, 1990; Trippany, Kress, & Wilcoxon, 2004). Where as vicariou trauma reactions is directly associated to the trauma material and is not a reaction to past life experiences (Trippany, et al., 2004).

Knowledge of psychological impacts.

I was not prepared, your new you're excited about working with people, no idea. I have had other conversations with colleagues and they've said the same thing the excitement that they've had and just how hard it is to keep well looking after yourself, and your just giving so much of yourself...(Mrs G).

It was important as the researcher to get an idea of how prepared the helping professionals were prior to working with clients. Exploring 'what information, if any, did you receive in the workplace about the impact of psychological trauma on practitioners, therapists, social workers etc.?' This question sought to determine the practitioner's knowledge base and awareness of the possible harm that is involved with helping others. Prior to the 1990's the psychological impacts on helping professionals were only just being touched upon, and it is still a fairly new concept today in some fields. There has been a major increase in studies into this area in the past few decades that outline the necessity for understanding the costs of caring (Pearlman & McCann, 1990; Pearlman & Mac Ian, 1995; Figley, 1995; 2002). A call for the inclusion of psychological trauma impacts in coursework introduced at graduate school level (Courtois & Gold, 2009) and recommendations for courses specifically designed to introduce trauma content

(Black T. G., 2006) and training on strategies for dealing with psychological impacts (O'Halloran & O'Halloran, 2001).

Probably my work with ACC, I worked with a serious portfolio of injured people there and I did get some training through ACC that was helpful into how to deal with it, but other than that I've had very little (Mrs C). Minimal... (Mrs J).

Etherington (2000) suggested the development of models specifically for clinical supervision that focuses on the supervisee's experiences of their work (Knight, 2006) and their own possible personal therapy.

I knew I had to bring to the fore everything that I had so I wouldn't be traumatised- ongoing training, workshops, practise is you minimise that type of thing, now they offer EAP but in the early days there was none of that, so being Māori I had things, I had things and I felt luckier than the other nurses to rely on, and if I hadn't of had those things I wouldn't have gone into that area... (Mrs A).

Māori practitioners refer to their cultural knowledge as a tool to ameliorate effects of vicarious trauma and Mr I used a metaphor to explain psychological impacts. Cultural connotations are interwoven throughout the Māori practitioners experiences. Spirituality is the hallmark of direct and indirect trauma, although the previous literature refers only to the disruption's of spirituality (McCann & Pearlman, 1990). Māori who practice their cultural traditions have a strong sense of their spirituality which provides an opportunity to deepen and expand a vicarious transformation.

Psychological trauma ...well I'm always a person that don't delve on the negatives so if there is a negative I will try to find out about, what are the positives within that, and help the families and il give you a scenario in terms of the Māori world what im talking there. Because when we're carving a piece of wood, a straight piece of wood, its too easy cos the grain goes with it, but if you get a piece of wood thats full of knots, you

got a lot of work to do and those I'm talking about, those knots, is about families or people experiencing trauma they've had to go round and round and inside out before they can see their way forward. Well the same as a knot on a piece of wood you have to go round and round and round backwards and forwards inside and outside before you can get a good finish on that piece of wood but when the piece of wood is finished it is a real treasure and that piece of wood will tell its own story...same as in the families in the traumatic state is actual work like that and there will be a way out...(Mr I).

The harmful effects of adversity on the helper professional has received extensive focus over the years. A recent shift in the aspects of vicarious trauma has now begun to concentrate on the prospect of personal growth (Murphy & Joseph, 2011). Following the exposure to psychological trauma posttraumatic growth refers to positive changes that individuals may also experience (Brockhouse et al., 2011).

Knowledge of vicarious trauma.

Whats that? ... I try and put myself in their shoes, in the same sense its not to get tied in there, not to lock yourself in there, you need to always have an open mind so you can find a way out and hopefully you bring that one whose traumatised through with you, you can get pulled down, you wont be a well person and thats the importance of karakia at the end because that what theyve talked to you about doesn't belong to you so the karakia is to return and give it back to those people it belongs to, not to you..thats a safety mechanism for myself and others who work in the same way..... (Mr I).

The third question “what is your knowledge of vicarious trauma?” in addition to understanding the psychological impacts, vicarious trauma implies that there is a change in the way that a therapist endures ways of “experiencing self, others and the world” (Mac Ian & Pearlman, 1995, p. 558). Over half (6) of the practitioner’s were unsure of its exact meaning and the rest (5) referred to it as

witnessing trauma experienced by someone else. The expansive knowledge of stress effects on professionals tend to include the various negative symptoms from client's traumatic material. Tabor (2011) argues then that "vicarious trauma is a type of empathetic engagement" (p. 203) and is a possible precursor for burnout or emotional exhaustion (Neumann & Gamble, 1995).

I learnt about it abit to late, when I worked at the unit at the prison. I love working out there and I worked really long hours and it wasnt fair that those kids were locked up the way they were and their stories. Because they trusted me and I was there all the time I heard alot of their stories and that was really sad.... I started what I didnt know was burnout ... and people would say unhelpful things 'you like need boundaries' and 'you need to sort it out'. Instead of listening and going heres somebody with passion, how do we navigate it and I went to a conference paid for it myself. A workshop that talked about vicarious trauma and I sat there with tears running down, going its not just me and so he talked about how you deal with and where you put it and that it doesn't mean your a bad person or a bad therapist, it just means its a life long journey of, how do you deal with that and how do you honour that...you have to look after yourself cause you are honouring the people you are working with...so thats how I learnt about it so I wasn't taught about it...(Mrs J).

Pack (2004) referred to the literature about vicarious traumatisation suggesting that counsellors' "exposure to their clients' trauma may increase their risk of burn-out and secondary traumatisation" (p. 19). The narrative stories are congruent with the literature that highlights the increased risk for some newer therapist's experiencing higher levels of burnout and negative effects of vicarious trauma (Mac Ian & Pearlman, 1995). This pervasive change occurs overtime as a result of working with trauma survivors and these changes effect a clinicians, "sense of self, spirituality, worldview, interpersonal relationships and behaviour" (Way et al., 2004, p. 49). In the past the literature seemed more concerned with

the negative effects, currently more research has developed which reflects positive growth through continual exposure to others pain. Brockhouse et al., (2011) argue that the results of their study suggest growth is experienced with the cumulative brushes of trauma over time in experienced clinicians by reinforcing their changing schema.

Personal experiences of vicarious trauma.

Well, I must say that there are some stories that I don't forget, that people tell me, I wish I could but umm some of them. I just think there are some people that have had a rotten old rough time of life through no fault of their own and those ones get me, sometimes, not often, but there is a few that I won't forget (Mrs C).

The impacts of experiencing vicarious trauma is far reaching creating ethical concerns as it greatly increases the risk of “clinical error”, “increases anger toward clients”, and increases the risk of “compromising therapeutic boundaries”, unintentionally “doubting their skill and knowledge” (Trippany, et al., 2004, p. 82). VT permeates across multidisciplinary settings and affects those that work close with highly stressed or traumatised clients (Neumann & Gamble, 1995).

Oh god I think I've heard it all...well no that's not true because I am always amazed the things I do hear that I haven't heard before but I've had things from confessions of murder, to crimes and things that they've done to abuse, they've admitted to things that have had to happened to them... (Mr E).

All of the participants answered “yes” to the question “have you personally experienced effects of vicarious trauma?” The typical disclosures that each of these practitioners experienced ranged from violations of sexual abuse, child abuse, neglect, victim and perpetrator accounts, substance abuse, suicide, identity and role confusion, criminogenics, domestic violence, early psychosis, confessions

of murder and horrendous crimes. The CSDT framework is significant in cognitive adaptation and suggests that the changes in the practitioners cognitive schema's are potentially permanent "because each traumatized client the therapist encounters reinforces these changes in the cognitive schemas" (Pearlman & McCann, 1990, as cited in Trippany, et al., 2004, p. 82).

Man watching tv whose father is yelling at him to change channel, walks outside the voices in his head said kill him, grabs an axe and puts it in his head, was asked what did you do after that..he said changed the channel...unwell, unwell...unwell... (Mrs A).

Impacts of listening to others pain.

I think it's about being non-judgemental, again initially I had trouble working with men who had committed sexual abuse. I struggle with that, because my first thing was I just wanted to thump them. But I've learnt over the years to be non-judgemental to actually detach away from it and look at the bigger picture opposed to the smaller picture tangled up on the little things so by looking at the bigger pictures and looking at the person as, that's only one part of the person, it's not the whole person, has enabled me to actually find good in just about everybody... (Mr E).

Each of the participants were asked 'how do they typically manage intense/hard to hear disclosures from clients?' Jung (1966) conceived the term "unconscious infection" as a side effect for those who work with the mentally ill. According to the literature (Trippany, Kress, & Wilcoxon, 2004) on vicarious trauma the repeated exposures to client's trauma causes a shift in the way the therapist's view world. The practitioner's spoke openly about the effects from different levels one referred to going home to her family and pulling them closer. Others felt all they could do is listen without judgement and be supportive focusing on the next step rather than ruminating on the problems. Mrs G spoke

about being real with her emotions, and showcases this to her client's as part of the healing process.

How do I manage it when I'm hearing it? I am as real as I need to be and if I'm impacted at that time by someone's story, well I can feel sad that's real and I share that cause I have a belief that sometimes a client needs to see that someone is affected by their story, cause they usually haven't had anyone hear how horrible or how sad that experience was, so I get teary over something I hear and I don't think that is inappropriate at all and sometimes it might not be in the session sometimes I've driven home and cried all the way home to get it out, yeah so that's how I deal with it. I will be true to whatever it is I'm feeling, it might be anger, I might be angry at the injustice... some clients will then go into, yea some of them will go into "I made you cry" and then I say "no" you didn't make me cry" I said "it's about what I've heard, this is how I'm feeling and honouring of your story". So they can go into that fairly bad because they made me cry and sometimes we need to do a little bit of work around that and to see that it's okay to see that some ones affected by what they went through...(Mrs G).

Identifying disrupted schemas and psychological needs.

The framework constructivist self development theory (CSDT) in the context of vicarious trauma, emphasises the “progressive development of a sense of self and world view in response to life experiences” (Pearlman & Saakvitne, 1995, p. 159). This section explores the psychological needs and disruptions in cognitive schemas. A review by Pearlman & McCann, (1990) on the literature ‘*adaption to trauma*’, “revealed seven fundamental psychological needs: safety, dependency/trust, power, esteem and intimacy, later including independence and frame of reference” (p. 137). These themes were explored to gain an understanding of the types of experiences that can impact on the practitioners

world and belief systems. This section focuses on the psychological needs and cognitive schemas that disrupted .

Safety, e.g., world is unsafe, need for stronger security etc.

It does make me think about, you know, if this can happen to somebody that I know right in front of me, that I know, then maybe the world isn't as safe and when they talk about being abused by someone they trusted someone they knew it makes me think oh I wonder how safe are my own kids and thats one of the more frightening thoughts of course (Mrs H).

The urge for stronger security may challenge the practitioners schema's within the area of safety, the fearful thoughts or images of harm to loved ones may increase and heighten the sense of vulnerability and awareness of the "fragility of life" (McCann & Pearlman, 1990, p. 139). The psychological needs shape our beliefs the effects of vicarious trauma disrupt these beliefs and alter the way in which safety, trust, intimacy, power, independence and esteem are experienced. Noticing these shifts is important to accurately interpret situations as sometimes caution maybe warranted (Trippany et al., 2004).

I would have to say that I'm pretty ignorant to the gang stuff and that's been quite shocking to be hearing a lot of that. Theres a part there that I started thinking what a horrible world this is. I could see why some people would want to get out of it, but there's always this hope that I have, that life can be better for people. I know that its my faith and hope that gets me through but I have certainly at times, where I've felt you know pretty sick world (Mrs G).

Trust, e.g., feel more suspicious of peoples motives, more cynical or distrustful etc.

Trust, well I'm cynical anyway ahm I'm not distrustful you know, I love people, but what it did do is because some of the people who were so disinhibited about what they said, they were not careful about what they said, it made me look at the rest of the world with, can I believe you,

really can I believe you, so i got to know, I learnt there how to look at people in a different way, normal people..ahh your full of shit you really are you know... (Mrs A).

Exposure to the many cruel ways that people can be deceived, betrayed or violated may disrupt the schema's of helper professionals about trust. This can increase suspicion and cynicism towards peoples motives in a gradual shift practitioners begin to question scenario's. For example; a man seen playing with young girl in the park, she could be his daughter, however thoughts of, is this girl is being molested by this man may creep in. Trust schemas can alter practitioners perceptions, from trusting some/most people to believing the opposite and trusting no one (McCann & Pearlman, 1990). Not all participants felt that they could not trust people and Mr B found that he had to push through those barriers and felt it was a sign to prioritise a meaningful relationship with that person. Mr I conveyed that if one was feeling that way then they have already prejudged the person or situation and closed off.

(trust) no...what that question tells me, that their prejudging and closed off, if that happens there's going to be a difficult ability to be able to engage because you've started to carry more baggage on top of yourself...they've closed off, absolutely (Mr I).

Intimacy, e.g., feeling alienated, separateness from family, friends or co-workers.

Intimacy, alienated in a sense I felt because of that ability that it was something that I learnt from working in psychiatry in general and forensics, I was about that korero. I was just talking about feeling alienated with my family, not my kids but my thing, it was them not me, them not me, who separated, because they didn't trust me because they felt that I was assessing them all the time and I probably am.....you know, I can see you, I can see you but all you see is a psych nurse and you get that (Mrs A).

Those who have experienced trauma can often feel alienated from the world and people in general. Therapists are at risk of this same alienation as a result of too much exposure to the horrendous atrocities that their clients disclose. It is further reinforced by others who cannot comprehend why people would work in such an environment some practitioners are hesitant to even explain what they do due to stigmatization. It's this sense of separateness coupled with the requirement for confidentiality, which inhibits connecting with others (McCann & Pearlman, 1990).

Effects on interpersonal relations can make it difficult in achieving rewarding relationships. Signs that propose vicarious trauma is present include (1) social withdraw this tends to happen if the helper professional feels different or knows something others do not, or feeling exhausted and depleted; (2) a lack of tolerance in maintaining the emotions necessary to maintain an intimate relationship; (3) feeling alienated from intimate partners or sexual partners, and friends or (4) the diminished capacity to enjoy forms of entertainment, like movies or TV. The demands from their work always helping others can make one less available to others in their own life. This can potentially lead to an imbalance of deeper connections with work colleagues than family (Pearlman & Saakvitne, 1995).

(Intimacy)

So sometimes I feel when I'm with my friends and family they talk about there work but I can't or it would be a downer and so I remember somebody saying your always happy all the time and I said 'no', I'm happy when I'm with you cos I let myself be happy. So sometimes I think its a false sense of who I am but I don't want to talk about that stuff, so it is different (Mrs J).

Power, e.g., overwhelmed helplessness and feeling more vulnerable, self-defence classes etc.

It is also a common trend for some health professionals to enrol in self defense classes expressing a need for personal power in case of situations where they are in similar situations as their clients. Alternatively the illusory nature of control over unexpected life events heightens despair and may lead to depression when they realise “how little control they have over life or death” (p. 140).

I've done self defence classes and I teach my kids that...I think thats countering that helplessness sometimes you got to make a balance of, this is the world. I get overwhelmed at systems that don't look after kids, thats probably the thing that upsets me the most, cause its not soft to be soft, it actually takes a lot of bravery (to be soft)...and thats the counter so while theres powerlessness and changing systems, if your in it for the young people then man you just listen, and there they are, all excited to see you, come and give you a hug and you think are they allowed to hug a psychologist? well too bad, sometimes, I think those rules inhibit the change (Mrs J).

Mrs J (2015) went on further to say;

I don't think the worlds safe, and I have to try and figure out how I live in that world knowing that its not safe..and how I live in a world where people believe it is and i don't want to ruin their belief systems, and that's the balance and then you've got the other extreme that the world is just crazy (Mrs J).

It is also a common trend for some health professionals to enrol in self defense classes expressing a need for personal power in case of situations where they are in similar situations as their clients. Alternatively the illusory nature of control over unexpected life events heightens despair and may lead to depression when they realise “how little control they have over life or death” (p. 140). The exposure to client's memories can have a profound impact on a helper

professionals need to control others or things in their own life and helper professionals can often push clients into acting on their fears rather than helping them to understand the meaning of their vulnerabilities (McCann & Pearlman, 1990).

I guess its more about safety for the most part...about my work sometimes it makes me also doubt whether, you know, how you can be (safe) sometimes. Like the changes that result from the trauma are so intractable it makes you wonder if you can possible help here...it's very hard work sometimes"...(vulnerable) "definitely...(Mrs H).

Independence, e.g., strong need to feel in control and free.

Free yep can certainly relate to that. I've had two trips recently and I went overseas and it was just incredible to just feel like I had left everything behind in NZ, so coming back was actually really hard cos I had just felt this sense of freedom yeah...ahh I just think it wasn't just work stuff for me. I have family things that without going into it has impacted on me too and I know I have to do more work on having boundaries in that area, certainly hugely better with it but it impacts on me at times, I think more so than the work thats my personal life. I need to be in control but I've gotten out of that cos I know the truth is I'm not. All I can control is how I think and how I act thats all I have control over really, so for me, thats very freeing because to realise that actually my control is only over me and my thoughts and actions, and so freedom for me comes everyday, I have to find ways to empower me...(Mrs G).

Pearlman & McCann (1990) describe a disruption in independence is often experienced by victims of trauma through the profound diminishment in personal freedom and autonomy. Sometimes therapists can over identify with their clients feelings and loss of independence and begin to experience dreams or feelings of being trapped or confined and may painfully lose their own "sense of personal control and freedom" (p. 140) which increases the need for more control.

Oooh yup, yup and I have to watch that one cos sometimes when your advocating for young people you have to be very strong but you also have to have people around you who will pull you in when you need to. I haven't won that I still think I'm to independent (Mrs J).

Esteem, e.g., sense of anger, bitterness or pessimism toward people, contemplating fate of the world.

hmm I guess the fate of the world oh gosh going to hell in a hand basket kind of thing but yeah being pessimistic, a little bit more pessimistic would make sense (Mrs H).

Helper professionals overtime can become cynical and pessimistic through the excessive exposure to people who have been violated, shattering their belief systems leaving them bitter and angry (McCann & Pearlman, 1990). Sometimes it can lead practioners to devalue their worth and ability (Pearlman & Saakvitne, 1995). It is also argued that the helper may find their view of human nature increasingly negative at the distressing realisation of how cruel the world can be and will often ponder the fate of the world (McCann & Pearlman, 1990).

I feel a bit of anger, if I can put it that way, what is that agency there for then, there put in a position to help families but actually they actually put up barriers for families and make it more difficult and whats that about? You know the more and more I think about it we give these government departments Māori names ay, so work and income, Te hiranga tangata, what does that mean and if they cant uphold that then take the name off get rid of it. It's a waste, it's a real waste, and the more I think about it, I think gee theres probably going to be a time where il get up and say that, maumau (waste), what a bloody waste, its all about money and not tangata (people) (Mr I).

Disruptions in self capacities, coping strategies.

Disruption in self capacities for individuals impair; the ability to maintain a positive sense of self, the ability to self-soothe and the ability to sustain

connection with others, “these can be disrupted by trauma and by the work of trauma therapy” (p. 163). This may skew ones judgement when beliefs are disrupted and can dramatically alter the ability to pick up on unforeseen consequences (Pearlman & Saakvitne, 1995).

I recently had a client suicide it was my first one... and you know I didnt see her body, I listened to what she chose to do and what the coroner found and all those things and so that that bugs me, that really bugs me. So I think of that and I'm more sensitive to triggers in other clients that look like this, that sound like this, you know just a little more careful around suicide or possible suicide so I guess maybe thats a little bit more cynical... not absentee I haven't avoided anything, I have had a wine or two. Intrusive thoughts, yeah, I would definitely say that so like you know even if I just hear a name thats similar to hers I think of her and I certainly wasn't intended to think of her...I think of the aftermath, you know her parents, even her GP, how it affected everyone and yeah thats definitely intrusive...(Mrs H).

The role of functioning self capacities for health professionals stress the importance of developing and maintaining a positive sense of self (Pearlman & Saakvitne, 1995). The next question looked at ‘what other effects of vicarious trauma have you experienced? E.g., overextending yourself, overindulging, cynicism, avoiding situations, absenteeism, substance abuse, intrusive thoughts etc..

All of the above, and I love it because it keeps it real, all of the above. I think, yeah, I suppose I mean the whole lot it's happened but you know, I'm aware of it, so I am okay with it (Mr D).

All the practitioner's cope in different ways some opting for a glass of wine after work while others felt the full range of negative coping strategies. Mr I and Mrs F denied any negative coping strategies and felt they knew how to separate and detach from their work. The interesting aspect there is that Mrs F was less

than five years into her supportive role, according to the literature newer practitioner's have a higher risk of coping negatively (Pearlman & Mac Ian, 1995; Pearlman & McCann, 1990; Pearlman & Saakvitne, 1995).

Ego resources.

Ego resources is the ability to meet our own psychological needs and to relate to others, however with trauma and in trauma work these can become disrupted (Pearlman & Saakvitne, 1995). According to Buczny, Layton, & Muraven (2015) any "exertion of self-control requires reliance on ego resources" (p.669). It is important to make self-protective judgements, maintain appropriate boundaries professionally and personally and to establish mature relations with others (Pearlman & Saakvitne, 1995). The authors also mention that one's judgement can be impaired by disrupted beliefs that result in an inability to foresee consequences accurately" (p.163).

Some of the practitioners who dealt with perpetrators were typically at higher risk of developing vicarious trauma effects. The difference in helping sexual abuse victims to treating sexual offenders can result in the latter clinicians having to manage stronger feelings of anxiety, anger, and distrust towards hearing and witnessing perversion or "stories of perpetration and deviant fantasies" (Way et al., 2004, p.51). The cognitive distortions seem to alter the ability to remain helpful at times when needed. Mrs A spoke of a traumatic experience with a paedophile offender that left her feeling like she didn't care and momentarily pausing to offer help while the patient was being attacked.

Ahmm coping strategies, it was around a paedophile, knowing that he was in the safest place in the world that he could be in, was allowed on unescorted walks and comes back with a little pair of babies tights. I said 'ooh whose are those'? Guess what he says, 'my girlfriends'. Okay, I

wanted to %#\$ stab him, really I did.. What another client did, well we weren't fast enough like nobody was reading it, all though, when you see a person sharpening a pencil, and sharpening a pencil, you think arrgh you gonna run out of pencil soon but none of us did. So she stabbed him with a pencil but you know I think we were all in the mindset we didn't care about him and he lay on the floor, usually we're into it straight away but in that situation you could have counted to five before we reacted to his plea and he was laying on the floor, saying somebody please help me, shes just stabbed me and the pencil was stuck in his arm, so all of us didn't drop down really for him because we all felt, we all had children, grandchildren some of us, and then there was an incident with the courts, why, why were we so slow and horrible, we were horrible, you know usually we were on to it, but I really do believe it was because of our things about paedophilia that made us slow...(Mrs A).*

Perceptions of profession, past vs., current.

The participants were asked 'Has your perception of your role changed since starting this work?' and how do you feel about your role now?

So starting yup, yea probably has in terms of professional outlook but from a cultural perspective nah cos I've always had cultural roles, so I've always been led by that. I can say that my cultural knowledge has increased tenfold and suppose my ability to teach and give has increased more and I suppose it goes hand in hand my professional side knowledge has increased at the same time at the same rate.. so giving those things balance aye (Mr D).

Only one of the eleven practitioners felt that her perception hadn't change towards her role.

I was raised in that similar fashion growing up, however, I guess I taught myself what not to do..whereas I don't think a lot of these kids have that opportunity..yeah..and I can relate (Mrs F).

The remaining ten participants all felt their perception changed in regards to their roles evolving over time. An increase in a more realistic outlook of their

work, self-awareness increased and all of the practitioners expressed a passion for their role and the gradual growth in their profession. The practitioners also touch on noticing their patterns and shifts in their behaviour and have learned to address them as soon as these thoughts, feelings or behaviours arise.

Yeah especially as I've moved different roles within the work, so starting out at just plain old ethical face and now being a little bit more removed from that and doing private practice that's my only kind of direct contact with clients..but yeah it has changed"

How do you feel about your role now?...

"more realistic I guess, you know you start out very idealistic and then you start going oh well you can't save the whole world but then so little changes, you know individual successes are what kind of sustain you more now...(Mrs H).

Help seeking and support.

Mrs A continued...

We had a team talk, we always debrief and that's a good part of about being inside, we always debrief and we were blasted for our reaction times we were... as professionals we should not...and you know, I may not have realised at the time, that although we were okay with the other business, somebody should have come and talked about that particular thing yeah so...so that was put in place, reactionary, but yeah it was put in place...(Mrs A).

In addition to the negative ways of coping a follow up question asked "*did you access help at the time? If so, where? E.g. Supervision, friends, or colleagues*". The practitioner-participants referred to various resources, such as EAP, debrief and supervision, and accessing leave if needed. Mr B spoke of his journey connecting with nature and isolating himself through cultural practices and wanting to be alone, the only human. The practitioner's spoke of three

different areas of support, professionally, personally and at an organisational level.

Another occasion when my marriage broke up, I went and saw somebody I couldn't identify with except for their role and responsibility, and that was about having some type of reflection of myself, cos that would of pissed me off if I had somebody else that was kind of like me, standing there telling me what I could do, then I would be sitting there, why didnt you figure this out your dam self" (Mr B).

All of the practioners experienced a time out period where they forcibly had to bring the focus to their own needs and take charge of their wellbeing. All of the participants mentioned supervision and its importance, accessing leave if needed and finding other alternatives necessary to foster healing. The practitioners learned overtime to notice their thoughts, feelings and behaviours finding unique strategies that would help ameliorate effects and increase self-efficacy.

Two EAPs at the moment, I have three supervisors. I've just gone hard at supervision because they help me in different ways. So one is, she's a social worker and she does DBT (dialectical behaviour therapy) and she talks with me and pulls me up about my underlying you knows what's going on in the emotions cause I'm really in my head and another ones a real challenge, why are you doing that why are you saying yes to that and then another one helps me progress my career and helps look after me so I go hard in that one...friends yep my brother he works in a hard area as well, so he's the one (Mrs J).

Personal strategies.

Identifying healing activities on a personal level is an important way to restore self-care practices. Activities that can reconnect the individual to their body and mind are especially useful (Pearlman & Saakvitne, 1995). This can also raise one's spiritual health in their own unique way. "Consciously expanding one's frame of reference", (p. 167) giving back to self, joy, wonder and awe,

loving and being loved these are like antidotes that address the disruptions that practitioners encounter in their work (Pearlman & Saakvitne, 1995).

I wanted to try things that weren't a western idea, so there is the hakari at the hakarimata walk, theres a waterfall, its up just on the left there. There is Tawhio's spring over in Maniapoto, there were Wairere falls and that was really helpful. Just take your shoes off and stand in the grass, remarkable, so there, stand there and see the wind blow, like see the wind blowing through the tress and stuff like that and for a short period of time I needed to be the only human, I just needed to reconnect.. (Mr B).

Organisational strategies.

So if I need to I take time off, someone to talk to, I will access someone that I trust and I will access those types of people as well so its okay to ask for help and for support...EAP ah we can certainly have that and that's the other thing we can have extra supervision if we're having difficulties with our client work we can ask for extra supervision so yeah we have things in place to support us through vicarious trauma happening (Mrs G).

At an organisational level promoting conversations at work around the impact of the work was considered a strategy (Rourke, 2007) for VT prevention and management. This co-insides with creating an atmosphere of respect, arranging services such as EAP, accessing or providing internal or external supervision for their staff. It is important for organisations to provide supportive, safe, comfortable spaces for self-care to progress. The provision of adequate resources such as continuing education, training and workshops on managing stress, adequate leave as required or expert medical professionals (Pearlman & Saakvitne, 1995) can help mitigate the potential harmful effects.

We have EAP and I have accessed it a lot while I've been here although its nothing to related to work, my wife has been very ill and she had got reasonable well again but half way through it she got very unwell again and it is certainly impacting on my ability tio work and this place really

they are brilliant... go and do what you need to and they set up EAP stuff for us so I'm very much much better at looking after myself now and I think that's why I have survived so long in the field (Mr E).

Effects on interpersonal relationships.

What kind of reactions/concerns did you receive from family, friends, or employers?

My family got a bit closer they were concerned a cousin of mine come down just to take me out get out for runs and just keep busy and didn't talk about the issue just supported me through that time so yeah there were concerns there...I took them (issues) to our kaumatua I wouldn't call him a kaumatua but like a tuakana type of person I didn't so much tell him the issue I just said I was experiencing these things and if you could give me some flexibility around what I needed to do and that happened so again opening up and sort of expressing those things to others was a good thing (Mr D).

Each practitioner spoke about having someone they could trust to off load too.

It was clear that the practitioners learned overtime not to suffer in silence as this only added to the torment and suffering that they were feeling. The role of a significant other either in friendship or partnership provides a necessary pillow to soften the blow of the negative effects. However one practitioner who did not go into detail mentioned that she had experienced a marriage breakdown but disclosed that it impacted on her wellbeing, personally and professionally.

I've got a dear friend a real close friend, that having her, she keeps me sane, cause I'm on my own now, I divorced in the last couple of years, so that's been huge and so yeah. I'm not sure what its like for, you know, if youve got a really supportive partner then that would make a huge difference, so I rely on my friend, I don't need to talk about stuff sometimes. I don't know how anyone could do this type of work without having someone that they're really close to where they can be totally

honest. That's another good question to ask, that in the helping profession about balance, about having that balance of work and fun. (Mrs G).

According to a study by Pack (2001), found that some significant others (husbands) felt that the type of work their partners had were taking them away from them. Those who do not have an understanding of the roles of a sexual abuse counsellor found the increasing intolerance of 'unacceptable' oppressive behaviour towards women and higher expectations of 'acceptable' behaviours. One husband in her study felt he could not be himself for fear of being labelled "chauvinistic and aggressive or depressed (p. 255) making life harder. For personal significant others who had no understanding of the impact of working with traumatised clients, found the changes they observed in their partner/mum or friend less easy to understand. Feelings were expressed of their therapist partner, friend or parent as being emotionally absent, other symptoms such as tiredness, voicing their annoyance of the constant emotional drain that their work places on them. The practitioner-participants in this study gradually found supervisors, significant friends, partners or family that were supportive in their roles which they learned overtime, a lesson in knowing who to trust and knowing where to offload professionally, leaving work at work, was paramount for recovery.

Reactions from loved ones, friends and work colleagues varied it was clear to the people around them that something was going on, noticing they were acting out of character. Mrs H felt after her first client suicide that people tried to help and were very gentle and caring, offering gestures of help. Having a supervisor who works with suicide, who delivers post-vention services and programmes was vital for her understanding the emotions and overwhelming feelings and legal processes that occur as part of the aftermath of client suicide. Another aspect of this is the confidentiality of a client's information.

I think lay people who arent in psychology, they wanna know the details, you know a little bit fascinated and of course you can't say anything, so that makes it really hard. How do you continue a conversation, they do want to offer support but their really curious, you know, stuff like that, so your kind of in a bind..thats hard, that's kind of wierd (Mrs H).

This is a sub question to the previous questions; *how did you perceive others treated you, differently or the same?* All the participants felt at some level they were treated differently.

Mrs H said she was treated “*differently but not for long*”. Mrs G praises having someone you can trust and that you don't always have to talk about it, but when you are ready having someone there is important. Mr D felt his family would come closer together and would show genuine concern. Mr B also praises the significance of good relationships at work, great support from managers he found “*humans are the resources there*” at his work.

I had something that I didn't expect a couple of years ago cos there was a couple of deaths with the (organisation omitted for confidential reasons) kids and when I talked to colleagues about it there immediate reaction was, I'd hate it if that happened to me, that would be terrible if it happened to me, and I can't talk to them cause they go off on their own, HELLO, I'm in it and that's when I started having the multiple supervisions. I thought, no there for me and I started not telling people. I'm learning who I can talk to and not talk to and so now when I do my trainings, I say, 'don't freak out, I'm the person whose going through a difficult time'. I get why people do it, I intellectually understand but it's not helpful in the moment.. (Mrs J).

Mrs J found that work colleagues were concerned with how it would effect them rather than understand what it was like for her going through it, she found the key for her was to increase supervision and being more mindful of who she spoke to.

What works.

Music has been a stable in my life since age 11, so I go back to my guitar, I go back to singing, I go back to that side of me (Mr D).

The following questions wanted to explore the best procedures or advise that works for the practitioners and what didn't work for them for dealing with the effects of vicarious trauma. As a form of relieving pressure and transitioning from work to non-work Neumann & Gamble (1995) suggest "decompression rituals such as listening to relaxing music on the way home" (p.346), using affirmations, alone time reading, exercise, and changing out of work clothes as helpful ways to transition.

Aww again debrief is the best, debrief... (Mrs A).

Expectations were mentioned whether it be on themselves or of others these expectations were challenged overtime and readjusted to a more realistic vantage point. In line with their prior answers on coping strategies all of the participants referred to supervision, debrief, people they can trust and adjusting expectations about their role. They also mentioned that they have to keep themselves well and learned eventually overtime to put their needs first to keep well and lead by example. Neumann & Gamble (1995) argue that helping professionals need to commit to their own health and well-being or "they are at greater risk of hurting their clients" (p. 345).

Seek supervision that's mainly the most helpful one, I think trying to know what to expect, so talking to other people in the field and getting your expectations in line before you get in that situation would be helpful. I knew a psychiatrist when I first started out, he said you're in a business where there is mortality it's going to happen it's just when. So knowing that it's going to happen and knowing that it's not the end of the world, it's not my fault, you know it's just the way things happen sometimes, knowing that adjusting my expectations that you can't save everybody

and somethings gonna happen someday, that was kind of helpful in advance. So I think expectations really matter, so if you went into the field thinking I'm going to cure everybody I meet, your destined to be in trouble...so that's before you experience and once you experience, expectations and supervision, I think (Mrs H).

What did not work.

What didnt work was isolation...I had to give up some expectations and some of those were expectations on myself and some of those were expectations placed on others (Mr B).

Isolation was a common theme amongst the participants, Mrs C spoke of wanting to be isolated. She felt Hamilton is a small town and always seeing clients frequently made her feel like she never wanted to see people in general. If she saw them she would recal their clients stories knowing that due to their disabilities limiting their working capacity, her client's have to go to soup kitchens for free food and it's overwhelming to see. She also spoke of feeling shallow for not wanting to see them and feeling that way.

Isolating, not sharing, not acknowledging it, tryin to think I can get over this I can do this by myself, all those...(Mr E).

Other comments were feeling judged and not supported for being open about how they were really feeling.

Not that this happens often but probably being told what to do as opposed to being given options yup that would probably be it. I think you kind of become defensive when somebody is telling you what to do (Mrs F).

Mrs H mentioned that at first she thought reading about vicarious trauma would be helpful however argued, it doesn't give you the practical application of it when your in the depth of it, what do you do?

The literature is helpful but it isn't, you know, you can't just say read about it and you'll be fine (Mrs H).

Noticing VT Effects In Others

This section was interested in the reactions of the practitioner-participants in noticing effects in their work colleagues. From their own experiences, to seeing it in others, did they react differently or respond in preference to how they would have liked to be treated. A literature search came up with studies that touched upon reactions from significant others (Pack, 2001; 2004) and the importance of collegial support buffering the effects of VT. However it was difficult to find studies that spoke about the indirect effect of vicarious trauma by witnessing the effects in others. A dichotomous question only requiring a yes or no answer directly asked, have you noticed effects of VT on work colleagues or other professionals? All (11) of the participants replied “yes”. The next question, “what did you notice about your colleagues that made you think they were experiencing negative effects of VT? E.g., overextending themselves, overindulging, cynicism, avoiding situations, absenteeism, substance abuse etc”. Is the same question asked to the participants previously of their own personal experiences of VT.

Yeah i did, I did, ahmm there was a lot of noticeable absentism and because I was senior staff... I'd say the drinking and absenteeism.. a lot of my mates who are on to their second or third marriages... So high rate of divorce and remarriage this is despite EAP and supervision... Ahh suicide I wonder cos a mate of ours he suicided his partner left him and he suicided and I wondered, if he wasn't a psych nurse or exposed to that would he have done that? you don't know (Mrs A).

The effects of VT were obvious to the practitioners as they reflected witnessing it in others. Mrs A also spoke of the predictability of absenteeism so did Mr B in his organisation. The practitioners also commented around people who would normally have a quiet demeanour extremely losing the plot, tiredness, irritability, past historical stuff being triggered, intrusive thoughts, over working,

extreme worry about clients, and colleagues not having the capacity to complete their work.

Staying at work a long time, not completing their stuff, always moaning, judgemental. I've got all this paper work and I can't get through it, I can't get through it, you know, so somethings obviously not happening for them, that they can't keep up with their work. I've noticed friends fight with their partners instead of dealing with the issue or vice versa bringing home into the work, confrontational in meetings (Mrs J).

Reactions to noticing the effects in others.

This next question, “*what reactions (behaviour/thoughts/feelings) did you notice in yourself as a result of witnessing VT in others? E.g., prioritising self-care, increased supervision, or avoiding colleague etc*”. This question sought to explore the different types of ways in which the practitioners coped with seeing their work colleagues distressed. Mrs A elaborated on how she felt when one of her colleagues committed suicide.

Anger..anger with the system, for not having anything in place..just anger what did I feel angry, distant, angry at them, you know, how farken dear you this is your job youve been looking after these people who have issues and you go and do that, youve left us, you were our work colleague you ve left us that way, what the hell legacy is that to leave. You know people come in expecting to be made well, or you know rehab, or be cared for I mean and how are we going to be looked at, you know, and you get to a point where you could defend him, defend your colleague, be angry at the system, but at the same time be angry at your colleague and you know you could you gotta defend him or maybe, you know or I'd avoid talking about it to clients when they asked, cos they find out. They all know stuff where it was sad, really sad for them, that they wernt able to say, aww come on guys can you help me out I'm doing this because. I think collegial support is important, important. Selfish thing to do suicide so all

those who. I don't know mixed feelings, but the strongest emotion being anger at the system (Mrs A).

Mrs A emphasises collegial support. Mr E spoke of empathy but also about wanting to help as he can see it quite obviously in others but it triggers him, so he will watch if anyone else notices it, if they don't he will step in but otherwise will “*back out of it*”. Mrs F stresses the importance of supervision and being concerned for her work colleagues “*feeling like that and why, whats going on*”. Mrs H spoke about the increase in self-awareness and looks for those same symptoms in herself and contemplates if “*resolutions ever pan out, actually*”.

Responses to reactions.

I use to try and rescue, but I don't do that anymore, cos some people aren't ready to, almost quite happy to be in the rescuing cynical place... I just sit down and go, you alright and just let them bring it up if they want to. I will quietly bring it in, I have to be careful that I don't get traumatised by their trauma (Mrs J).

The next question is similar to the previous one but further elaborated into what their response was to their reaction. *How have you responded to colleagues who are going through VT in the past?* These experiences help to explore the different types of circumstances and the importance of identifying it in others. It is a common reaction to ‘rescue’ the patient (Davis, 2009). Rescuing seeks to protect by actively intervening to solve problems, so that the rescuee no longer has to suffer as the rescuer have themselves. As a result the rescuer tends to collude with the rescuees distorted thought processes that gradually diminishes the rescuees ability to tolerate disappointment and suffering (Little, 2014; 2015). This disruptive cognitive schema is formed through the therapeutic relationship which compromises the therapeutic boundaries and unintentionally disempower’s people by rescuing (Martin, 2006).

The suicide is the angry part but if I saw a colleague that I felt was, it starts off, it seems to be patterns of that type behaviour with your colleagues and because communication is very important in a psych ward its observation, communication, documentation, to me broken down in those three steps (Mrs A).

Mrs A's response to the death of a colleague heightened her awareness of others who may be exhibiting similar patterns in colleagues, parallel to that is Mrs H who experienced a client suicide and felt an increased hypervigilance towards other client's motives in therapy.

Consequences of responses from reactions.

ahh development courses, yea because I was good at reporting, no narking. I hate that word. I was called a nark a few times but I was invited on to development programs you know. How to improve on the systems that were in place. I was invited to do quality assurance because of that ... so it was my job to sort out and you can only do that through reporting from collating the stats ... hey don't take it out on me ... but I can do that because I could do it..dont take it out on me neither...go to supervision being invited to do continuous quality assurance that was this awareness, this self awareness..self awareness (Mrs A).

Mrs A further elaborated that the nurses would abuse the reporting processes to get back at other nurses by pointing blame and excuses at others, for all types of reasons some she gave included; bitchiness, extramarital accusations and bullying.

I don't know if they realise there doing it and they bitch and they talk, and another thing I notice, bullying, you know their not coping if there bullying

High caseloads are associated with more disrupted beliefs for health professionals therefore increasing the symptoms of vicarious trauma (Mac Ian & Pearlman, 1995; Martin, 2006). To provide more of a balance the vicarious

trauma literature highly recommends that caseloads and workloads are regularly reviewed (Trippany et al., 2004).

I guess, I just sometimes wonder if I am wanting to work in social services all my life. I have done it now for a long time and probably what I did at ACC for 8 years and part of that was serious injured, so I guess at times, I think, do I really want to be a people worker and help... but I do find our role with helping people is helpful so that is is a good thing.. (Mrs C)

Learning outcomes from noticing effects in others.

Mr B suggested if you cannot recognise it in yourself then your not going to recognise it in others. Mrs C found that before the interview she had not looked at her work in a way that made her think she is exposed to “*a lot of stuff*” and didn’t realise the major impacts from hearing the suffering of others on herself. It reinforced her to keep up with her healthy living and not to take it too personally because it “*is bigger than her*”. She also commented on how this raised a good awareness and the insight has been very helpful upon reflection.

Mr E felt quite clear on, “*let it sit where it belongs, if it doesn’t belong to me, it’s not my problem*”. Dombo & Gray (2013) refer to a clear distinction of ‘taking in’ what the clients are experiencing, in contrast to ‘taking on’ the client’s experience’s. The authors suggest to remain fully present with clients, one needs tools, a comprehensive self-care model to mitigate and prevent the ‘taking on’ of their client’s burdens. A self-care model that engages with spiritual practices that address these types of issues can help “develop adaptive coping responses to reactions” (p. 93). They refer to a self-care model that incorporates an ecological systems theory to address vicarious trauma through spiritual practices on macro, mezzo and micro levels (Dombo & Gray, 2013).

Mrs J spoke of the impacts from other work colleagues lack of empathy having a negative effect on her and felt their energy would be better spent being compassionate. She would often hear her colleagues referring to their clients (youth) as, no good, or that these kids should know better, don't like this one or I don't like that one. This type of behaviour Mrs J felt was "*awful ... I'd rather be hanging out with a group of gang kids*". Mrs J has also spoke of the 'kids' (clients) being able to recognise this in their workers and would close off. Pack (2013) argued that there are various types of bullying or 'oppressive systems of management' that highlight "a lack of reflective space of training and supervision of the workers involved" (p. 71). Pack (2013) also mentions that if these areas are not addressed in the workplace clinicians will often leave, and may search for private practice options that align more consistently with their approaches. This was true for Mrs J who runs her own clinical practice which is congruent with her high levels of compassion and empathy and does not foster the disempowerment of her clients.

Ameliorating Effects of Vicarious Trauma

The focus of this section is to explore what the practitioners have learned to create a balance of work and home, how this is achieved and what it may look like for different health professionals at different levels. VT cannot be ultimately prevented but by adopting and enforcing practices that support a balance and enjoyment of ongoing job satisfaction will ameliorate the effects and endorse personal growth (Brockhouse, Msetfi, Cohen, & Joseph, 2011; Dombo & Gray, 2013; Gerding, 2012; Mac Ian & Pearlman, 1995; Figley, 1995; Pack, 2013; Trippany, Kress, & Wilcoxon, 2004).

Self-care practices

Part C in the interview schedule explored resilience and self-care processes. The first question asked, 'How do you take care of yourself?' additional to this it was specifically asked 'how do you manage to prevent, avoid, or reduce effects of VT?

Don't take it home, because if you take it home.. when I was younger I use to take things home in my head and I'd think aww shit did I do enough, did I do enough, did I do my job properly, is that what happened but then you get to realise that its over now so the next time it happens il be forewarned, so il try and avoid it from happening again and again (Mrs A).

Since vicarious trauma is referred to as invasion of work into all area's of a helper professionals life it is recommended in order to counter this, setting firm boundaries around one's work and home life as a fundamental tool. As suggested earlier carrying out decompression rituals can help transition from work to home (Neumann & Gamble, 1995).

Mr B commented on seperating work from home.. *"I actually do take leave, although I needed to get better at that..the other things there are its the stuff I do outside of work"* mentioning that he has left living situations and his marriage due to the similarity of aspects at home as to the way it was at work. He finds planning is key for him, accepting more joyful roles that are exciting and interesting, by figuring out the relationship before figuring out the task.

These area's were explored through four essential components of health; physical, mental, spiritual and social engagements.

What helps?

Mrs A's decompression rituals would include, writing, she referred to this as *Creating a space where its happy or creating a space on a page where its gone from dark to light but thats what I love doing and its healthy and im being productive.*

Mrs A commented that she's not a very physical person but finds her joy through writing and telling jokes which she says go hand and hand she refers to herself as a "storyteller".

Mr B felt mentally he needs entertainment, he doesn't have a TV but he needs to see colour and hear sound, spiritually he envelops wairua (spirit), manaaki (support) and aroha (love) into his family.

The concept of it, its just about going out and doing something, so for me its about where the spiritual place is, so where can I go where il feel more than I am in my mahi, more than I am with my family and stuff like that and it's a place not a practice its a place.

Mrs C praises keeping fit and healthy and felt fortunate she has great family and colleagues that she can trust, she also mentions education and focusing on the positives as helpful and key to how she takes care of herself. Within the four quadrants of health she spoke of, physically keeping active and eating well, spiritually, treat others how she would like to be treated, respectfully, openly and honestly. Mentally she trys to limit her drinking and increase her quality time with good friends through social engagements, and also endorses a good decent sleep this is usually achieved when she walks, runs or bike rides (physical).

Mr D believes in being active as well, walking running, he loves playing music and his cultural connections and his family. He finds the simplicity in life

If you walk alone and take time to notice the pathway ay...and I've found just a great joy in the rain drops you know that little bead or whatever it was and just taking that time to look.. which way is the wind blowing all that type of stuff

He loves to dive for seafood, he finds, being under water brings you in touch with a whole other world, a soul satisfaction, he also enjoys a beer, watching television, a little bit of reading or research, mowing his lawn and going into obsessive cleaning rituals so he can study more productively.

My wife would tell you, "poorly", I would say "really good" in some ways I do. Over the years I've learnt not to take my work home with me, I walk out the door it stops, but in saying that I'll be spending the weekend writing a manual for facilitators on how to facilitate one of the groups, so that's a lie but I don't do that very often (Mr E).

Mr E also practises, deep breathing and transcendental meditation for almost 30 years and he still plays premier grade basketball, he surfs and has 5 grandchildren which he's coached in soccer and rugby and probably next will be basketball. Mr E suffers from a condition called fibromyalgia that can flare up under stress so learning to take time out when needed he reported he's become better at it.

Mrs F found focusing on listening and focusing on service and knowing what her limits are helpful for her wellbeing. All four quadrants were important to her. One thing she felt she did learn was to put herself first in order to provide a happy, healthy life for her kids, reminding herself to take time out for herself and being kind to herself.

Mrs G spoke of stress leave and supervision. She values rest time, alone time, bringing attention back to her. Being in nature feeds her soul and without that she states she could not do her type of work. Intuition is big, working intuitively helps her to be guided, and went from a daily routine to becoming automatic for her.

Mrs H also compliments supervision in the first step. Going home to somebody you can trust and being able to discuss openly things that are bothersome. Being prepared before giving lectures or before a session with a client as being very important. Being clear around boundaries within her practice, risk plans to protect her clients and her self, so those types of preventative work is helpful. Making sure she takes care of her basic needs, eating, sleeping, exercise and seeking emotional support. Although it was not mentioned when I first entered Mrs H's offices she had the most beautiful and creative art on her walls that she had done herself.

Mr I says his therapy is his carving, being in his carving shed. Not allowing any baggage that has happened before hand to hang around. Working in the carving shed helps offload that baggage, you work under the tapu proces.

Putting that cloak on and you're in a different zone, you don't have time to think about those things...you know its off your mind

He also remarks talking to the right people, positive things breed positive stuff, he avoids drinking and reiterates his carving is what really helps him.

Mrs J praises routine getting up at the same time and going to bed at the same time, she makes sure she plays and escapes by watching movies. On a bad day she will watch a horror, she doesn't work at night, she gives herself permission to feel this helps the feeling not last as long as opposed to fighting it. She also commends her great group of friends, she loves music and if she has had a bad day will go out to listen to a live band. She also comments:

Spiritual, I do get angry at god in spiritual stuff and that's a constant I don't know about ...whatever your religious beliefs I can't figure out why children have to be hurt so I battle that one but I think there's this, I let my self battle that one and that's probably how I take care of it (Mrs J).

What does not help?

Mrs A despises dwelling, and brooding. Mr B felt trying to contain it, or others, fails each time, and has occasionally allowed himself to lose control. Mrs C felt her drinking was a double edge sword, with

Alcohol, I might do dumb things for a little bit but it actually doesn't take it away, in the end its worse, so, you know, and I've actually done drug and alcohol papers in the drug and alcohol field, they talk about alcohol as a double edge sword so its actually a depressant (Mrs C)..

Mr D felt, *"I can't study in mess, I've got to clean the house first and then I can study, obsessional perhaps yeah but I do"*.

Mr E felt that if he gave up his active roles he mentioned previously it would be very unhelpful. Mrs F felt the thoughts that arise as a mother, in regards to putting herself first and taking time out, as selfish, is not helpful. Mrs G mentions getting tired and pushing herself and forcing herself to do things, when her body needs rest and she doesn't listen. Mrs H felt if she started to withdraw or isolate herself, avoiding work not being able to face it makes her feel *"much worse"*. Mr I feels drinking is not good, although he doesn't drink, he believes its not helpful for anyone. Mrs J feels working too much is unhelpful.

Specific processes for effective practice.

Do you carry out any specific processes that you feel help you practice effectively at work? E.g., Any special procedures/rituals, prayer/karakia etc.

Mrs A spoke about places that hold spiritual significance to her in te ao Māori (the Māori world), stopping under Taupiri maunga (mountain) to go into the water, everytime if she is driving past.

I don't toot out, I don't wave out I stop..because as I said to my son, either your going to acknowledge them or you don't, so thats why you go

to the water, stop. So thats why I do it, its just not for me, all my kids, my moko, for all times until the next time.

Other places she spoke off if she is travelling in those directions are, Hatupatu's rock, Hongi's track, Fitzgerald Glade.

But if I don't and I know I'm crossing into another area ill just say 'kia ora Ngati Porou' 'kia ora Whanau Apanui' you know, as soon as I get to Hawaii, you know I do it.

Mr B spoke about heading straight to food and water. He also mentioned working under a particular Māori model a framework that encourages stepping back and forward into the leadership role its okay to not always be the leader. Mrs C felt she didn't have any ritualistic processes that she could think of. Mr D felt *"all those practises, the recital of karakia, you know, reciting a number of tauparapara that I've learnt over time, practicing my reo"* is vital to working effectively in the field for him. Mr E acknowledges karakia as part of there process at work everyday, before working in a Māori organisation when he first cleaned up

I had the serenity poster at the end of my bed, so every morning, I sit up, it was the first thing I saw, yeah right, okay. So the meditation is that. I would always at the end of any session, I always mentally unwind, I always debrief, so little things like that.

Mrs F,

In the work place?...normally in the work place yes...that's something we do, well it use to be regular then it stopped for awhile and now its come back on board, it's (karakia) really good for the environment that we work in it makes a huge difference...I guess, before it's just looking after my own health, mentally, spiritually, physically yeah....

Mrs G commented on other types of things others done like washing hands, or they shake their hands, she prefers to create a space inbetween clients to get ready for the next client, she is able to mentally go into what she needs to do next that's

spiritually inclined. Mrs H again stresses the importance of being prepared. Mrs J, washes her hands after she see's somebody and will often use breathing techniques and likes to plan happy events for the end of her week, so it gives her something to look forward to each week.

Key support.

Supervision, work colleagues, loved ones, family, friends, like minded friends, sports, culture, significant and sacred places were key themes throughout the practitioner-participants answers. It was evident that having someone they can trust to be themselves with and openly feel and speak about whats going on for them is vital in fostering healing.

Trauma history.

Deaths in the family, adoption into another culture, illness, losing a child, abuse that causes disassociation an out of body experience, experiencing physical trauma as a child, being in an abusive relationship at a young age. At some stage in their life, all of the practitioner-participants had experienced some type of trauma, not all experienced abuse, but most had experienced grief with the loss of a loved one.

Learning outcomes.

Coming to an end. Not all practitioners had something to say, but the common theme was for people to share their stories and speak openly about their experiences and being allowed to be real with their emotions. Important pointers were; having someone they can trust, relying on their own instinctive tools to nurture and guide them through hard times, empathy and not sympathy, the motivation to be helpful without enabling or burning out in the process and

knowing that there is going to be some kind of an impact from hearing painful stories all the time and knowing how to release it in a safe way, so that one can find the healthy balance between work and life.

Mrs A comments on the need for more psychologists in particular for supervision.

I wanted a wahine Māori clin psych, because I felt she better than anyone would be able to relate to what I wanted to talk about in terms of personal development, clinical development, and professional development.

Mrs J commented

I would love to see different people, different cultures have different ways of dealing with this, so we can learn, so somebody can go, aww you watch that tv, I might try that or you do that or you say that karakia and we can pull it together cause it's almost like we're all quietly doing our own little things and not sharing it, cos it might sound stupid. Maybe that's what your research will do, you'll put it out there, beginning the conversation.

Chapter Five: Conclusion

The aim of this study was to find out how helping professionals manage the psychological impacts associated with their work that affects their wellbeing personally, professionally and at an organisational level. The research indicates that at some stage helping professionals may experience some effects of vicarious trauma (Pack, 2013). The results found from this study confirmed that all of the participant-practitioners at some point in their career had personally experienced effects of vicarious trauma. To date very little research on vicarious trauma effects had been undertaken in New Zealand, however this small group of NZ researchers agree that psychological impacts must be talked about openly and typically taught prior to commencing in the helping profession as part of the training curriculum.

The findings suggest that there is a need for helping professionals to understand the psychological impacts as part of their work experience that is, vicarious trauma is a 'rite of passage' (Pack, 2004). Consistent with the literature (Davis, 2009) knowing what these psychological impacts are is beneficial to identify early warning signs. The types of effects the practitioner-participants experienced were at times debilitating and severe; leading to burnout and for some the consequences also included relationship break ups, PTSD and depressive type symptoms. It would appear that New Zealand helping professionals report similar challenges and issues to those that have been reported internationally.

The major themes associated with the CSDT model identified risk factors, vulnerabilities and predictable effects experienced by the participants. Identifying my own predispositions for vicarious trauma as a trainee psychologist highlighted the need to self-monitor and regularly reflect on practice and experiences that could jeopardise my own wellbeing. These included personal trauma history and

high levels of empathy and compassion. The participants themes pulled from the interviews explored the disruptions in their cognitive schemas that occurred for them as a result of caring for others. Vicarious trauma themes looked at seven fundamental psychological needs; safety, dependency/trust, power, esteem and intimacy, frame of reference and later included independence.

Before the themes of vicarious trauma were discussed the question was posed to the participants, what motivated the participants into the helping profession? Early works by Jung described theories of the 'wounded healer' that could possibly be a motivational aspect and predisposition to helping others, if old wounds are not healed. It is reported that 73.9% of helping professionals had some form of wounding experience that led them to their chosen career (Barr, 2006). An altruistic nature was also discussed as some of the participants had referred to early childhood memories of helping others that motivated them to seek professional development in their chosen profession.

Spirituality was also a major theme and motivator for all of the Māori participants who paid homage to their resources, skills and qualities handed down through their cultural underpinnings. These cultural tools included, visions and signs from tohunga, significant landmarks and prayers that contributed to their wellbeing and managing effects of psychological impacts from their work. For future reference looking into spiritual practices from a Māori cultural perspective would be interesting to note, spirituality for Māori is an important component for mental health and wellbeing. These cultural and spiritual practices aided in buffering and ameliorating some of the effects of vicarious trauma.

The research on vicarious trauma has predominantly been outside of New Zealand but a few pivotal studies have realised the impacts of trauma work on

helping professionals. The scope of vicarious trauma in itself has been extensively researched since 1990. The introduction of other transmissions of trauma simultaneously has led to the belief that vicarious trauma is a 'rite of passage' for those in the helping profession (Pack, 2004; 2013). In order for treatment of vicarious trauma one must understand the effects and address the areas in which they have the most difficulty with. The disrupted schemas became evident overtime for each of the participants who at some stage experienced negative effects of vicarious trauma. The remarkable tenacity of the participants who overtime recognised and customised their own self-healing and coping processes. This successfully keeps them safe and helps them achieve balance both personally and professionally.

Limitations of the study was the initial aim to include police officers, frontline personnel, lawyers and possibly doctors as participants as these roles are also vulnerable to effects of vicarious trauma. The small sample size, instrument usage and failing to ask enough demographic questions, for example, relationship status, dependents, or religious/spiritual practices (church) could have captured more information spiritually. It was important for this study to apply qualitative methods that allow participants to share their experiences as lived realities. Additionally using narrative methods to understand how these experiences impacted on practitioners over time and how they navigate their way through it.

The self-report measures gave an overall look at the different aspects of compassion fatigue using the ProQOL and secondary traumatic stress using the STSS. On the first scale the professional quality of life (ProQOL) the scores were divided into three; burnout, secondary traumatic stress and compassion satisfaction. The aggregate scores on the burnout scale produced a Low result

with an average score of 21. Meaning a score of 22 or less reflects a positive feeling about meeting work fulfilments. The second component of compassion fatigue, secondary traumatic stress revealed an aggregate average score of 21 also falling into the Low category. This also represents a positive result that there are no significant concerns for the practitioner-participants momentarily in regards to their work efficacy. It could also mean that these practitioners are “good influences on their colleagues and organisation as well as being liked by their clients who seek out their assistance” (Stamm, 2010, p. 22).

The positive component compassion satisfaction results showed an aggregate score of 43 that falls into the High category. This reveals a general satisfaction with one’s job and from being helpful it’s characterised by feelings of success, making a difference and feeling invigorated by their work. Overall the scales in combination are the most positive results that can be scored, High compassion satisfaction and Low burnout and Low secondary traumatic stress scores.

The secondary traumatic stress scale was designed around symptoms of PTSD, intrusion, avoidance and arousal symptoms. The lowest score achieved is 17 and the maximum is 85. The aggregate average result of 35 scored mild STS falling into the 76th – 90th percentile. Although the scores were averaged as a collective score there was one score during initial scoring that resulted in a severe score. The occupation of this practitioner-participant has a higher rate of sexual trauma disclosures (ACC counsellor) that may reflect on the impact of their work in comparison to the other participants.

The self-report measures were more for the practitioner-participants to use as a guide for their practice and future checking in of how their work maybe

impacting on them. Both these measures are not diagnostic tools and are not used for the purpose of diagnosing disorders (Stamm, 2010).

This study only show's snapshot's of each practitioner-participants experiences of vicarious trauma. The experiences and reactions from the practitioner-participants overall presentation of vicarious trauma revealed that they all experience at some stage effects of vicarious trauma. From the data it revealed, factors such as; personal trauma history, professional development, family history, and cultural underpinnings were influential to the practitioners chosen profession.

Although each practitioner-participant spoke of unique experiences the outcome of psychological impacts eventually led to the same emotional and behavioural outcomes experienced by all, such as absenteeism, PTSD symptoms, overextending, or substance abuse. In section one the motives for helping looked at viable factors that influenced the participants into pursuing a career in helping others. The main theme from this identified that the participants were motivated to help from a young age. Exploring what knowledge the practitioners had of psychological impacts prior to or upon commencing their helper role. The common answer was minimal or none at all, about two of the practitioners who were both not from New Zealand originally stated that they were well prepared theoretically of the psychological impacts as part of their role.

The majority of the participants did not know what vicarious trauma was however some in recent years had sought and obtained training. Those who did not know what vicarious trauma was were given an overview of VT and accepted in agreement that they had at some stage experienced varying effects of VT. The

practitioner-participants also briefly described the typical disclosures they would hear overtime. This ranged from, sexual abuse, child abuse, neglect, substance abuse, identity and role confusion, domestic violence, confessions of murder, early psychosis and other horrendous crimes.

All the practitioners contributed to different aspects that helped them, to draw their family to them closer, listening without judgement and focusing on the solution rather than the problem. It was also discussed that being real with your feelings to your clients is a major tool for recovery for both helper and client. A major element to healing vicarious trauma is identifying the disrupted schemas by focusing on the met or unmet psychological needs of the helper. Self awareness is vital to knowing what those needs are and taking the time to meet those needs are crucial for recovery and maintaining balance. These needs included; safety, trust, intimacy, power, independence and esteem. All of these aspects were explored and touched upon from the practitioners perceptions of what those psychological needs looked like for them. Disruptions in self-capacities placed helping professionals at risk making it harder to judge or predict possible consequences at times. The importance to tolerate strong affect, maintain a positive sense of self and connection with others are vital for interpersonal relationships. The negative effects of vicarious trauma impacting on self-capacities included; overextending, overindulging, avoiding situations, absenteeism, substance abuse, self-criticism, and self-loathing and experiencing intrusive thoughts.

Although the participants had felt the harsh effects of their work and in reflection they were able to identify coping strategies specific to their own interests and resources. Supervision, professional support, trust, being real, good organisational resources, having fun and not taking work home, a positive interest

in helping others, are all factors that help health professionals manage the effects of vicarious trauma. The findings from this study align with the vicarious trauma literature and added a space for culture and spirituality to be explored as intended by the authors (McCann & Pearlman, 1990). A highlight was the use of Māori tools such as karakia to help ameliorate effects of VT and the openness and honesty of the participants to share and explore their experiences.

This study was worth the wait to complete. The knowledge I gained from this research project was informative, insightful and has helped me on my journey in the Mental Health sector.

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Appendix A: Ethics Approval

School of Psychology
The University of Waikato
Private Bag 3105
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Phone 64-7-856 2889
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3 November 2014

Nina Rakei
14 Lyon Street
Frankton
Hamilton

Dear Nina

Ethics Approval Application – # 14:65

Title: Exploring vicarious trauma with practitioners in New Zealand

Thank you for your ethics application which has been fully considered and approved by the Psychology Research and Ethics Committee.

Please note that approval is for three years. If this project has not been completed within three years from the date of this letter, you must request reapproval.

If any modifications are required to your application, e.g., nature, content, location, procedures or personnel these will need to be submitted to the Convenor of the Committee.

I wish you success with your research.

Yours sincerely

Assoc. Prof. John Perrone
Convenor
Psychology Research and Ethics Committee
School of Psychology
University of Waikato

Appendix B: School of Psychology cover letter

MSocSci – Nina Rakei

School of Psychology

Advertisement: You are invited to participate in this research study

To whom it may concern,

My name is Nina Rakei and I am a master's student at Waikato University. I am seeking potential participants to partake in my research study exploring the effects of empathic engagements with clients. The theoretical concepts are based on *Vicarious Trauma* this term has also been referred to as secondary traumatic stress or compassion fatigue, which is a common occurrence for those in the helping industry. Therapists at any level can participate the requirement is that you engage on a regular basis with traumatic disclosures of others.

My research would like to explore experiences of professionals who deal on a regular basis with highly stressed or traumatized people. To understand how therapists manage others stories, personal/home and work balance. As a student looking to enter in this field I was curious for my own safety on how I would manage with these types of scenarios. I have the privilege and opportunity to design this research around these concerns.

I have attached an information sheet providing the outline for the project and what information is needed. I would like to arrange a time with you or people in your organisation who may be interested in participating. All information is confidential and this project is in no way interested in any types of diagnosis or stereotyping.

Please let me know how I could best serve your organisation in recruiting participants for this research project please feel free to contact me or my supervisor Dr. Armon Tamatea on the contact details given below.

I look forward to hearing from you!

Kind regards

Nina Rakei

Masters student Waikato University, email: nrmr1@waikato.ac.nz ph/txt: 021 081 45042

Dr Armon Tamatea

School of Psychology, Waikato University, email: tamatea@waikato.ac.nz Ph: 07 8384466 ext. 5157

Appendix C : Information sheet



Information Sheet for Participants

Exploring Vicarious Trauma with Practitioners in New Zealand

Greetings, my name is Nina, you are invited to participate in this research study. Please contact me and I will arrange with you an interview time that best suits you. Thank you for your interest!

About the project

This research project seeks to explore the experiences of practitioners who deal with traumatised clients on a regular basis and to find out how they manage with these stressful situations. At present, there is little information in New Zealand about the lived experiences of practitioners and vicarious trauma and the types of support available or not available. There is extensive research available on this topic in general however in contrast there is very little research done in New Zealand. We plan to interview and record the stories of 20 Practitioners and to explore those stories to look for key themes of vicarious trauma and how their journeys can help support wellbeing and prevent burnout.

Recruitment

I aim to interview people over the next 3-4 weeks and will recruit participants who are practising counsellors, social workers or psychologists. It is also open to those who work in the mental health field or who provide regular pastoral-care for people. I will contact you directly if interested.

Participation

I would like to interview Practitioners who are managing their work conditions and are currently well. Your participation in this research is voluntary. We will organise a time and a place that suits you. When we meet, I will discuss the project and go over the surveys and questionnaire. I will answer questions you might have and then ask you to sign a consent form if you are still interested. With your permission, there will be two ways to complete the second part of the interview either I can record the interview so that nothing you say is lost or you can have the choice to contemplate and write down your answers in your own time.

The interview is informal and it is important you be as comfortable as possible. We expect that the interview will take up to 60 minutes. Firstly, two surveys are provided to be completed and then I will ask you to talk about or write, in your own words, your knowledge and experience of vicarious trauma and how you manage any effects. You may stop at any time for any reason and if you decide that you do not wish to continue the interview, you may do so with no explanations needed. There is no pressure on you to continue. It is possible if you need to conduct the interview at another time to do so.

Confidentiality

No material that could personally identify you will be used in any reports or presentations without your consent. All information held about you will be kept in a secure room and will not be accessible to anyone other than the researchers named above. After 10 years, the information is destroyed.

Results

After the interview, I will prepare a copy of all documents you have completed to give to you for your own personal report. After you have read the report, you are free to change any part that does not suit you and will provide another copy after corrections for you to check. If you decide to withdraw your information from the study at this stage, you will not receive any pressure to change your mind. After you have seen and approved your information, it will be analysed according to the overall goal of the research. There is a period of 4 weeks post interview to withdraw any information.

Ethical Approval

This research project has been approved by the School of Psychology Research and Ethics Committee of the Faculty of Arts and Social Sciences, University of Waikato. Any questions about the ethical conduct of this research may be sent to the convenor of the Research and Ethics Committee (Associate Professor John Perrone, phone: 8384466 ext.8292, e-mail: jpnz@waikato.ac.nz).

Thank you for your time and attention. Please feel free to contact me if you have any questions about this study.

Researcher contacts:

Nina Rakei, Masters Student
University of Waikato,
Private Bag, 3105
Hamilton Ph: 021 081 45042
Email: nrmr1@waikato.ac.nz

Dr Armon Tamatea, Supervisor
University of Waikato,
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Appendix D: Consent forms



CONSENT FORM



A completed copy of this form should be retained by both the researcher and the participant.

Research Project: Exploring vicarious trauma with practitioners in NZ

| Please complete the following checklist. Tick (✓) the appropriate box for each point. | YES | NO |
|---|-----|----|
| 1. I have read the Participant Information Sheet (or it has been read to me) and I understand it. | | |
| 2. I have been given sufficient time to consider whether or not to participate in this study | | |
| 3. I am satisfied with the answers I have been given regarding the study and I have a copy of this consent form and information sheet | | |
| 4. I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without penalty | | |
| 5. I have the right to decline to participate in any part of the research activity | | |
| 6. I know who to contact if I have any questions about the study in general. | | |
| I understand that my participation in this study is confidential and that no material, which could identify me personally, will be used in any reports on this study. | | |
| I wish to receive a copy of the findings | | |
| I wish to view the summary report of my interview | | |
| | | |
| | | |

Declaration by participant:

I agree to participate in this research project and I understand that I may withdraw at any time. If I have any concerns about this project, I may contact the convenor of the Psychology Research and Ethics Committee (Associate Professor John Perrone, Tel: 07 838 4466 ext 8292, email: jpnz@waikato.ac.nz)

Participant's name (Please print): _____

Signature: _____ Date: _____

Declaration by member of research team:

I have given a verbal explanation of the research project to the participant, and have answered the participant's questions about it. I believe that the participant understands the study and has given informed consent to participate.

Researcher's name (Please print): _____

Signature: _____ Date: _____

Appendix E: Demographics form

Participant # _____



DEMOGRAPHICS

Name: _____

D.O.B: _____ Gender: Male Female

Ethnicity: _____

Highest form of education:

- ☐ Certified Training
- ☐ Bachelor's degree
- ☐ Post-Graduate Diplomain _____
- ☐ Master's degree
- ☐ Doctorate degree (phD) _____
- ☐ Other _____

What is your primary helping role? (e.g., counsellor, psychologist)

How many years of practice?

What areas do you specialise in? (e.g., sexual trauma, addictions therapist) _____

If for any reason you wish to withdraw from this experiment you may do so without explanation and there are no penalties, if you choose to leave. If you experience any difficulties as a result of this project or have any questions, please email me: nrmr1@waikato.ac.nz or contact my supervisor Dr. Armon Tamatea through the School of Psychology, University of Waikato +64 7 838 4466 ext. 5157 Email: tamatea@waikato.ac.nz

Appendix F: Interview schedule

Interview Schedule: *Exploring experiences of vicarious trauma*

INTERVIEW SCHEDULE

Thank you for completing the two surveys, I will now ask you some background questions.

1. Please tell me what lead you to become interested in this work?
2. What information, if any, did you receive in the workplace about the impact of psychological trauma on practitioners, therapists, social workers etc.?
3. What is your understanding of vicarious trauma?

Thank you for your responses to my questions the next set of questions refers to personal experiences of VT.

Part A: *Experiences of VT* (where examples are given these are for the interviewer as guides only)

A. Have you personally experienced effects of VT?

If the answer is "YES" then ask questions below. If the answer is "NO" go to Part B.

1. What types of traumatic disclosures do you typically hear from clients?
2. How do you typically manage intense/hard-to-hear disclosures from clients?
3. What impact, if any, has listening to other's disclosures of pain had on your beliefs about the work?(*Depending on the response [i.e., vague], query around the following*);
 - a. Safety, e.g., world is unsafe, need for stronger security etc..
 - b. Trust, e.g., feel more suspicious of peoples motives, more cynical or distrustful etc..
 - c. Intimacy, e.g., feeling alienated, separateness from family, friends or co-workers
 - d. Power, e.g., overwhelmed helplessness and feeling more vulnerable, self-defence classes etc
 - e. Independence, e.g., strong need to feel in control and free
 - f. Esteem, e.g., sense of anger, bitterness or pessimism toward people, contemplating fate of the world
4. Has your perception of your role changed since starting this work?
 - a. How do you feel about your role now?
5. What other effects of vicarious trauma have you experienced? (pending the response; suggest the following coping strategies that have been identified in the literature) E.g., overextending yourself, overindulging, cynicism, avoiding situations, absenteeism, substance abuse, intrusive thoughts etc...
6. Did you access help at the time? If so, where? E.g. Supervision, friends, or colleagues.
7. What kind of reactions/concerns did you receive from family, friends, or employers?
 - a. How did you perceive others treated you, differently or the same?
8. In your experience of managing VT, what advice/processes worked for you?
 - a. What resources are available for you at your work, to deal with effects of VT?
9. In your experience of vicarious trauma, what processes/advice did not work for you?

Thank participant for their responses, now let's move on.

Interview Schedule: *Exploring experiences of vicarious trauma*

Part B – Noticing effects of VT in other professionals.

B. Have you notice effects of VT on work colleagues or other professionals?

If the answer is “YES” please ask the questions below. If the answer is “NO” proceed to Part C.

1. What did you notice about your colleagues that made you think they were experiencing negative effects of VT? E.g., overextending themselves, overindulging, cynicism, avoiding situations, absenteeism, substance abuse etc...
2. What reactions (behaviour/thoughts/feelings) did you notice in yourself as a result of witnessing VT in others? E.g., prioritising self-care, increased supervision, or avoiding colleague etc...
3. How have you responded to colleagues who are going through VT in the past?
4. What happened as a result of this indirect experience of vicarious trauma (any consequences)? E.g., time off work, training and development courses, supervision, therapy, awareness etc...
5. Please describe, what have you learned from this experience?

Thank you for your responses so far, we will now move on to the last section that looks at resilience and self-care processes. How do you to take care of yourself on a personal and organisational level. Go to Part C.

Interview Schedule: *Exploring experiences of vicarious trauma*

Part C – Resilience and self-care processes

B. How do you take care of yourself?

1. How do you manage to prevent, avoid or reduce effects of vicarious trauma?
 - a. What helps? E.g., physical, mental, spiritual or social engagements.
 - b. What doesn't?
2. Do you carry out any specific processes that you feel help you practice effectively at work? E.g., Any special procedures/rituals, prayer/karakia etc.
3. Help seeking patterns, where do you go to for help? E.g. Supervision, friends, or colleagues etc...
 - a. What types of supportive relationships do you have?
 - b. In the past have you experienced any personal types of trauma, if so, how did you deal with it then? E.g., personal therapy, family support etc.
4. We've covered a lot of areas so far, is there anything you would like to add that you think is important that I haven't raised?

I will contact you within the next 4 weeks to check accuracy of your transcribed material and to follow up with you.

Thank you so much for your time and sharing your experiences with me!

Appendix G: Secondary Traumatic Stress Scale

Participant # _____

2/2



SECONDARY TRAUMATIC STRESS SCALE

The following is a list of statements made by persons who have been impacted by their work with traumatized clients. Read each statement then indicate how frequently the statement was true for you in the past by circling the corresponding number next to the statement.

NOTE: "Client" is used to indicate persons with whom you have been engaged in a helping relationship. You may substitute another noun that better represents your work such as consumer, patient, recipient, etc.

| | Never | Rarely | Occasionally | Often | Very Often |
|--|-------|--------|--------------|-------|------------|
| 1. I felt emotionally numb..... | 1 | 2 | 3 | 4 | 5 |
| 2. My heart started pounding when I thought about my work with clients..... | 1 | 2 | 3 | 4 | 5 |
| 3. It seemed as if I was reliving the trauma(s) experienced by my client(s)..... | 1 | 2 | 3 | 4 | 5 |
| 4. I had trouble sleeping..... | 1 | 2 | 3 | 4 | 5 |
| 5. I felt discouraged about the future..... | 1 | 2 | 3 | 4 | 5 |
| 6. Reminders of my work with clients upset me..... | 1 | 2 | 3 | 4 | 5 |
| 7. I had little interest in being around others..... | 1 | 2 | 3 | 4 | 5 |
| 8. I felt jumpy..... | 1 | 2 | 3 | 4 | 5 |
| 9. I was less active than usual..... | 1 | 2 | 3 | 4 | 5 |
| 10. I thought about my work with clients when I didn't intend to..... | 1 | 2 | 3 | 4 | 5 |
| 11. I had trouble concentrating..... | 1 | 2 | 3 | 4 | 5 |
| 12. I avoided people, places, or things that reminded me of my work with clients..... | 1 | 2 | 3 | 4 | 5 |
| 13. I had disturbing dreams about my work with clients..... | 1 | 2 | 3 | 4 | 5 |
| 14. I wanted to avoid working with some clients..... | 1 | 2 | 3 | 4 | 5 |
| 15. I was easily annoyed..... | 1 | 2 | 3 | 4 | 5 |
| 16. I expected something bad to happen..... | 1 | 2 | 3 | 4 | 5 |
| 17. I noticed gaps in my memory about client sessions..... | 1 | 2 | 3 | 4 | 5 |

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TOTAL:

Total Score: _____

Citation: Bride, B.E., Robinson, M.R., Yegidis, B., & Figley, C.R. (2004). Development and validation of the Secondary Traumatic Stress Scale. *Research on Social Work Practice, 14*, 27-35.

Professional Quality of Life Scale (ProQOL)

When you [help] people you have direct contact with their lives. As you may have found, your compassion for those you [help] can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a [helper]. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *last 30 days*.

| 1=Never | 2=Rarely | 3=Sometimes | 4=Often | 5=Very Often |
|---------|----------|-------------|---------|--|
| 1. | | | | I am happy. |
| 2. | | | | I am preoccupied with more than one person I [help]. |
| 3. | | | | I get satisfaction from being able to [help] people. |
| 4. | | | | I feel connected to others. |
| 5. | | | | I jump or am startled by unexpected sounds. |
| 6. | | | | I feel invigorated after working with those I [help]. |
| 7. | | | | I find it difficult to separate my personal life from my life as a [helper]. |
| 8. | | | | I am not as productive at work because I am losing sleep over traumatic experiences of a person I [help]. |
| 9. | | | | I think that I might have been affected by the traumatic stress of those I [help]. |
| 10. | | | | I feel trapped by my job as a [helper]. |
| 11. | | | | Because of my [helping], I have felt "on edge" about various things. |
| 12. | | | | I like my work as a [helper]. |
| 13. | | | | I feel depressed because of the traumatic experiences of the people I [help]. |
| 14. | | | | I feel as though I am experiencing the trauma of someone I have [helped]. |
| 15. | | | | I have beliefs that sustain me. |
| 16. | | | | I am pleased with how I am able to keep up with [helping] techniques and protocols. |
| 17. | | | | I am the person I always wanted to be. |
| 18. | | | | My work makes me feel satisfied. |
| 19. | | | | I feel worn out because of my work as a [helper]. |
| 20. | | | | I have happy thoughts and feelings about those I [help] and how I could help them. |
| 21. | | | | I feel overwhelmed because my case [work] load seems endless. |
| 22. | | | | I believe I can make a difference through my work. |
| 23. | | | | I avoid certain activities or situations because they remind me of frightening experiences of the people I [help]. |
| 24. | | | | I am proud of what I can do to [help]. |
| 25. | | | | As a result of my [helping], I have intrusive, frightening thoughts. |
| 26. | | | | I feel "bogged down" by the system. |
| 27. | | | | I have thoughts that I am a "success" as a [helper]. |
| 28. | | | | I can't recall important parts of my work with trauma victims. |
| 29. | | | | I am a very caring person. |
| 30. | | | | I am happy that I chose to do this work. |