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**Emotional Well-Being and Secondary Traumatic Stress In
New Zealand Youth Workers**

A thesis
submitted in fulfilment
of the requirements for the degree
of
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at
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by
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ABSTRACT

This study aimed to explore the relationship of STS and emotional well-being among New Zealand youth workers using a qualitative approach. Eleven participants were interviewed for the study using a semi-structured interviewing technique. The purpose of this study was to fill a gap in the literature about the impact of working with traumatised youth and to identify if youth workers were at risk and vulnerable to the effects of trauma exposure. Three aims were incorporated in the study to answer the research question. The first aim was to explore ways in which youth work may be associated with decreased emotional well-being and STS with the second aim of identifying symptoms and causes of decreased emotional well-being and STS. Lastly, the third aim was to explore how decreased emotional well-being is associated with the development of STS.

The findings suggest the majority of participants experienced moderate levels of decreased emotional well-being and displayed symptoms associated with the effects of secondary traumatic stress. The results confirmed the first aim of the study which identified youth work as being correlated with decreased emotional well-being and STS. The results suggested decreased emotional well-being increased vulnerability to developing STS and therefore, the third aim of the study was also confirmed.

Several themes were found in the participants' answers which revealed youth work is associated with emotional well-being and symptoms of STS. This included emotional detachment, suppression, and numbing, helplessness, burnout and lack of resources to cope, social withdrawal, difficulty sleeping and changes in appetite. Risk factors which appeared to increase vulnerability included personal trauma, PTSD, countertransference, and empathic engagement. Organisational stressors were also identified as increasing vulnerability which heavily influenced participants and contributed to extreme stress and exhaustion.

Findings in this study contribute to the knowledge of secondary traumatic stress as well as increasing knowledge about the emotional effects of working with traumatised individuals. Furthermore, the study

helps to educate helping professionals and increases knowledge of youth work.

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TABLE OF CONTENTS

ABSTRACT	ii
ACKNOWLEDGEMENTS	iv
INTRODUCTION	1
Aim	5
LITERATURE REVIEW	6
Trauma	6
Post-Traumatic Stress Disorder	8
Post-Traumatic Stress Disorder and Secondary Traumatic Stress Disorder	10
PTSD and STS compared.	11
Secondary Traumatic Stress Disorder	11
Constructivist self-development theory.	12
Theory of secondary traumatic stress	15
Secondary traumatic stress symptoms.	17
Concepts Related to Secondary Traumatic Stress Disorder	19
Burnout.	22
Countertransference.	24
Groups Most Susceptible to Developing Secondary Traumatic Stress Disorder	26
Child welfare workers	27
What Makes Individuals Susceptible to Secondary Traumatic Stress Disorder	29
<hr style="width: 100%;"/>	
Emotional Well-Being	32
Etiological model.	34
Emotional regulation	35
Cognitive schemas.	37
Youth Workers	39
PTSD in children and young people.	40
Working with traumatised children and youth.	41
Conclusion of Literature Review	45
METHODS	46
Methodological Approaches	46
Phenomenology	47

Descriptive versus interpretive phenomenology. _____	48
Sample _____	49
Purposive sampling _____	49
Procedure _____	50
Ethics _____	50
Cultural Considerations _____	50
Confidentiality. _____	51
Informed consent _____	51
Recruitment procedure _____	51
Interview procedure _____	52
Data Analysis _____	52
FINDINGS _____	53
The Effects of Working with Traumatized Youth _____	54
Changes in worldview _____	54
Viewing people differently _____	54
Desensitisation _____	55
Personal Impact of Youth Work _____	56
Emotional Well-Being _____	58
Symptoms of Decreased Emotional Well-Being _____	59
Anger and sadness _____	60
Helplessness, questioning your ability and resources to cope _____	61
Burnout _____	63
Emotional exhaustion and dysfunctional emotional regulation _____	64
Emotional detachment _____	66
Emotion suppression _____	67
Secondary Traumatic Stress _____	68
Secondary Trauma Symptoms _____	68
Risk Factors Increasing Vulnerability to STS and Decreased Emotional Well-Being _____	71
Personal trauma _____	71
Post-traumatic stress disorder _____	71
Countertransference _____	72
Empathic engagement _____	73
Organisational stressors _____	74

Boundaries and barriers _____	77
Personal responsibility, questioning your ability and lack of time for one's self. _____	78
Factors Protecting Youth Workers from Vulnerability: Supervision and Coping Strategies _____	79
Conclusion of Results _____	81
DISCUSSION _____	82
Prevalence _____	83
Theory of STS and Emotional Well-Being _____	85
Emotional Well-Being _____	87
Anger and sadness _____	88
Helplessness. _____	89
Emotion regulation _____	90
Burnout, emotional exhaustion, and emotional depletion _____	92
Emotion suppression and emotion detachment _____	95
Desensitisation. _____	97
Secondary Traumatic Stress Disorder _____	97
Symptoms of secondary traumatic stress _____	99
Risk Factors Increasing Vulnerability _____	101
Countertransference. _____	101
Empathic engagement _____	103
Organisational stressors. _____	104
Supervision _____	106
Personal Trauma _____	107
Conclusion of Discussion _____	108
CONCLUSION _____	110
Recommendations for Minimising Effects _____	113
Personal Implications _____	114
Organisational implications _____	115
Strengths and Limitations _____	116
Strengths _____	117
Limitations _____	118
REFERENCES _____	119

APPENDICES:	127
Appendix A: Ethics Approval	127
Appendix B: Email to Organisations	128
Appendix C: Recruitment Flyer	130
Appendix D: Information Sheet	131
Appendix E: Consent Form	135
Appendix F: Interview Procedure	136

INTRODUCTION

In this chapter, I will briefly discuss the three concepts of STS, emotional well-being, and youth work. I will discuss the symptoms associated with STS and the vulnerability of helping professionals as well as outline the emotional cost of trauma work. I will also discuss the role of youth workers and their vulnerability of developing STS and the possibility of decreased emotional well-being. Following on from this I will outline the three aims of the study.

Secondary traumatic stress (STS) is a phenomenon associated with the effects of working with trauma victims (Nelson-Gardell & Harris, 2003). It is a secondary form of post-traumatic stress disorder (PTSD), as it mimics the same symptoms though exposure to trauma is indirect. STS is triggered when individuals are exposed to another person's trauma and is a feeling of extreme empathy from wanting to help the person who has suffered a tragic ordeal (Hatcher, Bride, Oh, King, & Catrett, 2011). When a helping professional, for example, listens to the ordeal of a trauma victim, they can experience emotional distress themselves from empathising with them (Phelps, Lloyd, Creamer & Forbes, 2009). As research has revealed, the way in which professionals become indirectly traumatised is when they try to understand the pain of the victim. It is during this process the professional becomes vulnerable to STS (Nelson-Gardell & Harris, 2003). The deep emotions felt by the therapist or helping professional can cause an abundance of detrimental psychological problems which can subsequently lead to impaired psychological capability.

Professionals who work closely with trauma victims can suffer emotional disturbances and pathological responses (Cornille & Meyers, 1999). This could lead to the deleterious effects of STS as well as decreased emotional well-being. STS is becoming a common occupational hazard evidenced by researchers who have investigated and identified potential candidates who are at risk of developing the condition (Hatcher, Bride, Oh, King, & Catrett, 2011). Research in the field of STS has commonly focused on professionals most likely to develop the condition due to the nature of their work and level of exposure to trauma. Numerous

studies (Bercier & Maynard, 2015; Adams, Figley & Boscarino, 2006; Figley, 2002; Hensel, Ruiz, Finney & Dewa, 2015) have measured STS among helping professionals including: psychologists, mental health workers, child welfare workers, counsellors, and social workers.

Research on these population groups has highlighted the dangerous and psychological impact of being exposed to trauma and the negative consequences correlated with STS. The ramifications of being indirectly exposed to trauma can cause individuals to experience physical, emotional, behavioural, cognitive, and interpersonal problems (Nelson-Gardell & Harris, 2003). As described by Figley (2002), there are three categories individuals experience when working with trauma victim's. The categories include psychological distress or dysfunction, cognitive shifts, and relational disturbances.

Symptoms associated with STS can present as re-experiencing the traumatic event through nightmares or flash backs, avoidance of situations associated with the traumatic event, physiological arousal, and emotional disturbances (Cornille & Meyers, 1999; Wagaman, Geiger, Shockley, & Segal, 2015; Hensel, Ruiz, Finney & Dewa, 2015). Further symptoms correlated with STS include changes in memory, perception, and sense of self efficacy, difficulty sleeping, social withdrawal, and disconnection from family and friends (Hatcher et al., 2011; Bride, Jones & Macmaster, 2008; Osofsky, Putnam & Lederman, 2008). Research has also suggested STS can disrupt perceptions about safety, trust, and independence (Dursun, Sener, Esin, Ançi, & Sapmaz, 2014; Pryce, Shackelford & Prycem, 2007; Clemans, 2004). The effects of STS can be long-lasting and severe if untreated. Studies (Figley, 2002; Phelps, Lloyd, Creamer & Forbes, 2009; Hesse, 2002) have identified organisations which have implemented prevention strategies and helped employees to build resilience, mitigated the effects of STS and reduced development. It is crucial prevention and action take place as soon as possible to minimise psychological harm and reduce the emotional cost of trauma work.

In addition to STS, there is also an immense emotional cost when working with victims of trauma which has yet to be fully researched and understood. Previous research has demonstrated how STS develops, the

symptoms associated with the condition, and the population groups most at risk. However, little research has investigated the emotional cost of trauma exposure without the presence of STS, as well as explore the impact trauma exposure has on emotional well-being.

Studies which have explored STS have recognised employees can become emotionally exhausted and emotionally detached because of working with trauma victims, yet the severity of emotional disturbances is unknown (Barford & Whelton, 2010; Osofsky et al., 2008; Clemans, 2004; Baird & Kracen, 2006). Consideration should be taken of the impact trauma exposure has on emotional well-being, as well as a means of prevention and intervention.

Emotional well-being controls our thoughts and how we feel about ourselves and the world. It is an important function of positive well-being and mental health. When our emotional well-being is threatened, it can lead to negative psychological outcomes such anxiety, depression, and stress (Osofsky et al., 2008; Nelson-Gardell & Harris, 2003; Dursun et al., 2014). Importantly, when individuals are exposed to trauma, it can change how emotions are regulated, increasing risk and vulnerability (Billieux, Hearn, Furst, & Van Der Linden, 2014). Being able to regulate our emotions helps individuals to cope in highly stressful situations and manage behaviours. When exposed to trauma, our capability to handle stress is compromised and our ability to manage the situation exceeds. This can be problematic, resulting in an influx of emotions which our cognition simply cannot handle. It is in this instance, our emotions become irregular and impulsive behaviours begin (Billieux et al., 2014). This can lead to depressive moods, acting irrationally in highly intense situations, and psychoemotional strain (Billieux et al., 2014; Wagaman et al., 2015). The decrease in emotional well-being can impact how individuals behave and react to situations as well as their ability to work effectively (Nelson-Gardell & Harris, 2003).

Stress, anger, sadness, depression, and anxiety, are all associated with the effects of STS which demonstrates the psychological impact and emotional cost of trauma work (Bercier & Maynard, 2015; Hatcher, Bride, Oh, King, & Catrett, 2011; Osofsky et al., 2008; Cornille & Meyers, 1999).

However, further research is required to fully understand the emotional cost of working with traumatised individuals as well as understand the relationship between emotional well-being and STS. It is unknown whether decreased emotional well-being contributes to the vulnerability of developing STS and therefore, displays a gap in the literature determining the true impact trauma can have on emotional well-being.

The population group chosen for this study is New Zealand youth workers. The reason for this choice is previous research has investigated the effects of working with trauma victims amongst psychologists, social workers, counsellors, and child welfare workers, and therefore, there is a lack of research focusing on the vulnerability of other population groups who are also exposed to trauma. Subsequently, there is also little knowledge about the impact of working with vulnerable youth and minimal understanding of how this can psychologically effect youth workers. Due to lack of research, it is unknown if youth workers are susceptible to STS, as well as the emotional cost youth workers may suffer from when working in this environment.

Youth programmes are aimed at vulnerable young people which help them to overcome problems they may be experiencing at home or at school. It is used as a prevention tool to give youth the opportunities for positive outcomes and be in a safe environment (Nolas, 2014). Youth workers aim to promote positive youth development using a strengths-based approach to better understand and work with young people (Nolas, 2014). Youth programmes incorporating this approach seek to challenge youth's perception of society and correct their "broken views" (Nolas, 2014, p. 27). The job of the youth worker involves creating effective bonds and empathic relationships, increasing cohesion, and developing a sense of belonging and community, (Zackariasson, 2015) to help youths in need of psychosocial repair (Nolas, 2014).

Youth workers play a pivotal role in facilitating this behaviour, as well as providing emotional support. Youth workers become people who young people trust and go to for emotional support (Fouché, Elliot, Mundy-McPherson & Bingham, 2010). As the core component of youth work is to create relationships, which distinguishes youth work from other

professions (Fouché et al., 2010), it requires a lot more involvement and emotion, (Zackariasson, 2015) which leaves room for vulnerability. As youth workers create an empathic relationship with youth it is possible they may be exposed to children or youth who have encountered trauma, and there is a possibility for youth workers to also become traumatised. One of the most important steps for the youth worker is to be able to understand and sympathise with youth before trying to assist and create a beneficial relationship. This is an important part of being a youth worker as young people who are referred to programmes may come from a variety of different backgrounds, communities, and families, and it is unknown what exactly has occurred in their life.

As youth workers develop a close bond and empathic relationship with young people, they may be exposed to disturbing or traumatic information. This is because in a therapeutic relationship a young person may become more comfortable in revealing information or stories about their past, which could be disturbing to the youth worker and cause emotional harm. Items which may be disclosed to the youth worker may involve family violence, child abuse, rape, offending, or bullying. The resources needed to cope with the situations youth workers may find themselves in, could exceed their capabilities and leave them at risk. In this instance, the toll of being exposed to young people and their tragedies may have an emotional cost for the youth worker impacting their emotional well-being, and could lead to the deleterious effects of STS. Due to the possibility of youth workers experiencing psychological implications, research is needed to determine if youth workers are vulnerable to STS and decreased emotional well-being.

Aim

The aim of this study is to identify how youth work is associated with decreased emotional well-being and STS. A second aim is to identify symptoms and causes of decreased emotional well-being and STS. Lastly, as research (Osofsky, Putnam & Lederman, 2008; Bercier & Maynard, 2015) has suggested trauma can cause emotional disturbances, the third aim is to explore how decreased emotional well-being is associated with the development of STS.

The following chapters will: examine the literature on STS and emotional well-being; discuss the methodology incorporated in the study, and the theory which informed the study. Subsequently, results will be discussed, examining the relationships and themes which occurred through analysis of the semi-structured interviews. The next chapter will open the discussion drawing conclusions and making inferences. Lastly, conclusions, recommendations, and limitations of the study will follow and conclude the thesis.

LITERATURE REVIEW

As has been introduced in broad terms in the previous chapter, individuals working in helping professions appear to be at risk of decreased emotional well-being and STS. The purpose of this literature review is to develop understanding of secondary traumatic stress and emotional well-being. The first section will begin by reviewing the concept of trauma and post-traumatic stress disorder to understand how the concept of secondary traumatic stress was formed. A comparison of post-traumatic stress disorder and secondary traumatic stress disorder will follow. The next section will then go onto discuss the theory underpinning secondary trauma by focusing on key researchers who developed the concept of the disorder. Symptoms of the disorder will then be discussed, as well as other concepts relating to the condition. Following this, groups most susceptible to secondary trauma will be discussed as well as what makes individuals susceptible. Moving on from this, I will then explore the concept of emotional well-being by discussing theories and symptoms. The last part of the literature review will focus on youth workers and why they were chosen as the population group for this study. The last section will discuss post-traumatic stress in children and will conclude the literature review.

Trauma

Psychological trauma is described as a sudden uncontrollable disruption which impacts psychological, cognitive, emotional, and underlying biological coping mechanisms (Van der Kolk, 2003). As defined by the DSM V, trauma is a psychologically distressing event which occurs

outside the normal range of usual human experiences (Kring, Johnson, Davison & Neale, 2013). It is a catastrophic event where the person becomes helpless in the face of danger, causing anxiety, and physiological arousal (Armsworth & Holaday, 1993). The event would be distressing to any person and is marked by intense fear, terror, and helplessness. Events which are identified as being traumatic consist of; serious threat to one's life or serious threat to one's children, spouse or other close relatives and friends, destruction of home or community, seeing another person being harmed, and in some cases learning about a serious harm or threat to a close friend or relative (Kring et al., 2013). This could result in serious harm to one's psychological capability and comes in the form of first-hand trauma and secondary trauma.

The symptoms associated with being exposed to trauma are marked by cognitive, behavioural, psychological, and emotional changes, which causes individuals to have a host of severe psychological impairments (Nelson-Gardell & Harris, 2003; Barford & Whelton, 2010; Adams, Figley, & Boscarino, 2006; Pryce, Shackelford & Prycem, 2007). As proposed by psychiatrist Erich Lindemann (1944), when a person is exposed to a traumatic incident, their psychological responses to trauma involves phasic reliving and denial of the event, as well as intrusion and numbing responses (Van der Kolk, 2003). When individuals undergo trauma they experience intrusive symptoms such as hyperactivity, increased startle responses, outbursts of aggression, flashbacks, and re-enactments (Van der Kolk, 2003).

Comparing to Eric Lindemann's theory, Kardiner (1941) described trauma as being marked by five principal features. These included; 1) startle response and irritability, 2) outbursts of aggression, 3) fixation on traumatic event, 4) disruption to personality function and 5) atypical dream life (Van der Kolk, 2003). It has been noted that when trauma occurs, one can lose a sense of feeling safe within themselves and the outside world, and undergo a loss of faith in life (Van der Kolk, 2003). Subsequently, individuals may experience a state of helplessness where they believe their actions have no bearing on life (Van der Kolk, 2003).

Trauma has been understood as causing post-traumatic stress disorder (PTSD) which is defined as a severe stress disorder. When an individual is exposed to a traumatic event, he or she does not have the capability to cope with the stress presented, resulting in psychological and physiological reactions (McCann & Pearlman, 1990). Additionally, secondary exposure to trauma can also cause severe harm which is defined as secondary traumatic stress disorder. The conceptualisations of both forms of trauma will be discussed in the next sections.

Post-Traumatic Stress Disorder

Post-traumatic stress disorder (PTSD) was first acknowledged as a diagnosable condition in the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) in the mid 1980s (Andreasen, 2010), which diagnosed individuals with a stress disorder affiliated with experiencing trauma. Before the condition was given the name PTSD, it was described as 'gross stress reaction' as published in the 1952 DSM-I. Gross stress reaction was linked to war and civilian settings (Andreasen, 2010) and was the first-time trauma-related experiences were seen as a mental health concern which required diagnosis and treatment. Gross stress reaction was caused by exceptional physical or mental stress and was commonly seen amongst soldiers. Individuals who were diagnosed with gross stress reaction presented with stress related symptoms which had persisted for several days to weeks (Andreasen, 2010). Once a diagnosis had been established and treatment began, it was expected stress related symptoms would decline.

From the diagnosis of gross stress reaction in the DSM I 1952, it is clear the essence of PTSD had been recognised for years within the context of war, however it was yet to be fully understood until a few decades later.

True understanding of PTSD was not validated until 1980 when the DSM-III was published. In the DSM-III the term PTSD was recognised as a chronic clinical disorder and came under the umbrella of a stress disorder. PTSD was said to occur because of different types of stressors associated with combat and civilian stress such as natural disasters, mass catastrophes, and serious accidental injuries (Andreasen, 2010). Since the

first acknowledgement of PTSD, the DSM has now released two more editions of the manual with the most recent being DSM V. In the 5th edition, PTSD is understood as a stress disorder caused by a severe stressor where the individual is either exposed to actual or threatened death, serious injury, sexual violence, physical violence, experiencing a natural disaster, or witnessing a death (Kring et al., 2013). Symptoms associated with PTSD include increased anxiety, avoidance of stimuli associated with trauma, and increased arousal (Kring et al., 2013).

Previously, PTSD symptoms had been categorised into three clusters, however in the DSM V four clusters are now present. The four clusters in the DSM V each represent a main symptom associated with PTSD. Each cluster also umbrellas numerous other symptoms related to PTSD. The four clusters represent the following: intrusively re-experiencing the traumatic event; avoidance of stimuli associated with the event; mood and cognitive changes after trauma; and lastly increased arousal and reactivity (Kring et al., 2013). Re-experiencing the traumatic event involves having repetitive memories or nightmares of trauma events. This could cause a series of intrusive thoughts and flashbacks (Kring et al., 2013). Avoidance of stimuli sees individuals try and avoid stimuli which would remind them of a specific trauma event such as: people or situations resembling the event; thinking about the trauma and blocking it out of their mind; masking feelings; avoiding conversations and places. Mood and cognitive changes consist of: being detached from others and emotions; lack of interest in activities; and increased negative cognition. Lastly, increased arousal and reactivity could cause individuals to become aggressive and reckless or self-destructive. Individuals may have trouble falling or staying asleep as well as difficulty concentrating. Individuals can also experience hypervigilance and increased startle response. Based on the in-depth accounts for each PTSD symptom, it is clear the distinction and conceptualisation of PTSD has grown vastly from its earlier days in the DSM-III mid 1980s, to the DSM V. There are now clear categories which represent symptoms of PTSD and how the condition presents and manifests.

Along with expanded knowledge of PTSD, it is now known PTSD not only resides within adults but within children as well. As acknowledged by the DSM V, PTSD can present in any person over the age of six years old meaning children can be diagnosed with the condition (Kring et al., 2013). With the latest knowledge of PTSD, it shows the understanding of this condition has developed and evolved. It is understood as a chronic form of stress which has severe pathological and psychological consequences upon the individual who possesses the condition. This conceptualisation has changed dramatically from its first definition in the 1980s DSM-III. As we now understand how PTSD has evolved and its relevant causes and symptoms, we can better understand the condition and further explain its relevance to secondary traumatic stress.

Post-Traumatic Stress Disorder and Secondary Traumatic Stress Disorder

With further establishment of what PTSD is, how it manifests and develops, and how the condition is diagnosed, several other conditions have become associated with PTSD such as secondary traumatic stress disorder (STS). STS was first described by Figley in 1978. STS is believed to be caused by exposure to another person's trauma where the individual becomes indirectly traumatised from hearing about a traumatic incident. When individuals such as family, friends, or therapists, are exposed to traumatic information, they could in turn experience emotional distress from hearing about the trauma.

Stamm (1999), and Cornille and Meyers (1999), noted the symptoms associated with STS were very similar to the symptoms presented in individuals with PTSD, therefore it was possible a relationship between the two conditions existed. As described by Ivicic and Motta (2016), the symptoms experienced by individuals with STS include; re-experiencing the trauma of another; intrusive cognition; avoidance of trauma reminders; and a state of persistent arousal. Wagaman, Geiger, Shockley, and Segal (2015) further described symptoms of STS are marked by hypervigilance, nightmares, sleeplessness, agitation, and fatigue. The symptoms identified by the two studies highlights a relationship with PTSD symptoms as individuals who are exposed to

trauma indirectly appear to have similar symptoms observed in those who experience trauma first-hand (Bride, Jones & Macmaster, 2008). As Stamm (1999) recognised STS as being nearly identical to PTSD due to similarity of symptoms, it was assumed STS was a branch of PTSD and researchers began to associate STS with PTSD despite the two conditions developing in separate ways. However, as further research explored the nature of STS and its difference from PTSD, it became clear there was true distinction between the conditions.

PTSD and STS compared. Marchand (2005) discusses the key difference between PTSD and STS by focusing on how individuals experience a traumatic event. Based on the descriptions provided by Marchand (2005), the key distinction between PTSD and STS is focused on how the person has experienced the trauma, whether directly or indirectly. How the individual experienced the trauma determines the type of trauma despite the symptoms for both being similar. According to Marchand (2005), PTSD relates to people who have experienced trauma first-hand and are suffering as a result of direct trauma exposure, which differs from a STS experience. As described by Marchand (2005), STS occurs as a result of learning or knowing about the trauma of another person, in other words they are exposed to knowledge about a traumatising event rather than the event itself. As such these individuals become traumatised indirectly. As PTSD and STS are defined differently based on the source of trauma, it demonstrates the two phenomena are independent in their nature and development. Furthermore, Marchand (2005) also highlighted how individuals exposed to trauma indirectly can in fact suffer their own type of trauma. With this recognition, the DSM V acknowledged the idea that secondary exposure to trauma can lead to development of symptoms similar to PTSD which required diagnosis and treatment (Hensel, Ruiz, Finney & Dewa, 2015). This clearly identifies STS as being separate from a PTSD diagnosis.

Secondary Traumatic Stress Disorder

A growing body of research (Cornille & Meyers, 1999; Nelson-Gardell & Harris, 2003) has examined the conceptualisation of STS, its development and manifestation. STS, first described by Figley (1978)

suggested friends, family, and professionals, were at increased risk of developing STS as a result of being empathically engaged with traumatised individuals (Cornille & Meyers, 1999). Figley believed emotional distress was triggered from wanting to help traumatised victim's which created extreme empathy. When individuals become emotionally distressed over traumatic events it causes severe stressor-like symptoms (Figley, 1995a). Figley (1995a) termed this process STS and defined it as a natural consequence of behaviours and emotions which result from knowing about the trauma experienced by another person. The phenomenon of learning about a traumatic incident, the process of internalising this information and then becoming emotionally distressed by the trauma is what Figley termed STS (Cornille & Meyers, 1999).

As described by Cornille and Meyers (1999), STS is a pathological response which is formed when an individual is indirectly exposed to another's trauma causing psychological responses. As identified earlier, STS occurs as a result of secondary exposure to trauma rather than first-hand where individuals can become exposed by listening to and hearing about the traumatic events suffered by others (Nelson-Gardell & Harris, 2003). The consequences of being exposed to trauma indirectly creates risk of developing negative psychological responses, causing symptoms similar to PTSD (Nelson-Gardell & Harris, 2003; Cornille & Meyers, 1999). Generally, individuals who suffer the consequences of STS are those who are repeatedly exposed to details of traumatic accounts (Hensel et al., 2015). However, it can occur amongst any individual who hears about traumatic information. Individuals who are repeatedly exposed to traumatic information and are at heightened risk of developing STS, have been identified as those who engage empathically with victims of trauma such as: psychologists, mental health workers, social workers or counsellors. Researchers have identified these helping professionals are at increased risk of developing STS as they are repeatedly exposed to trauma and are more likely than others to become distressed over wanting to help traumatised individuals (Figley, 1995a).

Constructivist self-development theory. Though Figley was first to identify STS as being a secondary form of trauma, the term itself was

informed through McCann and Pearlman's (1990) constructivist self-development theory. The constructivist self-development theory is focused on the effect trauma has on an individual's psychological development, adaptation, and identity (Nelson-Gardell & Harris, 2003). Constructivist self-development theory is based on the concept of 'self', which is understood as how individuals see and interpret the world (Pryce, Shackleford & Prycem, 2007). Self is who we think we are and how we experience new settings and meanings (Pryce et al., 2007). As individuals grow and adapt to new life experiences they are developing their self-concept and cognitive schemas which shape how individuals see the world and themselves in it (Nelson-Gardell & Harris, 2003). Cognitive schemas are central to constructing the self as it defines and develops a person's psychological needs (Pryce et al., 2007). Psychological needs consist of safety, trust, dependency and independence, power, esteem, intimacy, and control. These items define an individual's schema, which controls how they interpret meanings, experience situations, and react to the world. Importantly, cognitive schemas help us to adapt to new settings and situations, and are crucial for controlling how we act emotionally and rationally. Trauma is important when it comes to how cognitive schemas are formed or changed, as when individuals experience trauma it disrupts predetermined cognitive schemas and may change how they see and interpret meanings, and react to situations (Nelson-Gardell & Harris, 2003, Pryce et al., 2007).

When trauma is introduced, the psychological growth of cognitive schemas is disrupted and psychological abilities are exceeded as the resources to cope with the new situation are exhausted. Symptoms experienced by individuals are based on their ability to cope with the stressor presented, which according to constructivist self-development theory can change cognitive schemas and psychological needs. Consequently, exposure to trauma may generate irrational reactions as well as psychological, emotional, and physical disturbances.

Previous developmental history of personal trauma, interpersonal and psychological style, current stressors, and emotional supports, may also disrupt psychological growth (Nelson-Gardell & Harris, 2003). Pryce

et al. (2007) notes, individuals who are exposed to rape, child abuse, or neglect, may become less trusting of the world around them and feel the world is unsafe (Pryce et al., 2007). Further studies have revealed an individual's view of the world may become altered after hearing about traumatic accounts which can then result in changes to cognitive schemas (Ben-Porat & Itzhaky, 2009; Clemans, 2004; Salston & Figley, 2003; Nelson-Gardell & Harris, 2003; Osofsky, Putnam and Lederman, 2008; Bride, et al., 2008; Menashe et al., 2014). This was the case of participants in Ben-Porat et al., (2009) study. Participants in this study were social workers employed in a violence prevention centre. Social workers reported experiencing changes in their views of the world and humanity and viewed the world through grey lenses (Ben-Porat et al., 2009). They perceived the world as less safe and viewed society as aggressive and malicious. Comparing with this, a similar result was found in Menashe et al.'s (2014) study. Participants explained their perception of the world had changed as a result of being a child welfare worker where they became anxious about the world and now viewed it as a very dangerous place. The results from both studies highlight how trauma exposure can change preconceived views of the world, demonstrating a change in cognitive schemas. Based on this conceptualisation, constructivist self-development theory contends trauma impacts our self-development and psychological growth which can implicate an individual's ability to move forward and adapt to new life experiences. As trauma is introduced and erodes cognitive schemas this threatens psychological growth which is detrimental for overall development (Nelson-Gardell & Harris, 2003; Pryce et al., 2007).

As Pearlman and McCann (1990) constructed this theory and hypothesised the effect of trauma on psychological growth and development, Figley determined secondary exposure to trauma can have psychological impairments. With the knowledge that trauma can disrupt cognitive schemas and 'self' Figley was able to conclude that indirect trauma (STS) can have the same impact on individuals as those exposed to direct trauma (PTSD). Therefore, through the constructivist self-

development theory (McCann & Pearlman, 1990), Figley defined the construct of STS.

Theory of secondary traumatic stress. Based on Figley's first definition of STS informed through the constructivist self-development theory, the conceptualisation of STS has evolved and knowledge about its existence has expanded. STS is understood as a secondary form of trauma caused from exposure to traumatic information (Figley, 1995a). It is defined as a dysfunctional emotional response from indirect exposure to traumatic events, which occurs as a result of hearing emotionally shocking material (Menashe et al., 2014; Nelson-Gardell & Harris, 2003). Traumatic incidents can include: community violence and crime; sexual abuse and assault; child maltreatment and abuse; natural disasters, war, accidents, physical or emotional abuse; rape or death of a loved one; and other traumatic events (Hatcher, Bride, Oh, King, & Catrett, 2011; Hesse, 2002; Nelson-Gardell & Harris, 2003).

Research has found exposure to a traumatic event is associated with severe emotional and behavioural outcomes (Hatcher, et al., 2011). Individuals who work with trauma victims such as family, friends, and helping professionals, are at risk of developing STS as they become indirect victims of trauma as a result of their close contact with trauma survivors (Hatcher et al., 2011). According to Figley's (1995) theory, any person who works directly with or is exposed to trauma on a regular basis, are at risk of developing traumatic stress symptoms (Cornille & Meyers, 1999; Hatcher et al., 2011).

Research on STS which has examined the cost of trauma exposure have found individuals can experience emotional and behavioural disturbances such as: disturbed sleep, anger, fear and loss of control; anxiety, nightmares, flashbacks, feelings of insanity and irritability; suppression of emotions, alienation and suicidal thoughts (Cornille & Meyers, 1999). Furthermore, research has also found individuals can experience emotional disturbances of emotional detachment, depersonalisation, a sense of numbness, as well as sadness and depression, (Osofsky et al., 2008) which can severely implicate emotional well-being. This has been demonstrated in Osofsky et al.'s (2008) study

on child welfare workers where participants described experiencing emotional disturbances as a result of being exposed to traumatised children. Participants described symptoms of; cynicism, anger, irritability and anxiety as well as developing new fears such as the safety of one's family. Participants also described having thoughts about victims, patients and clients and experienced nightmares, difficulty sleeping, social withdrawal, disconnection from family and friends, changes in world view, and spiritual beliefs. The researchers also revealed participants had increased physical ailments and illness, diminished self-care, and increased use of alcohol and drugs, which was used as a way to forget about work. The research highlights participants experienced significant emotional and behavioural disturbances as a result of being exposed to child abuse and neglect, demonstrating the effect of trauma exposure.

Comparing with Osofsky et al.'s (2002) study, Follette, Polusny and Millbecks (1994), found that participants who were exposed to victims of sexual abuse reported symptoms of secondary traumatisation which caused negative coping, personal stress, and negative response to sexual abuse. All the participants in this study reported increased levels of personal stress as well as depression, sexual problems, anxiety, dissociation and eating disturbances. The results of this study also highlight the consequences of repeated trauma exposure and the psychological impairments associated with STS.

Contrasting with this, Billieux, Hearn, Furst, and Van der Linden (2014) study has demonstrated how trauma exposure can interfere with emotional regulation and impulsive behaviour. In Billieux et al.'s (2014) study which measured life time trauma exposure, results identified that individuals exposed to trauma tended to have a strong urgency to act rashly in intense situations and used fewer emotional regulation strategies compared with other participants. The researchers suggest emotional regulation is disrupted as a result of trauma exposure which exacerbates emotional distress. The researchers highlight emotional regulation is an important factor in explaining the relationship between trauma and general emotional distress as dysfunctional emotional regulation can intensify distress. The results demonstrate increased trauma exposure may disrupt

emotional regulation, accentuating impulsive behaviour and emotional disturbances.

Secondary traumatic stress symptoms. The symptoms of STS are similar to PTSD and, according to Cornille and Meyers (1999), are identical to the symptoms of the primary victim of whom suffered the trauma first-hand. As helping professionals hear about the trauma experienced by another they can develop symptoms related to the primary victim's traumatic disclosures and physiological arousal (Hatcher et al., 2011). Individuals can experience intrusive thoughts about the trauma such as nightmares or flashbacks and may develop hypervigilance and increased avoidance response (Cornille & Meyers, 1999). Research has proposed individuals develop STS symptoms as a result of repeated exposure to traumatic information (Dane, 2000). This is then exacerbated by stress over wanting to help those who have experienced the trauma (Cornille & Meyers, 1999).

To outline symptoms associated with STS, Hensel et al. (2015) has described the symptoms which may be present when an individual experiences STS. According to Hensel et al. (2015), STS is characterised by: intrusive imagery related to the primary victim's trauma; avoidance of situations associated with the traumatic incident; physiological arousal including; anxiety, difficulty falling or staying asleep; irritability, outbursts of anger, difficulty concentrating, hypervigilance, and exaggerated startle response; distressing emotions, functional impairment; intrusion and re-experiencing symptoms.

According to the National Institute of Mental Health, intrusion/re-experiencing, exposure to stimuli, and avoidance, are primary symptoms associated with STS which maintain and develop the condition (Wagaman, Geiger, Shockley, & Segal, 2015). These symptoms appear to be most common when an individual is experiencing STS, as well as hopelessness, inability to embrace, fear, guilt, and minimising problems (Wagaman et al., 2015). Interestingly, these primary symptoms are also the primary symptoms for PTSD which further demonstrates the relationship between these conditions. Consequently, when individuals experience these primary symptoms it can significantly impact their

personal and working lives, as well as the quality of care provided by helping professionals (Hensel et al., 2015). To expand our knowledge about STS further, it is important to understand what these symptoms are marked by and how they are maintained.

Firstly, exposure to certain stimuli can have major ramifications for individuals with STS. As noted by Hatcher et al. (2011), exposure to stimuli connected with the traumatic event can have abject consequences for the individual which can cause intense psychological distress or reactivity such as severe emotional and behavioural outcomes. Exposure to stimuli can adversely affect an individual's psychological ability which may lead to psychological impairment (Hatcher et al., 2011). This occurs when individuals are exposed to stimuli connected with the trauma event which further traumatises the individual and can lead to symptoms of avoidance.

Secondly, the American Psychiatric Association (APA, 2000) described intrusion and re-experiencing symptoms are marked by intrusive images, thoughts or perceptions associated with the traumatic event. When individuals encounter this symptom, they may have recurrent or distressing dreams where the traumatic incident is replayed and may also endure illusions, hallucinations, or flashbacks, associated with the trauma event. When individuals experience this symptom, it can be very confronting and difficult to manage, which creates further distress and has a major impact on how the individual copes with managing STS. This symptom can also manifest arousal symptoms such as difficulty falling or staying asleep, anxiety, difficulty concentrating, hypervigilance, or exaggerated startle response (Hatcher et al., 2011). Intrusion and re-experiencing symptoms can also implicate the ability to work effectively.

Contrasting to this symptom, avoidance of stimuli is another vital aspect of STS which further exacerbates the condition. According to Hatcher et al. (2011) the symptom of avoidance causes the individual to evade thoughts and feelings related to a traumatic event which involves avoiding places, activities, conversations, and people, which act as reminders of the event. For example, if an individual has been in close contact with victims of child abuse, it is possible they may avoid situations

which would remind them of a child abuse case, as well as people or places related to the incident. Individuals will also try to deny and reduce their exposure to anything which could be related to the trauma (Hesse, 2002). Individuals who experience symptoms of avoidance can find they have little interest in activities they would normally enjoy, are estranged from others (friends, family, colleagues) and estranged from people associated with the traumatic event (Hatcher et al., 2011). Individuals who use avoidance may find themselves very isolated and can become consumed by their psychological distress.

Bercier and Maynard (2015) have suggested these primary symptoms are indicators of psychological distress related to the development of STS and are negative responses from being exposed to traumatic events.

Overall, it appears from the research discussed in this section STS is marked by severe emotional and behavioural disturbances which can significantly affect one's psychological well-being. It is crucial helping professionals are aware of the effects of trauma work and are educated on ways to decrease vulnerability and mitigate stress to minimise development of STS. Not only this, but research has found individuals who are at risk of developing STS are also susceptible to developing compassionate fatigue, vicarious trauma, burnout, and countertransference, which have also been associated with the effects of trauma exposure. Research has commonly associated these conditions with STS, however there are key distinctions between the disorders. The next section will go on to discuss these disorders and their relevance to STS, as well as noting key differences between them.

Concepts Related to Secondary Traumatic Stress Disorder

STS has been used interchangeably with the terms compassion fatigue, vicarious trauma, burnout, and countertransference. However, it is important to recognise these conditions can occur with or without the presence of STS. Compassion fatigue, vicarious trauma, and secondary trauma, are all conceptualised as reactions to severe emotional demands from being exposed to traumatic information (Ivicic & Motta, 2016). All

three concepts have different interpretations and meanings while the approaches used to intervene are diverse.

Compassion fatigue and vicarious trauma are associated with the cumulative effects of working with distressed or traumatised victims or perpetrators (Osofsky et al., 2008). Adams, Figley, and Boscarino (2004) define compassion fatigue as reduced capacity or interest in being empathic or “bearing the suffering of clients” (p. 103). Compassion fatigue results from being exposed to trauma where helping professionals may endure emotional drain from increased contact with trauma victims and consistently displaying compassion towards victims (Ivicic & Motta, 2016). Being compassionate and empathic towards traumatised victims can come at an emotional cost which could result in emotional exhaustion and lead to the development of compassion fatigue (Figley, 2002). According to Adams et al. (2006) individuals who provide emotional support to trauma victims can become stressed which can often lead to signs of psychological distress.

Figley (1995), whose research explored the constructs of STS, vicarious trauma, and compassion fatigue, defined compassion fatigue as a reaction of STS (Adams et al., 2006). Figley determined compassion fatigue as a state of tension and preoccupation with traumatised individuals where sufferers can re-experience the traumatic event associated with the traumatised individual. Individuals can be drained emotionally and burnt-out out from providing constant emotional support to clients (Adams et al., 2006). Symptoms of compassion fatigue include avoidance and numbing, reminders of the event, exhaustion, hypervigilance, and increased arousal (e.g. anxiety) which are similar to the symptoms experienced by the traumatised individual (Adams et al., 2006; Baird & Kracen, 2006). Therefore, compared with STS, compassion fatigue occurs as a result of becoming empathically fatigued when being repeatedly exposed to traumatic information and comes at the cost of caring (Figley, 2002).

In contrast to compassion fatigue, Pearlman and Mac Ian (1995) have defined vicarious trauma as the “cumulative transformation of the inner experience of an individual” (p, 31). Vicarious trauma occurs from

long term exposure to traumatised victims which can cause disruptions to the individual's view of themselves, others, and the world (Baird & Kracen, 2006; Hesse, 2002). The responses individuals experience from being exposed to challenging situations, such as trauma, can threaten their beliefs and values about the world as well as themselves causing decreased motivation, efficacy, and empathy (Baird & Kracen, 2006). These symptoms can lead to the development of vicarious trauma.

Similar to STS, the theory of vicarious trauma was established through the constructivist self-development theory by McCann and Pearlman (1990), which focuses on engaging empathically with traumatised clients. It is a theory of personality which describes the impact of indirect exposure to trauma (Dane, 2000). The model posits that individuals who engage empathically with traumatised individuals, can also gain a sense of their own trauma through their clients, though exposure is secondary. McCann and Pearlman (1990) identified vicarious trauma occurs from being exposed to trauma and works within the same realms as the constructivist self-development theory (Dane, 2000). Despite initial reactions to trauma which are normal considering the challenging situations helping professionals find themselves exposed to, it is the on-going costs of these responses which causes harm (Hesse, 2002). This can have long lasting effects on the individual's emotional well-being, relationships, and life (Hesse, 2002).

Dane (2000) has identified signs and symptoms which indicate the presence of vicarious trauma to include; decreased sense of energy, no time for one's self, increased disconnection from loved ones, social withdrawal, increased sensitivity to violence or fear, decreased sensitivity, generalised despair, and hopelessness. The researchers explained that when individuals begin to experience a few of these symptoms, it is an indication that the long term effects of being exposed to trauma are coming to the surface and are beginning to have lasting effects on the individual which challenges their cognitive schemas (Baird & Kracen, 2006). As people experience vicarious trauma, they undergo disruptions to their schemas which can challenge their values and beliefs of themselves, others, and the world (Baird & Kracen, 2006; Hesse, 2002). Research has

described the psychological problems caused by disruption to schemas can cause problems for esteem (loss of the self and others), sense of safety and intimacy, and control (Baird & Kracen, 2006). Sufferers of vicarious trauma can begin to question their own identity, self-worth (if they are good enough for the job) and the role they play in their clients lives (Hesse, 2002). Therefore, the experiences of vicarious trauma are related to our inner self, focusing on our internal experiences which contrasts with STS which appears to be focused on external experiences, however some symptoms can overlap (Ben-Porat et al., 2009)

Burnout. Another concept which overlaps with STS is burnout. They share similar symptoms and are characterised by emotional exhaustion through nature of work (Adams et al., 2006). Due to their similarities, researchers often use 'burnout' interchangeably with 'STS' despite there being significant differences between the concepts. Burnout, however, has been described as a reaction to STS and a critical component of compassion fatigue (Adams et al., 2006), which may be where the overlap occurs.

Figley (2002) described burnout as "a state of physical, emotional, and mental exhaustion" (p. 1436) caused by prolonged emotional involvement with clients, patients, or other individuals. Research has found burnout results from the cumulative effect of emotionally demanding situations which increases an individual's stress levels beyond their capacity to control and cope (Phelps, Lloyd, Creamer & Forbes, 2009; Nelson-Gardell & Harris, 2003). The result of being exposed to demanding interpersonal situations, can cause individuals to feel over whelmed, stressed, and depleted, which can cause burnout. Being in a high emotionally demanding situation may leave the worker feeling emotionally exhausted and fatigued causing the individual to feel worn down and incapable of facilitating positive change in their line of work (Adams et al., 2006; Figley, 2002; Phelps et al., 2009). Research (Barford & Whelton, 2010; Van Hook & Rothenberg, 2009; Wagaman et al., 2015) has revealed trauma workers are highly susceptible to burnout as they are increasingly exposed to trauma victims and engage empathically with clients. Due to the nature of work, trauma workers are at risk of emotional

and mental exhaustion which can lead to the development of burnout. Individuals who are burnout can become unproductive, have significant psychological, behavioural, and emotional problems, which implicate their professional and personal lives (Nelson-Gardell & Harris 2003; Beaton & Murphy, 1995)

Comparing with Figley's (2002) definition of burnout, Freudemberger (1974) defined burnout as being termed by four conditions. These include; being depressed or suspicious, being easily angered, cynical, and resistant to change, and spending too much unproductive time at work. This was one of the first definitions of burnout, though over the years the conceptualisation of burnout has grown and is now mainly characterised by emotional exhaustion. Further to this concept, Maslach, Jackson and Leiter (1996) posited three dimensions of burnout which included emotional exhaustion, depersonalisation, and feelings of incompetence or reduced personal accomplishment, as being cornerstone symptoms of burnout. Most conceptualisations of burnout include these symptoms as being crucial, with psychometric testing also incorporating them as being prominent features when diagnosing an individual with burnout. The dimensions provide a basic understanding of what an individual can experience when they are feeling burnout and how this may affect psychological well-being.

Further symptoms of burnout, which are similar to STS, include fatigue, irritability, depression, indifference, reduced insight, and capacity to make decisions (Nelson-Gardell & Harris, 2003; Phelps et al., 2009). These symptoms impair the individual's social and occupational functioning, reducing the individual's ability to work effectively and is associated with poor work performance (Nelson-Gardell & Harris, 2003; Phelps et al., 2009). Individuals may also experience physical, emotional, behavioural, and interpersonal problems (Nelson-Gardell & Harris, 2003).

Incidents which develop burnout have been described by Adams et al. (2006), outlining burnout evolves from being exposed to demanding interpersonal situations, which causes emotional exhaustion and depersonalisation. Studies exploring the concept of burnout have found organisational stressors such as working long hours, poor supervision and

support, in-experience and isolation, are factors which can promote the development of burnout (Phelps et al., 2009). Beaton and Murphy (1995) revealed large caseloads, working long hours, and increased client contact, predicted burnout as well as poor psychological well-being. The cumulative effect of working prolonged hours coupled with increased caseloads in emotionally demanding environments caused crisis workers to become depleted. Comparing with this, a study by Barford and Whelton (2010), on child and youth workers found those who were emotionally drained displayed high levels of burnout compared with participants who were not emotionally drained. In the same study, younger participants who were less experienced displayed similar levels of emotional exhaustion and personal accomplishment, compared with older workers. The results of this study revealed in-experience or lack of experience in roles were correlated with emotional drain and higher levels of burnout.

A similar finding was found in Van Hook and Rothenbergs study (2009) which revealed burnout levels were higher among younger therapists and those who worked closely with vulnerable populations. The researchers explained this result occurred as younger workers had less experience and came in with the perception of high hopes of wanting to help, and change the world. However, when participants were exposed to the cruelty and harsh conditions of the world their views of the world changed. Moreover, their ability to cope with the challenges of the environment were reduced. As a result, younger workers became burnout and emotionally drained, which may be correlated with in-experience.

Lack of professional support and supervision have also been identified as a high predictor of burnout in several studies (Adams et al., 2004, Leiter & Maslach, 2000; Phelps et al., 2009) which contributed to stress, burnout, and overall negative well-being. Overall, the studies have found working long hours, in-experience, being emotionally and mentally drained/exhausted, poor professional support and supervision, were found to be precursors to burnout.

Countertransference. Countertransference is also closely linked with the effects of STS and has been associated within the realms of compassion fatigue and vicarious trauma as individuals who experience

any of these conditions may also experience countertransference in conjunction. The term countertransference originates from psychodynamic therapy and is caused by an emotional reaction towards a client from the therapist through over identification (Figley, 2002). Countertransference is the process of seeing oneself within the individual or meeting their own needs through the client and can occur among therapists working with trauma victims (Figley, 2002).

The term refers to the thoughts, feelings, and behaviours, a therapist experiences when working with trauma victims, and their own emotional reactions (Dutton, 1992; Nelson-Gardell & Harris, 2003). The therapist can become overly involved in the client's story by relating it to their own unresolved conflicts, and may have difficulty separating from it (Dutton, 1992). This involves over identification with a client and can cause a sense of helplessness, despair, and inundation (Ben-Porat et al., 2009). Tosone, Nuttman-Shwartz and Stephens (2012) explained this could occur as trauma victims elicit strong polarising countertransference responses and without knowledge this induces the therapist into the reality of the tragic ordeal. It is without awareness therapists or helping professionals engage deeply with their clients as they are influenced by the re-enactments of a traumatic incident. This can create strong emotional responses such as anger, guilt or arousal, because of the polarising reactions of countertransference. Therefore, countertransference appears to be a consequence of working with trauma victims where the helping professional can over identify or see themselves within the client which can cause negative emotional implications to the therapeutic relationship (Nelson-Gardell & Harris, 2003).

Overall, this section highlighted the key differences between compassion fatigue, vicarious trauma, burnout, and countertransference, and how they differ from STS. All these conditions can occur with or without the presence of STS and trauma, and could be related to other situational factors such as organisational stressors. The research highlights how these conditions can occur from exposure to trauma which implicates psychological well-being. Following on from this, the next

section will discuss population groups most susceptible to developing STS.

Groups Most Susceptible to Developing Secondary Traumatic Stress Disorder

As knowledge about STS has evolved, it has now become a known phenomenon amongst helping professionals, and is deemed a potential side effect of working with traumatised individuals. As highlighted in the previous section the psychological consequences of examining the pain of others can cause severe emotional and behavioural disturbances for helping professionals, which can have detrimental consequences (Dursun, Sener, Esin, Ançi, & Sapmaz, 2014). Research has found professionals who are repeatedly exposed to traumatic information can become psychologically implicated and are at increased risk of developing STS as well as vicarious trauma, burnout, compassion fatigue, and countertransference, which can decrease emotional well-being (Adams et al., 2006).

Helping professionals who have been identified as being most susceptible to developing STS include child welfare workers, counsellors, psychologists, and social workers. This is based on their likelihood of being repeatedly exposed to traumatic information indirectly through their clients when examining the pain of others. Though helping professionals have identified the work they do can be highly rewarding, where they feel they are achieving something and helping those in need, research has revealed the work can have a major impact on psychological health and overall well-being (Adams et al., 2006).

Helping professionals aim to alter the behaviour and thought processes of clients and help work through symptoms of distress. Professionals are providing clients with emotional support, empathy, and coping strategies, to manage emotions and cognitive behaviours. However, by emotionally supporting the client, it can deplete the helping professional's emotional resources, which can make them vulnerable to the psychological effects of STS (Adams et al., 2006). As a helping professional provides emotional support and empathy through empathic engagement, they are in turn taking on the emotions and trauma of their

clients (Adams et al., 2006). Nelson-Gardell and Harris (2003) have noted empathic engagement with a client can in turn traumatise the helping professional who provides psychological support to trauma victims. This is caused from being exposed to traumatic information which can be very distressing as well as emotionally taxing. In Adams, et al. (2006) study, researchers revealed helping professionals who work with traumatised clients often show signs of psychological distress after interactions with trauma victims which highlights the risk of working in a vulnerable environment.

Triggers which develop and maintain STS are heightened based on the type of trauma the individual is exposed to. For helping professionals, certain groups are more likely to be vulnerable to the effects of STS than others, for example those who work with traumatised children. In Cunningham (2003) and Pistorius, Feinauer, Harper, Stahmann, and Miller (2008) studies, the researchers found that individuals who worked with child abuse cases were severally affected on a personal and interpersonal level. The research identified that child abuse cases were found to strongly affect participants, compared with other types of trauma. The same result was identified in Clemans (2004) and Menashe, Possick and Buchbunder (2014) studies which found participants who worked with abused children suffered significant problems. Their basic sense of safety was adversely affected and the interaction also threatened their psychological needs and cognitive schemas. The studies emphasise helping professionals who work with children or youth appear to be more vulnerable to the effects of STS.

Child welfare workers. Studies of child welfare workers (CWW) have been selected to explore the psychological consequences of working with traumatised children. Helping professionals who work with traumatised children appear to be more vulnerable to the consequences of trauma exposure which further exacerbates the effects of STS (Clemans, 2004; Menashe et al., 2014; Cunningham, 2003; Pistorious et.al, 2008). Menashe et al. (2014) highlights CWW are at increased risk of STS due to the nature of their work environment where they are exposed to child neglect and abuse. As CWW bear the responsibility of a child's physical

and emotional well-being this can increase emotional stress as the professional feels a great deal of responsibility for their client (Menashe et al., 2014). CWW are expected to listen to children's stories with a great deal of empathy and help them through their painful and distressing experiences. Through this, the professional develops an empathic relationship as they meet the needs of the traumatised child (Nelson-Gardell & Harris, 2003). As this relationship develops CWW are at increased risk of developing STS through indirect exposure to traumatic information (Nelson-Gardell & Harris, 2003). Creating an empathic relationship with the child and helping them to overcome the distressing encounters they have experienced means CWW can endure a tremendous amount of emotional disruption as they take on the emotional disturbances of their client (Bride, et al., 2008).

The psychological consequences of working with traumatised children are detrimental and the risk of developing STS increases. This is highlighted in Bride et al.'s (2008) study on child protective service workers. The results of Bride et al.'s (2008) study revealed out of 187 participants, 92% reported experiencing at least one symptom of STS while 59% experienced one or more symptoms of STS. In the same study, 34% of participants meet the criteria for PTSD. Factors which correlated with the development of STS included peer support, size of caseload, personal history of trauma, administrative support, and professional experience. The findings call attention to organisational factors which contributed to the vulnerability of STS and further exacerbated risk.

Contrasting with this, Dane's (2000) study focused its attention on the emotional harm for CWW. In this study, sadness was a common emotion expressed by majority of the participants who were working with neglected or abused children. One of the participants explained how they cried after removing a child from their home and afterwards felt great sadness which resulted in difficulty sleeping. When it came time to remove another child from their home the participant experienced reliving the memory from their previous removal and exclaimed how difficult it was to complete the task. The study demonstrates situations CWW find themselves in and how this can cause intense emotions of sadness and

guilt. Another participant from Dane's (2000) study disclosed having flashbacks of a child fatality with whom he had worked with. The participant claimed to blame themselves for the outcome of the child, stating they did not do enough for the child. The participant expressed feelings of extreme guilt and sadness. Adding to this, the participant also avoided information about the fatality and situations which would remind them of the fatality, representing symptoms of STS. The researchers in the study explained the participants experienced emotional disturbances, increased arousal, flashbacks, and avoidance, which are all correlated with symptoms of STS. In another study by Cornille & Meyers (1999) on child protective workers, the results found out of 183 participants, 37% were experiencing clinical levels of emotional distress correlated with STS. Levels of work exposure and personal trauma were found to be strongly correlated with emotional distress which manifested the development of STS.

In summary, the results of these four studies accentuate how vulnerable CWW are to STS which is caused by the challenging nature of work and contexts the workers find themselves exposed to. As CWW are exposed to traumatised children the studies emphasise how emotionally exhausting and distressing the job is, causing a great deal of risk and vulnerability. Contrasting with this, there are also other causes which can increase vulnerability of STS for helping professionals such as personal trauma and organisational stressors. This will be discussed in the following section.

What Makes Individuals Susceptible to Secondary Traumatic Stress Disorder

Research (Bride, et al., 2008; Cornille & Meyers, 1999; Nelson-Gardell & Harris, 2003) has indicated that there are significant factors which may increase the likelihood of developing STS. This includes personal trauma, in-experience, age, decreased support network, and organisational factors (Bride, et al., 2008).

As noted in Nelson-Gardell and Harris (2003); Cornille and Meyers (1999); Hensel et al., (2015); and Pryce et al. (2007) studies, having a history of personal trauma has been identified as a core component which

correlates with STS as these individuals appear to be more vulnerable to the effects of trauma exposure, especially when the trauma is similar to their own experience. In Nelson-Gardell and Harris (2003) study, the results found personal experience of childhood trauma such as child abuse and neglect increased CWW risk of developing STS. By having their own childhood trauma, it often leads to countertransference where welfare workers would overly empathise with the clients they were seeing. Results revealed participants who worked with trauma victims and had experienced their own trauma reported negative coping strategies, increased personal stress, and negative responses to sexual abuse cases (Nelson-Gardell & Harris, 2003). The same result was found in Cornille and Meyers (1999) and, Cornille and Meyers (2002) studies amongst child service protective workers. In Cornille and Meyers (1999) study of 183 participants, 37% were found to be experiencing clinical levels of emotional distress associated with STS. The levels of work exposure and personal trauma were found to be strong indicators correlated with the presence of STS symptoms. In their 2002 study, 82% of participants had experienced their own personal trauma prior to working in the child protective services field which were found to increase their levels of distress. Participants with a personal history of trauma reported increased levels of depression, anxiety, and distress, and became more withdrawn, isolated, and somatic, compared with participants who had not experienced personal trauma (Cornille & Meyers, 2002). The studies identify personal trauma is strongly correlated with the onset of STS, and is a core component which increases vulnerability and risk (Cornille & Meyers, 1999). This is due to personal trauma acting as a trigger which reminds the professional of their own trauma experiences and unresolved conflicts which can cause over identification and seeing oneself within the client.

Contrasting with personal trauma, organisational stressors have also been associated with predictions of STS. Osofsky et al. (2008) have identified several job-related factors which were strong in predicting the onset of STS. These included; high caseload, little support from supervisors, being in conflicting roles, lack of peer support, inadequate

resources to meet demands, excessive workload, increased paper work, physical risks, and concerns about safety. Further job related elements which also correlated with STS included little job recognition, shift work, and sleep deprivation. The eleven elements in this study were found to be the strongest predictors of STS which contributed to development and maintenance of the condition. Moreover, Osofsky et al. (2008) concluded when employees are suffering from STS, this can decrease their ability to function effectively at work and therefore undermines the working environment of the organisation. A further study which demonstrates the relationship between organisational problems and STS was conducted by Bennett, Plint and Clifford (2005) on child protection workers. The results of this study found one third of participants experienced emotional exhaustion, high levels of cynicism, and low levels of professional efficacy, that were symptomatic of being a child protection worker. Participants cited job stress as being a key reason for leaving and changing jobs due to the demands of being a child protection worker. The study draws attention to organisational stressors as being a precursor for stress related symptoms which increased vulnerability of STS. A similar study conducted by Cornille and Myers (2002) on child protective service workers revealed the intensity of exposure to trauma and working more than 40 hours per week, intensified an employee's susceptibility to STS. The researchers conclude that participants who worked more than 40 hours per week experienced increased anger, irritability, trouble concentrating, exaggerated startle response, hypervigilance, intrusive thoughts and nightmares. The results also found employees who worked long hours felt increased distress, hostility, anxiety, suspicion, paranoia, and delusional thoughts.

Interestingly, these studies emphasise how organisational stressors play an important role in increasing the vulnerability of STS as workers become distressed as a result of poor supervision and support, increased workload, and lack of time off. Overall the research in this section demonstrates how exposure to trauma coupled with personal trauma and organisational stressors intensifies susceptibility to STS. To discuss the issue of trauma further, the next section will discuss the impact of exposure to trauma on emotional well-being.

Emotional Well-Being

As research on STS is growing, there appears to be few studies which focus on the emotional harm of trauma exposure. Research has found STS can cause significant impairment to an individual's professional and personal well-being (Hesse, 2002; Phelps et al., 2009) however, it appears there are minimal studies which examine a direct relationship between emotional well-being and trauma without the presence of STS. Adding to this, it is unknown if decreased emotional well-being contributes or increases vulnerability of STS.

A general definition of emotional well-being refers to the "emotional quality of everyday experiences and the frequency of joy, stress, sadness, anger, and affection" (Kahneman & Deaton, 2010, p. 16489). In the health field, there appears to be no definite definition of emotional well-being. However, Phelps et al. (2009) have defined it as being similar to mental health and is "a state of emotional and social well-being in which the individual can cope with the normal stresses of life and achieve his or her potential" (p. 314).

As discussed in the previous sections, individuals exposed to frequent and distressing traumatic experiences have been found to cause significant impairment to one's psychological well-being (Hatcher et al., 2011). Figley (2002) identified that any individual who examines the pain of others are at risk of developing severe emotional and behavioural disturbances. A vast amount of research has demonstrated Figley's (2002) theory and have found individuals can experience negative emotional disturbances of anxiety, depression, sadness, and anger, as a result of trauma exposure (Bercier & Maynard, 2015; Dursun et al., 2014; Nelson-Gardell & Harris, 2003; Osofsky et al., 2008; Cornille & Meyers, 1999; Clemans, 2004; Hesse, 2002). Further research has shown it is also common for those who experience STS to also experience emotional detachment, exhaustion, depersonalisation, and emotional suppression (Barford & Whelton, 2010; Osofsky et al., 2008; Cornille & Meyers, 1999; 20, Bercier & Maynard, 2015; Nelson-Gardell & Harris, 2003).

Several studies have examined the impact of trauma on workers. Follette, et. al (1994) study examined the effects of personal trauma

history and trauma work among 554 mental health professionals. Results from their study found all participants reported high levels of personal stress, anxiety, depression, and eating disturbances, as a result of exposure to trauma. Similarly, Barford and Whelton (2010) study on child and youth care workers found participants were emotionally drained and emotionally exhausted as a result of their work with traumatised children and youth and also experienced aspects of burnout. The researchers note, exhaustion appeared to be intensified by work pressure, role ambiguity, and involvement. Another study by Clemans (2004) on rape and crisis workers revealed two participants felt emotionally numb and detached after interactions with traumatised clients. The researchers also found nearly all participants experienced increased anxiety and hypervigilance with one reporting panic attacks. Comparing with this study, participants in Pryce et al.'s (2007) study also reported feeling emotionally numb when working with traumatised clients, however they stated numbing was crucial as it enabled them to intervene in a traumatic situation and provide support and empathy to their clients. The results from this study suggest participants who became emotionally numb and detached did so to protect themselves against the ramifications of hearing about traumatic information. This may act as a protector against STS and decreased emotional well-being. Alternatively, it may be worthy to note this may cause adverse effects as the helping professional is not processing their emotions in a positive way and therefore emotions may build up which could cause further emotional implications.

Further research on emotional numbing has identified it as a prominent symptom of STS which is included in the secondary traumatic stress psychometric scale deeming it a significant implication when working with traumatised individuals (Craun & Bourke, 2015). Emotional numbing occurs as individuals try and suppress their emotions to move forward and provide clients with emotional support (Pryce et al., 2007). Nelson-Gardell & Harris (2003) claim therapists typically elicit some sort of defence mode when hearing about trauma incidents which involves numbing, avoidance, denial, and distancing. Consequently, when individuals elicit these defence modes, it can increase their vulnerability of

further distress as they fail to work through emotions they are experiencing which can exceed their capabilities. This may indicate psychological distress is associated with the effects of STS, compassion fatigue, or emotional contagion (Bercier & Maynard, 2015). Studies conducted by Clemans (2004); Nelson-Gardell and Harris (2003); Bercier and Maynard (2015); and Osofsky et al. (2008) on STS, revealed participants in all of these studies experienced emotional numbing and emotional detachment when exposed to trauma and highlights it as being a significant problem when working as a helping professional.

To further understand why individuals experience emotional disturbances when working with traumatised individuals, the following section will discuss Figley's (2002) etiological model which explains the impact trauma has on emotional well-being. Adding onto this, the concepts of emotional regulation dysfunction and cognitive schemas will follow which will explore their effects on emotional well-being.

Etiological model. According to Figley (2002), the impact of trauma on emotional well-being stems from the driving forces of empathy and emotional energy which are expended when working with traumatised victims. Figley (2002) created this model to understand the consequences of working with trauma victims and the impact it has on psychological well-being. In the etiological model, Figley (2002) demonstrates that when helping professionals display empathy and use emotional energy, this can have adverse consequences for the individual's health. Figley (2002) identified this process through the etiological model and called it compassion fatigue. The etiological model was designed to demonstrate the driving forces which predicts the onset of compassion fatigue and comprises of 11 variables which form a causal model examining cause and prevention (Figley, 2002). The variables include: exposure to the client, disengagement, empathic concern, empathic ability, prolonged exposure, degree of life disruptions, traumatic memories, satisfaction, empathic response, and residual compassion stress. Figley (2002) found when these forces combine and work together, it results in exhaustion of emotional energy and causes compassion fatigue. Though Figley (2002) identified emotional energy and empathy are important when establishing

therapeutic relationships, the model has suggested there are other elements working against this relationship which work to decrease emotional energy and cause emotional fatigue. By creating this model and examining causes and prevention of compassion fatigue, the model is a tool used to help those most susceptible in developing compassion fatigue by demonstrating ways in which the condition can be prevented and mitigated (Figley, 2002). The model is crucial for understanding how working with victims of trauma causes negative emotional disturbances, which can lead to decreased emotional well-being. The model is also important for understanding the emotional consequences of working in a vulnerable environment which demonstrates exposure to traumatic information can severely strain our mental health system and consequently may lead to a break down in our ability to function.

Further to this concept, Figley (2002) defined the term emotional contagion which relates to a therapist's capacity of empathy and further explains how helping professionals become vulnerable to decreased emotional well-being. Emotional contagion forms when therapists are exposed to frequent and distressing trauma experiences. As therapists are empathetic and try to understand and relate to the distress of another person (Phelps et al., 2009), they are themselves vulnerable to becoming traumatised. Figley (2002) called this process emotional contagion which relates to the concept outlined in the etiological model where empathy and emotional energy act as driving forces in a therapeutic alliance (Phelps et al., 2009). According to Figley (2002), when either of these two forces are threatened, it can lead to individuals becoming traumatised (emotional contagion), and can lead to a break down in emotional well-being. This concept is important when defining emotional well-being, which explains the process of how therapists become traumatised and plays a vital role determining the vulnerability of helping professionals in the therapeutic alliance.

Emotional regulation. Another concept which appears to implicate emotional well-being is emotional regulation. The next section will discuss the importance of emotional regulation and how this plays a significant role

in the development of emotional disturbances leading to decreased emotional well-being.

Emotional regulation is described as the individual's ability to regulate emotions which mitigates impulsive behaviour. Research has found emotional regulation strategies are crucial for adaption to stressful life events which aids individuals in their ability to cope in stressful situations (Billieux et al., 2014). Previous research has found emotional regulation is important when it comes to how individuals cope with trauma as it regulates impulsive behaviour (Billieux et al., 2014). Cognitive emotional regulation is vital when adapting to stressful life events (Ochsner & Gross, 2005) as trauma exposure has been found to increase impulsive behaviour (Billieux et al., 2014) which highlights emotional regulation as being crucial to mitigate the effects of emotional and behavioural disturbances.

Emotional regulation is a cognitive component of empathy which determines the individual's ability to regulate emotional responses (Wagaman et al., 2015) and determines how individuals will react and cope to distressing situations (Billieux et al., 2014). Emotional regulation acts as a mediator between trauma and emotional distress, which can protect workers from exceeding emotional capabilities (Wagaman et al., 2015). Furthermore, Billieux et al. (2014) describes emotional regulation may also act as a moderator between stressful life events and resilience.

Emotional regulation is disrupted when individuals are exposed to trauma which threatens psychological capabilities and ability to regulate emotions. This can lead to dysfunctional regulation causing depressive moods (Billieux et al., 2014). When emotional resources are exceeded this disrupts emotional regulation and consequently may contribute to emotional disturbances and psychological distress. Research has found professionals working with traumatised individuals typically experience distressing emotions which is a common symptom of STS and is caused by dysfunctional regulation (Bride, et al., 2008; Bercier & Maynard, 2015; Cornille & Meyers, 1999; Billieux et al., 2014). Research by Menashe et al. (2014); Barford and Whelton (2010); and Osofsky et al. (2008), have revealed child welfare workers are prime candidates for development of

STS and emotional distress from being burdened with the responsibility of a child's physical and emotional well-being which may cause distress. Helping professionals in this environment are exposed to emotionally demanding situations which creates significant emotional distress, varying in frequency, severity, and quality (Brewin, 2003). The emotionally demanding situations and responsibility of a child's welfare may start to become overwhelming and exceed the child welfare worker's psychological capabilities which threatens emotional regulation. Studies in this area have found child welfare workers are increasingly experiencing emotional exhaustion, detachment, and depression, which may be caused by emotional regulation dysfunction (Barford & Whelton, 2010; Osofsky et al., 2008).

Moreover, research has also found emotional regulation contributes to depressive moods. Depressive mood has been cited in many studies (Billieux et al., 2014; David, Ceschi, Billieux, & Van der Linden, 2008) when measuring the emotional effects of exposure to trauma. Research suggests depressive moods occur from emotional depletion and is associated with the effects of STS (Osofsky et al., 2008). As trauma exposure changes how individuals behave and increases their ability to act impulsively, it is during this process emotional regulation strategies are disrupted which may cause depressive moods (Billieux et al., 2014). This demonstrates the importance of emotional regulation as it can protect individuals from experiencing negative emotional disturbances.

Cognitive schemas. Another concept which has been found to effect emotional functioning and may contribute to decreased emotional well-being is changes in cognitive schemas. As discussed previously, cognitive schemas are central to constructing the self as it defines and develops psychological needs including safety, trust, and dependency (Pryce et al., 2007). Cognitive schemas develop our views of the world as well as how we see ourselves in the world and determines how we react and cope to new stressors. Unfortunately, trauma can disrupt predetermined cognitive schemas which impacts 'self' and changes an individual's ability to cope with new stressors. As a result, this threatens psychological needs and creates a shift in our cognitions which can

change our beliefs (Pryce et al., 2007; Salston & Figley, 2003). This can negatively impact emotional well-being, as the ability to manage new stressors are exceeded.

Scaer (2001) stated trauma can impact one's physiology as well as how the brain functions. Therefore, when individuals are faced with chronic stress such as trauma, it can alter physiology and cause physical and mental health problems. An example of this is highlighted in Salston and Figley's (2003) study. The researchers have suggested changes in cognitive schemas caused from trauma exposure could lead to hypervigilance, anxiousness, low self-esteem, and depressive moods, which can overall effect emotional functioning (Salston & Figley, 2003). Similarly, Follette et al.'s (1994) study on mental health workers found all participants experienced high levels of personal stress as well as anxiety, depression, and dissociation, from exposure to traumatised individuals. This was demonstrated through negative coping strategies. The results suggest, individuals preconceived beliefs about the world were altered from exposure to traumatic incidents which caused a breakdown in their ability to cope with new stressors and resulted in severe personal stress. This highlights a clear relationship between cognitive schemas and the development of decreased emotional well-being, as cognitive disruptions create emotional disturbances associated with trauma exposure.

In summary, this section has demonstrated trauma exposure is correlated with emotional disturbances of anxiety, depression, sadness, low self-esteem, emotional numbing, detachment, and depersonalisation, which draws attention to the negative emotional consequences from exposure to trauma. Figley determined the forces of emotional energy and empathy contribute to negative health consequences leading to decreased emotional well-being, with further researchers identifying emotional regulation dysfunction and changes in cognitive schemas can also cause emotional disturbances. Further research is required to fully understand the essence of emotional implications associated with trauma exposure without the presence of STS, however it is clear individuals can suffer an emotional cost when working with victims of trauma and helping

professionals should be aware of ways to mitigate and reduce vulnerability.

Youth Workers

The last section of the literature review will discuss the relevance of conducting research on youth workers and why they were chosen as the population group for this study. The following sections will discuss PTSD in children as well as the effects on helping professionals when working with traumatised children. Due to minimal research focused specifically on youth workers, research on child welfare workers is discussed.

As previous sections of the literature review have outlined the adverse implications of working with the traumatised population, it is understood working in this environment generates significant problems for helping professionals as they are exposed to graphic descriptions of unpleasant events (Sprang, Craig & Clark, 2011). Child welfare workers (CWW) have been acknowledged as being increasingly vulnerable to the development of STS from exposure to traumatising incidents. CWW are tasked with hearing about violent events youths have had to live through, and consequently are forced to deal with the effects of trauma. Figley (1995a) has noted individuals who are exposed to traumatised children are particularly vulnerable to the effects of STS which is exacerbated by daily exposure to traumatised children. Not only are the workers vulnerable to STS, previous research has found helping professionals are at risk of experiencing emotional exhaustion, suppression, numbing, depletion, and psychological distress (Clemans, 2004; Nelson-Gardell & Harris, 2003; Bercier & Maynard, 2015; Osofsky et al., 2008; Pryce et al., 2007; Menashe et al., 2014). Given the vast amount of research on CWW around the world and the adverse effects of working with traumatised children it appeared this population group required more attention, particularly in New Zealand.

In New Zealand, child abuse and neglect continues to be problematic. Though it is vitally important to recognise the need for more help in this area, it is also equally as important to understand the effect trauma exposure has on helping professionals as previous research has shown helping professionals are increasingly vulnerable to STS. Research

on STS for CWW is expanding, and due to the lasting effects of repeated exposure to trauma, STS is becoming an occupational hazard for CWW and other professionals who work with trauma victims (Hatcher et al., 2011). As research in New Zealand exists for counsellors and social workers, it seemed there was a gap in literature on other population groups exposed to trauma such as youth workers. Youth workers play a vital role in facilitating behaviour, and are commonly exposed to trauma. Therefore, due to the lack of knowledge on this population group, youth workers were selected as the population group for the current study.

PTSD in children and young people. To be able to understand the impact of working with traumatised children and youth, it is vital to first discuss how PTSD effects children and young people.

The DSM V has outlined PTSD as being present in any person over 6 years of age (Kring et al., 2013). The symptoms experienced by adults are the same for children and adolescents, though how symptoms persist and present may vary from case to case. For example, in the criteria for intrusively re-experiencing the traumatic event, children may display this symptom through repetitive play, compared with adults who may have repetitive memories (APA, 5th ed, 2013). Under the same cluster of re-experiencing the traumatic event, children may have disturbing nightmares not related to the traumatic event compared with adults who would typically have nightmares directly related to trauma event (APA, 5th ed, 2013). The difference in how the symptoms present and persist demonstrate children, adolescents, and adults, can experience the same symptoms related to PTSD despite the symptoms presenting in differing ways. It is important to recognise children and adolescents can experience PTSD and endure long term adverse effects which can cause a multitude of problems through to adulthood.

PTSD in children and youth is a chronic problem diagnosed throughout the world. Research in the United States has revealed 15.5 million children are exposed to domestic violence per year, seven million are exposed to family related violence, and 10 million children under the age of 10 are hospitalised due to injuries (APA, 5th ed, 2013). The statistics demonstrate how widespread exposure to trauma is and

highlights the need to minimise harm. The high rate of PTSD statistics emphasises how vulnerable children and youth are when exposed to trauma and stresses the importance of mitigating the effects of PTSD. Furthermore, the statistics draw attention to the reality that thousands of children and youth are exposed to truly horrific events and environments and have become victimised and psychologically impaired by something out of their control.

Research has found PTSD is a serious problem amongst children and youth (APA, 5th ed, 2013). Increasingly they are becoming more vulnerable to experiencing PTSD as they are the subject of extreme maltreatment, victimisation, unintentional injury, as well as witnessing traumatic events (APA, 5th ed, 2013). The detrimental effects of being exposed to trauma at such a vulnerable age can cause significant psychological impairment. A study by Finkelhor, Ormrod and Turner (2009) investigated poly victimisation which is defined as experiencing more than one traumatic or victimising event. Participants in this study were youths aged 10-17 who were interviewed about their exposure to violence, crime, and abuse. Sixty percent of respondents had experienced at least one potentially traumatic event which accentuates how vulnerable children and youth are to traumatic events.

Koolick, Galano, Grogan-Kaylor, Clark, Montalvo-Liendo, and Graham-Bermann (2016) have suggested children and youth who have been exposed to or experienced trauma first-hand can have internalising and externalising problems. Internalising problems may include depression, anxiety, and somatic complaints, whilst externalising problems include greater levels of aggression and hostility towards others (Koolick et al., 2016). Koolick et al. (2016) suggests, children and youth can experience emotional and behavioural problems from enduring trauma which can have long lasting effects. The impact on helping professionals when working with traumatised children and youth is discussed in the following section.

Working with traumatised children and youth. Due to the implications of trauma and increasing statistics, children and youth are being referred to youth programmes, child and youth services, and foster

homes, to prevent further suffering and despair. To do this, helping professionals are employed to reduce and alleviate the stress and tension surrounding PTSD and manage behaviour. Though some may be referred to social workers, counsellors, or psychologists, others become involved in programmes aimed at helping vulnerable children and youth.

In New Zealand, youth programmes are aimed at helping vulnerable youth aged 10 – 17 with specific programmes focused on helping victims of abuse, rape, bullying, family violence, and youth offending. Individuals involved in these programmes may be referred via Child Youth and Family or via schools, family, friends, or communities. These individuals have been recognised as needing emotional support and help, which may not be available at home. Programmes are utilised to help vulnerable youth overcome challenges they have faced in their life, as well as provide positive outcomes, teach new skills, manage behaviour, and regulate emotions. This helps to give youth the opportunity for positive outcomes and prevent further harm.

Youth workers play an important role in providing youth with positive outcomes, as they help to facilitate behaviour and provide emotional support. Youth workers tend to take on the responsibility of the young person's well-being as they develop and maintain a close therapeutic relationship and become their role model. The close bond can become dangerous as workers may be exposed to distressing information and may be faced with the difficulty of managing youth who have experienced or witnessed trauma. From this, youth workers are at risk of becoming traumatised themselves as they help to manage the pain and torment youth may have experienced.

As described by Barford and Whelton (2010), the profession of a child and youth care worker is a difficult task which is emotionally exhausting. This is due to children and youth coming from families who lack positive support systems which can make youth resentful and afraid. Amongst this children and youth may have been exposed to traumatic situations or have experienced trauma first-hand and therefore may display behaviour which deviates from social norms. According to Barford and Whelton (2010), when a child has had a traumatic experience they

can have significant psychological, behavioural, and emotional problems, and youth workers may find themselves having to manage and regulate antisocial behaviour, as well as manage the effects of traumatised children (Molepo & Delpont, 2015).

Youths can present with behavioural, traumatising, or emotional disturbances, which could be caused by a history of abuse or neglect (Molepo & Delpont, 2015). Anglin (2004) noted the most common behaviours of children and youth who have witnessed trauma or experienced their own personal trauma, may require additional help and guidance with their behaviour and are likely to behave chaotically, have poor impulse control, and make physical threats. Vanderwoerd (1991) has indicated working with children who display emotional disturbances and who have a history of abuse and neglect creates difficulty for workers who try to manage and facilitate behaviour and often causes workers to feel distressed and burnout. Research by Cornille and Meyers (2002) describes working with youth who display challenging behaviour creates its own barriers and distress. In their study, which examined the experiences of youth workers, participants described verbal aggression as being the most challenging behaviour amongst youths which created difficulty when trying to facilitate and manage behaviours. The participants also revealed one in five youths would become physically aggressive which involved fighting, throwing objects, kicking, and being verbally aggressive. From working in an environment with youth who displayed emotional and behavioural disturbances, the results revealed 77% of participants experienced assault whilst on the job and from this, participants experienced at least one symptom of STS.

Previous research has also demonstrated helping professionals can be personally, interpersonally, and professionally impacted (Nelson-Gardell & Harris, 2003; Barford & Whelton, 2010; Dursun et al., 2014; Osofsky et al., 2008). Carers of trauma victims can experience a great sense of empathy from wanting to help the traumatised individual which causes emotional distress and psychological implications. As previous sections have outlined, feeling extreme empathy can lead to the helping professional becoming traumatised which can have severe psychological

consequences and lead to the deleterious effects of STS and decreased emotional well-being (Phelps et al., 2009).

Dane (2000) found professionals working with child abuse and neglect cases led workers to experiencing feelings of sadness, loneliness, alienation, and hopelessness, with some stating they felt a desire to withdraw and distance themselves from others. In Cornille and Meyers (1999) study on child protection workers the researchers state working with traumatised children and youth can generate numerous problems. Most of the participants in their study experienced high levels of distress as a result of working with traumatised children. Participants also experienced depression, hostility, paranoia, anxiety, and disruption, to interpersonal relations. Likewise, Nen, Astbury, Subhi, Alavi, Lukman, Sarnon, Fauziah, Hoesni and Mohamad (2011) describe individuals who work with child abuse cases are more likely to report emotional responses of anger, fear, guilt, grief, and sadness, as well as embarrassment, lack of confidence, feelings of discomfort, and empathy. Alternatively, Menashe et al. (2014) indicates individuals who are exposed to child neglect, abuse, and injury, suffer from emotional stress, with Pryce et al. (2007) stating they also lose a sense of innocence at the price of protecting children and youth from harm. Studies have further demonstrated helping professionals exposed to child abuse and neglect can alter their beliefs about the world and people which can change their relationships with others (Nen et al., 2011, Clemans 2004, Menashe et al., 2014; Pistorious et al., 2008). Moreover, individuals can experience a negative effect on basic sense of safety (Clemans 2004, Menashe et al., 2014; Pistorious et al., 2008).

To add further detail about the difficulty of working with traumatised children and youth, West (1997) has stated witnessing or hearing about traumatising incidents involving children leaves helping professionals with negative responses of anger, hatred, grief, sadness, and distress, paralleling the responses indicated in Nen et al.'s (2011) study. Interestingly, West (1997) explained, helping professionals endure negative emotional responses when exposed to traumatising information as this goes against their own preconceived beliefs about society. This

theory is similar to the constructivist self-development theory provided by McCann and Pearlman (1999) which calls attention to the impact trauma has on cognitive schemas. As outlined in the previous section trauma can change one's view of the world as well as their beliefs and values. Consequently, this could implicate one's ability to regulate emotions, and may lead to negative emotional responses.

Overall based on the research discussed in this section, it is clear working with traumatised children and youth could have adverse consequences which challenges emotional well-being and behaviour. Individuals who work closely with traumatised children and youth are at risk of developing negative health consequences and as research has suggested, this could affect individuals personally, interpersonally, and professionally. Therefore, it is crucial helping professionals, particularly youth workers, are aware of the possible risks of working with traumatised children and youth and are educated on how to minimise the effects of STS and decreased emotional well-being. Research which examines the effects of working with traumatised youth is crucial to understand whether youth workers are vulnerable to the risks of STS and if this is associated with decreased emotional well-being.

Conclusion of Literature Review

Research has shown that hearing about the traumatic incidents clients experience could have negative psychological implications on the lives of helping professionals. Being exposed to traumatising information could be emotionally exhausting causing a great deal of distress which increases vulnerability of developing STS and decreased emotional well-being. Subsequently, helping professionals are also at risk of developing compassionate fatigue, burnout, and vicarious trauma. It is clear STS is a prominent problem for helping professionals, which is further exacerbated via personal trauma and organisational stressors.

To further understand the impact of trauma work, additional qualitative research is required to explore the concept in other population groups who may be susceptible to STS given it is becoming a common occupational hazard. Subsequently, further research on the emotional impact of trauma work is required to understand how trauma exposure

implicates our emotional well-being and whether this can increase vulnerability of STS. By exploring the effects of youth workers working in a vulnerable environment, we can begin to establish whether this population group is at risk of decreased emotional well-being and STS as well as establish the causes and symptoms in this area. As limited research exists for this population group, it is unknown whether youth workers are at risk and if they are aware of the possible negative effects of trauma work. Therefore, by conducting research in this area it is hoped this study can add to knowledge about the risks of trauma work, and identify if youth workers are vulnerable to STS and decreased emotional well-being.

METHODS

This chapter will give an overview of the methodological approaches used to conduct this research and discuss the importance of incorporating a phenomenological approach. Following on from this, I will discuss the sample and procedures used for selecting participants and conducting interviews, as well as ethics and confidentiality. Lastly, I will discuss thematic analysis which was used to analyse the data.

This study incorporated a qualitative approach to explore emotional well-being and secondary traumatic stress among a sample of New Zealand youth workers. The design of the research incorporates a phenomenological approach using a mix of descriptive and interpretive inquiry. This allows the researcher to understand the lived experiences of participants as well as describe and interpret the conditions being studied and demonstrate how this affects participants overall well-being. The research employs no explicit theoretical orientation due to using a phenomenological approach where the essence of experience is built from the participants (Creswell, 2014).

Methodological Approaches

Several approaches were considered before phenomenology inquiry was selected. Creswell (2014) recommended five types of qualitative research methods which were most popular in social and health science research. The five types included: narrative, phenomenology, ethnography, case study, and grounded theory. Narrative and

phenomenology approaches both focus on studying the individual while case study and grounded theory focus on activities and events. Ethnography, which came from anthropology analyses cultures as well as social interactions and behaviours. Given this study was concerned with individuals and exploring their experiences it was clear the research was concerned with either a narrative or phenomenological approach. However, upon further consideration, it seemed the narrative approach did not fit with the research aims of the study. Narrative inquiry focuses on narrating lived experiences and analysing individual's stories to create descriptions and themes of events. In this way, it seemed the approach would not explore how individuals relate to experiences or gauge a deeper understanding of lived experiences. Given these circumstances, a narrative approach was dismissed. Therefore, as the current study was focused on exploring the lived experiences of individuals to understand what individuals experienced and how they experienced it, a phenomenological inquiry was selected.

Phenomenology

Phenomenological research is a design of inquiry formed through philosophy and psychology (Creswell, 2014). Phenomenology is used in psychology to describe how individuals act or react to a phenomenon. Phenomenology is a gateway to understanding how individuals interpret experiences and how they relate to them, as well as understanding what processes are used to manage and cope with a new situation. Phenomenology research seeks to describe how individuals see and interpret a phenomenon within their own subjective experience (Creswell, 2014; Gelling, 2015). It is in this way researchers can begin to understand the whole human being, rather than specific parts (Curtis, Ramsden & Friendship, 2007), by providing a clear and thorough picture to understand how individuals interpret lived experiences.

The way in which psychologists use phenomenology is by focusing on the inner dimensions of thoughts and feelings. Further inquiry into thoughts and feelings allows researchers to see how individuals are experiencing a phenomenon and the effects this may have. Therefore, the attraction of using a phenomenological approach is to further understand

the internal subjective structures of individuals, and delve deeper into how others interpret the meaning of lived experiences (Percy et al., 2015). It is in this way researchers learn how individuals react to new experiences such as trauma, and ways in which they interpret and cope with the situation.

Descriptive versus interpretive phenomenology. There are two types of phenomenology commonly used in human sciences research, descriptive and interpretive. Descriptive phenomenology aims to describe the experiences of participants without any preconceptions clouding the researcher's judgement which would affect the research (Gelling, 2015). This approach focuses on describing, analysing, and exploring a phenomenon, and ignoring all pre-conceptions surrounding the issue (Matua & Van Der Wal, 2015). By doing so the research attempts to divulge the real picture behind the experience and seek content in its pure form to gauge all elements (Matua & Van Der Wal, 2015). When using a descriptive approach researchers are able to learn about the first-hand experience of a particular phenomenon by seeing and feeling it. In this approach, social, cultural, and political contexts are not incorporated as this would follow an interpretive approach which investigates hidden meanings (Matua & Van Der Wal, 2015).

Contrasting to descriptive phenomenology, the interpretive approach provides a deeper understanding of a situation where researchers seek a more detailed interpretation of a phenomenon by focusing on meanings and structures (Matua & Van Der Wal, 2015). Interpretive phenomenology involves a hermeneutic approach where researchers seek to explain the meaning of speech and language. By doing so, researchers are analysing the implications of an experience and investigating the meaning of language and text used to describe the phenomenon (Matua & Van Der Wal, 2015). Compared with descriptive phenomenology, interpretive phenomenology does more than describe, it assesses how a phenomenon can alter a person's entire being and how they experience it within their own social-cultural contexts (Matua & Van Der Wal, 2015). This approach creates further insight of an experience compared with a descriptive approach.

After reviewing both types of phenomenology, in this study I decided to use a mixture of both approaches. Descriptive is used to understand the experiences youth workers have had. The data collected will be analysed and described to provide a detailed picture of the experiences youth workers have endured. As the interviews are semi-structured the participant is able to tell their own story without researcher bias therefore data is collected in its pure form. Interpretive phenomenology is used to analyse the impact of the experiences discussed in the interviews. Data will be analysed to understand the effects of experiences and determine if the participants are experiencing decreased emotional well-being and/or secondary traumatic stress.

Sample

The participants are a sample of 11 New Zealand youth workers who responded to a recruitment flyer displayed in their place of work and were chosen via nonprobability purposive sampling. Participants had all worked with youth in a close capacity and the majority of participants displayed moderate levels of decreased emotional well-being. The participants worked in community-based youth programmes, residential care, sexual abuse services, counselling services, and youth justice programmes.

Purposive sampling. In qualitative research, a common procedure used to select participants is purposive sampling (Devers & Frankel, 2000). This strategy is designed to select participants who would enhance the development of theories or concepts. Individuals are selected based on their ability to provide information most valuable for the research and provide the greatest insight to the research question (Devers & Frankel, 2000). The reason why this type of sampling was selected is due to lack of research on emotional well-being and trauma, particularly among populations groups which have yet to be studied and are possibly at risk. As most research for secondary traumatic stress focuses on social workers, psychologists, and counsellors, it appears there is no research which solely focused on youth workers who may also be vulnerable to STS. Furthermore, there is also a lack of research on the emotional impact of trauma work and whether this increases the vulnerability of STS. To

investigate these conditions among this population sample, it is crucial participants in the study were those who would likely be at risk of developing either of the conditions and therefore purposive sampling was used. By incorporating purpose sampling and selecting youth workers who were deemed as at risk, it allowed a thorough evaluation of the conditions being explored to assess the true impact youth work may have upon individuals. Additionally, this approach can also help to identify if youth work is associated with decreased emotional well-being and/or secondary traumatic stress. Based on this premises, the purpose sampling technique was selected to explore whether either of the conditions being studied were present. Organisations which provided youth programmes aimed at vulnerable youth were contacted.

Procedure

Ethics. The research was conducted according to the principles of The New Zealand Psychological Society and included consideration of cultural and ethical aspects of the study. The University of Waikato human ethics committee approval was obtained for this study (see Appendix A). Careful consideration was taken to ensure the information provided by participants was confidential and their identity remained anonymous. For example, raw data was kept on a password protected computer, as well as storing written notes in a locked draw. Participants were given pseudonyms to protect their identity and organisation names were not disclosed. For the interview procedure, participants selected a place to hold the interview which was either in a private room at their workplace or their home.

Cultural Considerations. Though the study did not target any specific ethnic groups cultural implications were considered. For example, by incorporating phenomenological inquiry this ensured individuals were not under-represented or disadvantaged as it allowed the participant to narrate their own story without interference from the researcher which in some cases can disadvantage ethnic groups. Additionally, participants who were Maori were asked if their organisation provided a Maori cultural advisor, and if so, they were given the opportunity to discuss the study with the advisor before proceeding with the interview.

Confidentiality. Information regarding the participant's name were only disclosed to the researcher and no other parties were involved. Organisations were not given information which would reveal the participant's identity. Equally, organisation names have also been kept confidential and have not been revealed in the study.

Informed consent. Consent forms (see Appendix E) were used and given to the participant before the interview began. The consent form outlined 11 questions the participant had to agree to before the interview could begin. The form also outlined the participant's right to withdraw from the study and seeking permission to record the interview. Participants were also informed of their right to refuse to answer any of the questions before and throughout the interview. The participants demonstrated consent by signing the document and agreeing to all 11 questions.

Recruitment procedure. Organisations who provided youth programmes to vulnerable young people were contacted via email, asking if they would be interested in being a part of a research study exploring the topics of emotional well-being and secondary trauma (see Appendix B). Organisations contacted were those who provided programmes for vulnerable children or youth which were aimed at helping victims of rape, youth offending, suicide prevention, and children of prisoners. The agencies were contacted due to the likelihood of secondary traumatic stress being present as an occupational hazard, and the impact youth work could have on emotional well-being.

Once the organisation confirmed their interest, emails were sent to the organisation asking them to display a recruitment flyer in their staff rooms and mention it in staff meetings to attract potential participants. The flyer outlined information about the research, highlighted the goals of the research, and why participants may be interested in taking part (see Appendix C). Contact details for the researcher were located at the bottom of the flyer containing a phone number and email address where employees were invited to contact the researcher if they were interested in being part of the study. When a participant contacted the researcher, they were emailed an information sheet outlining further details of the research, before committing to being a participant (see Appendix D). Participants

were invited to raise any questions/queries or concerns about the research after reading the information sheet and all concerns would be addressed. If the participant was satisfied with all the information and had no further concerns, the researcher and participant discussed an appropriate time and place to meet for a one-hour interview.

Interview procedure. Once the informed consent process was completed, the goals of the study were outlined to the participant, as well as their right to withdraw from the study up to three weeks after the interview takes place.

To perform the interview, a semi-structured interview process was utilised which included a series of five sections (see Appendix F). Each section covered elements of emotional well-being and secondary traumatic stress. By incorporating a semi-structured technique, the questions asked in the interview were broad which allowed the participant to answer the questions at their own discretion, providing a more conversational approach. Prompts were available for each section and were used when required to gain further insight. The topics discussed throughout the interview comprised the following five sections;

Section A: Extent of participant work and difficult youth.

Section B: Work related experiences/lingering effects

Section C: Symptoms of emotional well-Being, symptoms of secondary trauma, timeline of symptoms, intrusive thinking

Section D: Disruption to home life

Section E: Coping strategies/protective factors

Data Analysis

A thematic analysis approach was used to analyse the data collected from the interviews. Braun and Clarke (2006) describe thematic analysis as a method for “identifying, analysing, and reporting patterns” (p. 6). Interpretive phenomenological analysis was selected as the theoretical framework underpinning thematic analysis given its relation to phenomenological epistemology. This is used to understand the reality of individuals everyday experiences to further understand the phenomenon being researched which reports experiences, meanings, and reality of participants (Braun & Clarke, 2006). The scope of this research is to

understand youth work from the participant's standpoint and therefore the study will reflect the lived experiences of participants without interference. This will give a true account of the experiences participants are living through and provide a detailed picture of the effects of trauma work. By utilising this approach, I was able to draw patterns and trends derived from the participants detailed accounts which were then devised into common themes. This was achieved by writing out each interview and highlighting similar response patterns. The responses were then divided into common themes related to symptoms of decreased emotional well-being and STS and items which increased vulnerability.

FINDINGS

The purpose of this study was to establish whether youth work is associated with decreased emotional well-being and secondary traumatic stress. The study had three aims: (1) identify how youth work is associated with decreased emotional well-being and STS; (2) identify symptoms which contributed to the development of decreased emotional well-being and STS; and (3) explore how decreased emotional well-being is associated with the development of secondary traumatic stress. The results revealed youth workers displayed elements of decreased emotional well-being which increased vulnerability to developing STS.

The following sections are divided into themes which were derived from the participants' answers to semi-structured questions. Sections include: effects of working with traumatised youth; personal impact of youth work; emotional well-being; symptoms of emotional well-being; secondary traumatic stress; implications increasing vulnerability of decreased emotional well-being and STS; and protective factors.

To provide a general overview, themes which were identified throughout the interviews and acknowledged as symptoms of decreased emotional well-being included; anger and sadness, helplessness and resources to cope, burnout, emotional exhaustion, distress, depletion and emotional regulation, emotional detachment, and emotional suppression.

Themes which were identified as symptoms of STS included changes in appetite, social withdrawal, decreased sense of energy, and

distressing emotions, as well as physiological arousal including difficulty sleeping, anxiety, and irritability. Importantly, participants explained they experienced these symptoms a result of organisational stressors such as increased workloads, lack of professional support, and resources to meet demands.

Themes which appeared to increase vulnerability of decreased emotional well-being and STS included; PTSD, countertransference and empathic engagement, organisational stressors, boundaries and barriers, personal responsibility, and questioning yourself and your ability. Lastly, items which were revealed as protecting youth workers from the effects of decreased emotional well-being and STS included supervision and coping strategies.

The Effects of Working with Traumatized Youth

Participants were asked to describe changes in themselves during their time as a youth worker to understand the effect of working with traumatized youth. Common themes included: changes in world view, viewing people differently, and desensitisation. It appeared that being exposed to the harsh realities of a young person's world changed participants preconceived perceptions, beliefs, and values, and to some degree resulted in desensitisation.

Changes in worldview. Two participants described experiencing changes in their world view with one participant stating "The world sucks". The participant explained from hearing about incidents youth experienced, they began to see the world as an unfair place and viewed it in a different way. Adding to this, another participant stated their view of the world had changed and mentioned the world is unfair. The participant explained they had lost faith in humanity and have become disheartened. When asked if their view of the world had changed the participant explained "*Yeah I think it has, it really has*", "*I'm like wow the world is not set up the way that I want it to be I just want to go live on a commune somewhere where everyone's happy*".

Viewing people differently. Alongside changes in world view, three participants described how their view of people had changed during their time as a youth worker which involved increased judgement of

others. For example, one participant explained *“if I’m hanging around little kids I’m really wary of the men around them, it’s really interesting. I sort of am more aware of people interacting with people a lot more”*. Similarly, another participant stated *“I always feel really suspicious of adults but like I don’t want to be like that”*. The participant appeared to be less trusting of others and had increased caution which seems to be an effect of working with traumatised youth who have been abused. Lastly, another participant explained *“I find myself tending to judge people, just look and try to judge a person’s character”*. The participant appeared to experience similar situations to the other two participants and explained how their view of individuals had changed which has made them more vigilant and less trusting.

Desensitisation. Three participants described becoming desensitised from working with traumatised youth which appeared to be a result of repeated exposure to traumatic information. For example, one participant explained *“I get a lot less shocked by things. I think I probably am still a bit desensitised to some things and I sometimes have to make a conscious effort to connect with people’s pain and brokenness”*.

A participant who worked in a mental health setting described this type of work as being confronting which could have caused desensitisation. The participant explained *“in mental health you’re obviously dealing with people who are suicidal and risky so you’ve got persistent self-harmers that you work with, you’ve got kids who regularly say they want to die and they’ve got plans to die, they’ve stock-piled medicine planning to die so you’re often having conversations with the families saying ‘hey you need to look around your house to make sure there’s no ropes they can hang themselves with’, that there’s no drugs they can over dose on. So you’re constantly in a way bringing the thought of a horrific sort of possibility to the families and that in itself can be quite shocking and I guess in some ways you can become a little bit desensitised to that”*.

Adding to this, another participant explained they have become desensitised to risky situations which has given them the confidence to intervene. The participant explained *“There’s not much that worries me*

anymore I feel confident whether it's a time of crisis or something highly unexpected happens. Sometimes that worries me, are there more things I should be worried about? And that kind of thing so there's definitely some desensitisation there that has happened over the years to a lot of things but I think that has made me more open to stepping into situations that others might not want to".

Personal Impact of Youth Work

Research participants were asked to describe or identify incidents which have impacted or played on their mind during their time as a youth worker. Several participants explained being affected by the majority of youths' experiences which have affected them on a personal level. Cases which caused significant impact included incidents of self-harm, suicide, and abuse. Participants explained these cases were more difficult to manage as it involved being exposed to distressing circumstances. The findings revealed seven participants were emotionally affected by at least one case during their time as a youth worker.

Participant two described being affected by numerous cases throughout their duration as a youth worker. They stated *"Yeah there's been heaps"*. Incidents which appeared to emotionally affect the participant included family issues, pregnancy, and suicide. Though the participant did not elaborate on what family issues were, statistics suggest family issues include: suicide, physical and sexual abuse, and domestic violence. The participant explained, *"I think a big one would be family issues. One would have been an unwanted pregnancy. I've had quite a few suicide ones as well abuse and stuff"*. Similar to this, participant five stated a number of cases have affected them *"I think the majority of them in all honesty, a lot of them have been sexually abused, physically assaulted things like that"*. Another participant stated *"Thinking back there's a few cases that I know had an effect on me and kind of had kept me awake at night and affected well-being in that way"*.

Incidents of self-harm appeared to affect the majority of the participants emotionally which has had a lasting impact. One participant explained *"Yeah there was probably a bunch of times that I can think of, working with kids who were at the extreme ends of difficulties and had*

usually multiple episodes of trauma themselves probably the times when it was most difficult was seeing incidents of self-harm and suicidal ideation". The participant went on to explain *"For one specific incident it was a young lady who had done some fairly significant self-harm and even to this day I can remember the scene the sounds and the emotion of that time", "I spent a good chunk of the night ruminating on what had happened and trying to process that myself".* The participant explained how those types of incidents had an effect on their emotional well-being which created several emotional disturbances.

Contrasting to this, another participant explained the difficulty of working in a youth residence which required behavioural management. The participant explained how working in this environment effected their well-being. The participant explained *"Yeah the first year I worked at that residence most nights I was dreaming about being there and the kids and stuff so that was real full on", "Sometimes I did feel pretty upset hearing the kid's stories, I think you become pretty desensitised pretty quickly or else you just don't survive", "I think when I got home I didn't feel emotionally or anything just lots of adrenaline and I don't think I was very good at processing".* Similar to this, another participant described the difficulty of working with youth who displayed threatening behaviour and how this had an effect. The participant explained *"I've been transporting kids and they've decided to beat me up in the car or try hurt me in the car. Pulling off head rests to hit me with so it's a risk you're thinking next time you get in the car are they going to do the same thing should I take someone with me. I think in the way you operate, after you've had a couple of different moments like that you're more cautious and you're less comfortable in those environments. Those are the effects I've had"*

Contrasting to the negative effects of working with traumatised youth, some participants explained how rewarding the job can be which is what keeps them from leaving. For example, one participant described *"You know the work that you do is purposeful but that's the kind of attitude you have to have when working with people because if you took it lightly then I guess you wouldn't get significance of it".* A further participant referred back to their answers, and discussed their personal trauma *"For*

me personally, despite all I did mention about the frustration, guilt, and anger at not having resources more readily available, these experiences are what drive me to continue the work we do. If one child is saved from a life of horror and abuse, then it is a job well done. This is why I carry on doing what I'm doing, because I can see a small part of myself in each of these young people and don't want them or their children to endure what I went through as a young child and into young adult years."

Emotional Well-Being

From the experiences research participants discussed in the previous section, they were then asked to describe how the experiences had effected their life. Majority of the participants explained how difficult it was to hear distressing information which caused significant impact to their emotional well-being. For example, participant 11 explained *"Because of the heart breaking stories of trauma and abuse it's a lot to process and to be able to put that to one side you can't always do that"*. The participant went onto explain *"Youth work never stops so you're consistently thinking about work which can be distressing"*. Another participant explained the difficulty of hearing distressing information which affected them internally. The participant explained *"There have definitely been cases which have affected me internally and played on my mind"*, *"There have been times where I couldn't handle information I have heard"*. The participant went onto explain how difficult it was when they did not know how to help youth and explained how they would experience feelings of panic, urgency, and fear during these times. Several other participants mentioned how they were now *"easily saddened by things"*, with another exclaiming *"I can be quite hard on myself at times"*.

Furthermore, participants explained how these experiences have affected their behaviour. For example, one participant stated they feel more tired and defensive which appeared to contribute to emotional exhaustion and decreased energy. The participant explained the difficulty of working in a youth residential home which at times required intense behavioural management; *"I think I probably felt really tired and drained quite often because of the lack of sleep and shift work. I would say the first*

year I was pretty effected in all aspects of life, social life, kind of just felt emotionally and physically exhausted most of the time”.

Another participant experienced a breakdown during their time as a youth worker. The participant explained they would suppress their emotional reactions when hearing about distressing incidents. The participant stated they did this deliberately as a way to continue working with youth and provide them with emotional support. Consequently, as the participant suppressed their emotions they were decreasing their emotional capability which appeared to cause a breakdown. The participant explained *“definitely at the beginning of this year I had break down, and I stepped back and reduced my hours and it was then that I had the breakdown because I wasn’t keeping busy. It was actually really really scary. And I’ve been through the anxiety, the depression in my younger years and that as well and I was like this sucks I don’t want to be in this hole again”.* Adding to this, it appeared the participant may have had difficulty regulating their emotions and as they suggested, they suppressed their emotions which may have contributed to emotional exhaustion and burnout. Comparing with this, another participant explained how they have experienced feelings of distress from hearing about traumatic incidents which caused the participant to experience symptoms of anxiety. The participant explained *“I’ve been irritable at times, there’s been times where I’ve been under a lot of stress with lots of risky cases at once or a high caseload”, “I think there’s a degree of anxiety attached to it especially when you’re working with risky kids you definitely find yourself wondering if they will be alive the next day or the next week”.*

From the participants’ responses, it is clear they were emotionally affected from learning about the traumatic ordeals youth have experienced. This appears to have increased their vulnerability of experiencing decreased emotional well-being and STS. Themes derived from these answers are discussed in the following section which will outline symptoms associated with decreased emotional well-being.

Symptoms of Decreased Emotional Well-Being

As discussed in the previous section, participants were emotionally affected from hearing about youths’ experiences. The findings suggested

82% (n=9) of participants experienced moderate levels of decreased emotional well-being. Symptoms which appeared to be most common included: anger and sadness; helplessness; burnout; emotional exhaustion, distress and depletion; dysfunctional emotional regulation; detachment, and suppression.

Anger and sadness. Four participants identified experiencing symptoms of anger and sadness from being exposed to traumatised youth. When asked to identify incidents which may have affected the participant emotionally, participant five stated *"it's really hard seeing the kids go through what they go through and the family not really backing them, or I don't know maybe it's not the families backing them but more it's the families that don't have the right tools to back their kids and to raise them to be decent members of society because it's that whole cycle"*. The participant explained this made them feel angry towards the youth's family. Adding to this the participant explained *"I'm a lot grumpier. I feel sometimes I'm so angry at even society. I think that's probably the worst thing is the anger, and that comes back to seeing those gaps in the system as well and just feeling hopeless or just that you can't do enough"*. From this response, it appeared not only was the participant angry, they also felt a sense of helplessness and sadness. The same result was identified in participant three. When asked to describe their emotions from hearing about traumatic incidents they stated *"Probably everything to be honest, I can be quite hard on myself at times if I can't do something and I have to remind myself that we have done what we can do and that is enough for the clients you are working with they recognise that, you can only do your best. But sometimes you know you can't change the world so you do get left with some anger with people and sadness that they haven't got anything"*.

Participant three identified the difficulty of hearing about traumatic incidents which caused reactions of sadness and anger. The participant stated *"it was hard to hear it. Especially because when you come from a really good home you're surrounded by love and stuff and just hearing how they are it hurts so much you just want to like grab them make sure nothing happens to them. Its either you get really sad or really angry"*

because your like why is this happening to you kind of thing. It just plays with you a lot”.

Contrasting with these responses participant 11 identified feelings of resentment when having to witness incidents of self-harm and suicide. The participant explained *“what does come into it is actually the I wouldn’t quite call it blame but at sometimes it’s almost a feeling of resentment of having to be put in that place yourself you know. I think it becomes blurry when you’re in that emotional state you think why have I as a youth worker been put in this position? I know I want to care but this is a lot more”.*

From the respondents answers it appeared anger and sadness was triggered from hearing about traumatic events. Individuals became angry with families or individuals who inflicted harm upon youth, as well as gaps in the system which did not prevent harm from occurring. Sadness was correlated with participants feeling extreme empathy for youth who endured trauma and feeling as though they could not do enough to help. As a result, this appeared to decrease emotional well-being as participants were emotionally impacted.

Helplessness, questioning your ability and resources to cope.

A further element which contributed to decreased emotional well-being was helplessness. The findings revealed seven participants appeared to feel helpless in their ability to provide youth with enough resources to prevent harm. This also caused some participants to question their ability.

For example, one participant described the difficulty of not being able to keep youth safe which contributed to feelings of helplessness. The participant explained *“because we work with young people sometimes we can’t make them safe and I think that’s a really hard thing to sit with. So we can only do what we can do”.* The participant further explained *“The things that really upset me is when the young person doesn’t have anything, so they don’t have anybody at home that is ok with them, they’re unhappy in every way and that’s one of those things that you can’t do anything about, so usually they’re the ones I have the hardest time with, you know because it feels like there’s nothing I can do”.* Another participant also mentioned the difficulty of not being able to help youth which caused them to question their ability. The participant stated *“I just*

found out one of my kid's lives in a 3-bedroom house with 16 other people, I want to help with but what I can do with that? I feel disheartened a lot of times with things I can't help out with you know you just want to change a lot of things instantly. Makes you question is what I'm doing is it enough". As the participant could not help the youth with their housing situation, the participant felt guilty and helpless, which made them question their ability. Similar to this, another respondent questioned their ability when discussing incidents of suicide and self-harm. The participant stated *"why has the situation come to this and what could have been done earlier or differently"*. Additionally, participant five identified *"feeling hopeless or just that you can't do enough"* to help youth because of gaps in the system which prevented them from taking further action. Comparing with this, participant 10 also mentioned feeling helpless when youth revealed certain information *"I have had some clients share some stuff and it brings out those feelings within yourself, helplessness"*.

Lack of resources was also identified as an element which contributed to feelings of helplessness. For example, one participant explained *"I don't feel like I have any power at all but to some extent with the young people that I do see I feel I can kind of help sometimes but I'm not resourced at all"*.

Additionally, one participant explained how they have taken youth home due to lack of resources as they felt there was nothing else they could do to keep the young person safe. The participant explained *"Yeah definitely, and I have felt guilty which is why I take them home so I can have a better eye on them"*. The participant went on to further explain how this transcends into their personal life where they feel guilty about being away from youth *"And definitely times being away I felt guilty because I'm not there to help them or there was nothing I could do if they really wanted me to help them"*. It appeared the participant felt a certain degree of personal responsibility which caused them to take youth home.

From the respondents answers it has highlighted how youth workers can experience a great deal of personal responsibility for the safety of youth which can lead to feelings of helplessness and guilt. This

could contribute to elements of emotional exhaustion, distress, and burnout, which could negatively impact the participant.

Burnout. A second symptom which correlated with decreased emotional well-being was burnout. As described by Figley (2002) burnout is “a state of physical, emotional, and mental exhaustion”. In the study, six participants displayed elements of burnout which appeared to implicate emotional well-being. Items which were associated with causing burnout included shift work, being on call, and the emotional demands of the job. As a result, participants felt overworked and emotionally drained which may have contributed to exhaustion.

The following response explains how youth workers became burnt-out. The participant explained “*there certainly came a point where I knew that I couldn’t do the frontline stuff anymore. It does depend on the physical context and what supports are in place but in any youth work setting it can reach a point where it becomes too much and having more to give*”. When asked if this was related to emotional depletion or burnout, the participant responded “*For sure yeah. I always look at the analogy of how full your tank is with things like that and if you have enough times where that tank is empty and you have no more to give I think there’s a lasting impact. I definitely say that there were elements of burnout*”.

Another participant explained “*My boss had to pull me aside and said ‘ok you need to take a break’ or something like, I was fine I felt fine but I was just always worried. I had to take leave and get away for a bit just to come back to myself and come back and be able to help more because it wasn’t healthy. I was definitely burnt-out.*” The participant explained they became burnt-out from being emotionally drained “*it kind of at times drains you a lot especially if you’re working or focusing so much on one kid it drains you so much*”.

Another element which increased burnout was work schedules. For example, one participant identified working 30 days without a day off which could have increased their vulnerability of developing burnout. The participant stated “*last term I think I worked a month straight every day was just constantly doing something with the students. I was tired and a bit over it all*”. The participant further mentioned “*we went to Bali in June and I*

think that was amazing for us because we were quite burnt-out”.

Furthermore, the participant revealed the youth have constant access to youth workers which meant it was difficult to have time to themselves and take proper breaks. Additionally, the participant was also involved in youth camps which were run continuously over the school holiday periods. This appeared to enhance burnout and caused the participant to feel tired as they did not get a break. The participant appeared to experience a decrease in energy due to these circumstances. Another participant from the same organisation mentioned *“We get tired a lot”* from working consistently, with another stating *“You can become quite worn-out because your mind is trying to focus on too many clients”*.

Two other participants had similar responses related to working conditions which contributed to feeling worn-out. Participant eight stated *“I feel like I need to escape just for two months get away and have a break from this industry”*. Participant six explained *“I wouldn’t go as far as to say I was burnt-out, but definitely tiring, I thought I will totally burnout if I stay here for too long”*. Interestingly, the participant mentioned how their organisation had a high turnover due to the demands of working with traumatised youth which required intense behavioural management. The participant stated *“I don’t think 90% of people would last there”*.

The findings also suggested participants experienced elements of burnout during their first few years as a youth worker which could be related to in-experience.

Emotional exhaustion and dysfunctional emotional regulation.

The findings revealed six participants were experiencing elements of emotional exhaustion, distress, and depletion, which hindered emotional well-being. The symptoms appeared to be caused by dysfunctional emotional regulation

Participant 11 used the metaphor “empty tank” to explain the emotional cost of working with youth which caused emotional exhaustion, depletion, and burnout. As mentioned in the previous section, the participant stated *“I always look at the analogy of how full your tank”*, and that by providing emotional support to youth and managing incidents of self-harm, abuse, and suicide, there is a lasting impact. The participant

explained they would like to implement a way to “*prevent getting to that lowest stage of output because it’s exhausting*”. The participant also mentioned working with traumatised youth is distressing and contributes to a lasting impact.

Another participant shared similar symptoms related to distress and exhaustion. They explained “*hearing all those stories and writing about them and processing it and keeping track of everything it is stressful, it’s like exhausted me and stopped me doing the things I love*”. The participant stated exhaustion as being a key reason why they did not socialise or participate in activities they would normally enjoy. Furthermore, the participant stated having a high workload contributed to exhaustion and depletion. The participant stated “*I’m really like oh my gosh I haven’t done any of this for weeks (activities they enjoy) because I’m so exhausted. Even this morning I didn’t want to come, it makes me be like I don’t want to be here sort of thing because of the workload it feels like there’s no way I can achieve it*”.

Another participant identified feeling exhausted from working with youth which was emotionally demanding for them. The participant also stated shift work effected their social life. The participant explained “*I think probably felt really tired and drained quite often because of the lack of sleep and shift work. I would say the first year I was pretty effected in all aspects of life, social life, kind of just felt emotionally and physically exhausted most of the time*”. Similar to this, participant two also experienced emotional exhaustion from not being able to discuss or debrief their experiences with anyone such as a supervisor. They explain “*I was definitely emotionally exhausted, it’s like a lot especially if like the things they tell you and although it’s like confidential it burns you so much that you can’t tell anyone else*”. It appeared the participant had difficulty processing their emotional reactions to traumatic information which may have been caused by not having a supervisor or support system in their work place. This may have contributed to emotional exhaustion.

In regards to emotional regulation, two participants identified having an inability to regulate their emotions which contributed to distress and outbursts of emotion. Participant 10 mentioned their three-month review

as being a major contributor to their current emotional state which overall impacted their work efficacy. The participant stated *“So that’s been a time where I have been really low really unable to cope and I spend a lot of time crying and I cried at work and that kind of thing and it’s been really confronting”*. When asked if the participant felt emotionally depleted, the participant responded *“Ability to cope with emotions depleted. So the emotions were too high. So rather not feeling in touch, because I was unable to control my emotions because I wasn’t working through them. My own emotions were being experienced on a really high scale where there was a cat on TV and I cried my eyes out because there was a kitten so you know you sort of over react”*. Though it is unclear, the participant’s emotional reactions may have been heightened as a result of working with traumatised youth which caused distress. Alternatively, the participant appeared to have difficulty regulating their emotions which may have led to emotional disturbances. Emotional regulation may be implicated as individuals cannot process or do not have the capability to manage emotionally charged situations which can lead to implications.

Emotional detachment. Another element which contributed to decreased emotional well-being was emotional detachment. Findings suggest four participants identified themselves as feeling emotionally detached at one point during their time as a youth worker which occurred as a result of the emotional demands of the job. Participant eight explained *“I feel emotionally detached sometimes it all gets so much like with the stress and everything gets to a certain level I’ll just cut out because of the work and the young people”*. Contrasting to this, participant three identified they became emotionally withdrawn as a way to protect themselves from experiencing emotional reactions *“The emotional outcome can be a hardening or an emotionally withdraw from things and then makes it harder to engage, its self-protection you don’t want to get to close just in case”*. The participant further stated *“I’ve had to fight against that withdraw because I see how it affects people over a long period of time”*. Furthermore, participant six explained at times they would emotionally detach after shifts which required intense behavioural management. The participant explained that at the end of shifts which

were emotionally draining and intense, the participant would emotionally detach.

Emotion suppression. The last element correlated with decreased emotional well-being was emotion suppression. Contrasting to emotional detachment which involves individuals detaching and numbing themselves from feeling emotions, emotion suppression occurs when individuals try to ignore and mask their feelings. This is achieved through consciously avoiding negative feelings which some individuals employ as a coping strategy. Consequently, when individuals suppress their emotions they can experience dysfunctional emotional regulation which can increase their vulnerability of psychological implications. In the study, the results found three participants were experiencing symptoms of emotion suppression during their time as a youth worker. This was associated with the participants' suppressing their own emotional reactions to ensure they could provide youth with emotional support.

For example, one respondent explained how they experienced a breakdown during their time as a youth worker. When asked if the breakdown was correlated with suppressing or detaching from their emotions the participant responded "*Definitely, it was classic for me it's what I do I throw myself into a job or project or something like that to distract from all of the other stuff that's going on. I could deal with your mental breakdown and push my own to the back*". From this response it appeared the participant was willing to suppress from their own emotions and anxiety, to emotionally support youth. The participant explained they did this because "*there is always someone in a worse off situation than myself and therefore who am I to complain*".

Another participant also explained suppressing their emotions because youth were their first priority. The participant stated "*Anytime where something was happening with me I would just push it aside like they have bigger problems than whatever is going on with me. They were always my first priority*". The same participant also experienced a breakdown which they described as a result of feeling burnt-out.

Contrasting with this, another participant explained suppressing their emotions because that was the expectation of the job. The participant

explained *“its condition to just move forward and keep going kind of thing, that’s how I deal with a lot of these things. I just have that carry-on attitude, that’s the expectation, to carry on, back to work”*. It appeared the participant did not allow themselves to experience emotional reactions as this was how they dealt with the emotional demands of the job.

Overall, the results in this section found numerous symptoms which related to decreased emotional well-being for youth workers and was displayed by majority of participants. It is clear, working with traumatised youth can cause an abundance of emotional disturbances which is intensified by lack of self-care. Participants revealed working with traumatised youth has personally affected them in various ways which highlights the need for prevention. Following on from the emotional effects of working with traumatised youth, the next section will outline symptoms correlated with STS.

Secondary Traumatic Stress

The findings of the study revealed eight participants displayed symptoms which were associated with the effects of secondary traumatic stress. However, as this study does not intend to diagnose participants with STS, the following report of results will only identify symptoms which appear to be correlated with the vulnerability of developing STS

When participants were asked to identify changes within themselves from working with traumatised youth, majority of participants identified symptoms of: difficulty sleeping; decreased sense of energy; changes in appetite; social withdrawal; and avoidance.

Secondary Trauma Symptoms. Six participants identified having difficulty sleeping after exposure to traumatised youth. When participants were asked if they had trouble sleeping, one participant stated *“Yes. When there’s a lot going on I find it really hard to settle my mind down”*. The participant identified how they always felt very tired which could contribute to decreased energy. The participant explained *“I could sleep more because I feel really tired all the time and I could sleep for 12 hours because I’m so tired”*. Contrasting with this, another participant identified having difficulty sleeping due to an increased workload. The participant stated *“Last night I woke up pressured by all the paper work I needed to get done today so I*

did that for two hours then went back to sleep, so I think yeah sleep wise".

The participant also revealed having difficulty sleeping after a distressing day with youth *"When I am sleeping I can't go to sleep because I am constantly thinking so I have to put like a movie on or something or music or whatever"*. Similar to this, another participant revealed losing sleep over thinking about distressing situations which played in their mind. They explained *"I lost a lot of sleep from it from those situations that happened. Especially just finding ways for them to deal with it especially about taking their own lives or going off at someone else. Just completely going off the rail and no one knowing where they are. I definitely lost a lot of sleep from that"*. The participant also identified having to take a break from work *"it was emotionally draining me and I couldn't focus on anything else so that's why I had to take leave as well because it wasn't helping me at all and especially from losing sleep from it I just couldn't deal anymore"*. Additionally, another participant explained how they would take sleeping pills as a way to stop thinking about work and youth. They explained *"There was a time where I used to take sleeping pills to get to sleep properly and have a decent night sleep and I wouldn't take them regularly but I took them to just knock myself on the head"*. The participant further explained *"Definitely sleepless nights from thinking through what's going to happen to that young person are they going to be with me the next day is there anything I could have said which would have made it better"*. Another participant also experienced similar sleep patterns stating *"what's sleep? (Laughs). What's sleep to start off with. Sleep is the biggest one, I try to go to bed and I will just have this kid in my face and it's like ok what can I do to get you out of this situation"*. The participant explained they would spend most of the night thinking about youth and how to help them. Lastly, one participant identified having difficulty sleeping when working with youth in residential care as they would dream about being at work. They explained *"The year I worked at that residence most nights I was dreaming about being there and the kids and stuff so that was real full on. So definitely that first year was pretty hellish to be honest. The responses from the participants suggests they were experiencing sleepless nights because of the emotional distress from being exposed to traumatised youth and thinking of ways to reduce harm. The*

responses also highlight the personal responsibility participants were feeling, demonstrating how highly stressful it is to be a youth worker and how this can lead to STS and decreased emotional well-being.

Aside from sleep, four participants identified having an increased appetite since starting as a youth worker. Participant eight explained their appetite had increased due to stress. They explain "*the main thing is appetite I'm just such a stress eater so is everyone in the office and there's this whole culture of like this is so stressful I'm just going to eat so that's something I'm really not happy about*".

Social withdrawal was also mentioned by one participant who identified withdrawing from activities as they experienced emotional and energy drain. The participant explained "*I have been long involved with church groups as well and I definitely felt myself withdrawing from a lot of the things I would be doing there and not having more to give. It would be that emotional drain and energy drain from the work, there was not much more to give in the places that I wanted to so that was difficult to accept*".

Contrasting with social withdrawal, one participant identified experiencing elements of avoidance from learning about a bullying incident. The participant stated they avoided situations which reminded them of the incident and avoided talking about it. The participant explained "*I couldn't deal with that at all it really affected me. Every time I had ever heard of bullying this girl came back into my mind*". The participant explained they went on to feel this way for numerous years, but fortunately they were able to overcome the ordeal.

From the findings it suggests some participants experienced symptoms of secondary traumatic stress from being exposed to traumatised youth which caused distress. This appeared to affect sleep, appetite, sense of energy, and socialising. Therefore, it could be suggested youth work is correlated with elements of secondary traumatic stress. The following section will discuss risk factors which increased vulnerability of decreased emotional well-being and secondary traumatic stress.

Risk Factors Increasing Vulnerability to STS and Decreased Emotional Well-Being

Along with the symptoms which were associated with decreased emotional well-being and secondary trauma, there were a significant amount of risk factors which appeared to increase vulnerability of developing these conditions. These factors included: personal trauma; PTSD; countertransference; empathic engagement; organisational stressors; barriers and boundaries; personal responsibility; questioning yourself and your ability.

Personal trauma. Personal trauma has been recognised in research as a risk factor which increases vulnerability of STS (Cornille & Meyers, 1999). The findings revealed two participants had a history of personal trauma. One participant stated they needed to be aware of their own triggers when working with traumatised youth which could cause a breakdown. The participant explained *“A lot of them have been sexually abused, physically assaulted things like that. I went through all that as a kid myself so I guess in a lot of ways I have to be really careful that it doesn’t set off triggers within myself and I have to be really aware of that as well, occasionally I’ll completely break”*. Furthermore, a second participant mentioned how pregnancy affects them as it related to a similar experience they had. The participant stated *“I think the pregnancy one it hit home quite big um because at the time, I went through that so when it happened here that was the first time I had to deal with that”*. Contrasting with this, other participants mentioned being part of the youth programme they are now employed in, highlighting the participants have been through similar experiences as youth which may also increase vulnerability.

Post-traumatic stress disorder. When participants were asked to identify incidents which impacted them, three participants revealed witnessing incidents of suicide, self-harm, and child removal. Participants stated these situations caused significant impact which appeared to be associated with elements of PTSD. One participant revealed they identified PTSD symptoms within themselves after a self-harming incident. They explained *“I certainly picked up signs within myself and others of post-traumatic stress symptoms. Constantly replaying the scene in my*

head, sometimes lack of sleep". The participant also explained having a strong sensory memory related to the incident "*Some of those sensory things like having that really sensory memory. There were two or three strong occasions where it was really fresh in my mind where I can still get the smell or the sound*".

Another participant also appeared to be significantly impacted after being called to a suicide scene. The participant became visibly upset when explaining the details of the night that occurred as they explained "*this was an hour after the student had committed suicide and I got brought in and I don't even know what I was there for. Just how recent the death was and the mum was still screaming in the hallway that her son had died, it just hit me*". The participant mentioned they hadn't thought about the incident till recently "*I was happy we provided support to the family and school, but within ourselves there was nothing. It was just the attitude of get on with it. I never really thought about it until it was mentioned you were coming in to talk about it, just straight away came into my mind*". Though the participant did not mention symptoms of PTSD it appeared they were significantly impacted from this traumatic event which occurred two years' prior and could increase their vulnerability of STS.

Another participant discussed the difficulty of having to remove children from their home which they explained was a direct trauma. The participant stated "*experiencing the moment sometimes with the police to uplift that child taking them away from their family, so obviously your witnessing this I guess direct in a way, it's their trauma being ripped away from their family's arms, family is crying, kids are crying, police are involved it's an unpleasant thing. Those kinds of things do weigh on your mind*". It appeared from several incidents of child removal, the participant became increasingly vulnerable to the effects of trauma exposure.

Countertransference. Countertransference has also been associated with the effects of trauma exposure. The findings suggested two participants related to their client's experiences which involved seeing oneself within the client. For example, participant seven explained "*Yeah I suppose each one that confides in you, I tend to relate a lot of the stuff that's happened in my life*". The participant identified comparing a

particular incident with their client which made them feel angry and bias. The participant explained *“my boy was talking to me about his dad, and I found myself getting mad or quite biased”*. The participant stated it was important for them to get involved with youth and share their pain to show commitment. The participant stated *“I think that if you don’t get involved then the kids see that and they just see you as another person who’s there and you don’t really have a good relationship with them. So you kind of have to get involved and share their pain”*. While there were elements of countertransference, the participant also displayed elements of empathic engagement which appeared to increase their vulnerability. Additionally, another participant displayed elements of countertransference and mentioned a mirroring effect when comparing the relationships in their life with their clients. They explained *“where the clients are talking about their relationships with others and your sitting there going oh my gosh that’s happening in my life too”*. Importantly, the participant identified when they were experiencing a connection or emotion with their client during a session, they note it down and take it to supervision to prevent any effects from occurring.

Empathic engagement. Empathic engagement was an element which appeared to increase vulnerability of STS and decreased emotional well-being and was a common theme amongst the participants. The findings revealed five participants displayed elements of empathic engagement which was related to participants sympathising with youth. One participant explained sympathising with a young person was a way of demonstrating their commitment and strengthening their relationship with youth. They explained *“From their stories you feel an emotional connection or sympathise with what they are going through. If the youth workers weren’t to sympathise and open themselves up the kids might not want to disclose information. So I guess if I wasn’t to sympathise or show my emotions to what they are expressing, then they would feel like I was putting a wall up where as they were putting there’s down”*. Similar to this, participant four identified that during engagement with youth it is difficult to not take on the youth’s emotions as your own. The participant explained it can be difficult to determine what feelings belong to the youth and what

feelings are your own. The participant explained *“So you definitely feel that sadness, but at the end of the day I’m the person that’s the stronger one to hold, so it’s sort of sitting with that and being aware that you’ve got the feelings and sometimes they’re not your feelings they’re their feelings, you need to distinguish what’s yours and what’s theirs”*.

Organisational stressors. A major contributor which significantly impacted majority of participants was organisational stressors. The findings revealed nine participants identified organisational stressors as being a key precursor which caused stress and exhaustion. Factors associated with organisational stressors included: being on call; lack of time off; increased paper work and workload; and supervision.

Three participants mentioned being on call 24/7 which contributed to one participant working 30 days with no time off. These participants stated they felt very tired and drained from being on call. One participant stated *“Some of our workers are complaining they don’t get weekends, but management who pay us it’s like they don’t care, or understand”*. The same participant also identified losing sleep over increased workloads as they did not have the time to complete paperwork. Alongside this, these participants were also involved in back to back camps which ran during school holidays. As a result, one participant stated *“we drain ourselves as well as the kids. And from being tired you become less efficient in your role or you’re doing things with less energy”*.

Paperwork and workload were also identified as being key components which increased stress and took time away from youth. One participant identified *“There’s definitely cases where you go home and take them home and are super worried about them, but then there’s also such a high number of work so it feels really hard sometimes not being able to give the attention and care”*. Another participant also mentioned the stress of increased paperwork and how this took time away from youth. They explained *“see we have just been audited and all of the paper work we need to get out is ridiculous and the time needed is taken away from the kids. So then it’s like ok fine well the youth still have their two hours a week, so I’ll just do this in my own time”*. The participant further

stated *“those things break me the polices, the procedures, the red tape, the politics”*

Several participants explained the stress associated with lack of funding. One participant described *“another huge distress is government funding. I feel like people are the most important thing and it’s really disheartening why is the world like this, why has everything been cut so much so that causes a lot of distress we haven’t been given any more resources but we’ve got ten times the work to do which is really stressful”*. When asked if the participant had enough resources to cope with workload the participant responded *“Completely not at all there’s so much pressure even last week I broke down in tears four times so it’s really stressful. It’s job stress. That compromises my actual work and the relationships I have with them (youth)”*. The participant explained they have more difficulty with the organisational issues than working with youth *“With the young people I am more understanding have less frustration and they’re just young people, but I think the work and the organisation of it effects my work with the young people”*. In terms of workload the participant also stated *“the workload it feels like there’s no way I can achieve it and they can’t resource us because they don’t have the resources”*. The participant also mentioned having physical reactions to the job stress *“I get sick all the time when the seasons change four times a year plus double that. I get tension headaches I have a lot of headaches I thought it was my eyes from looking at the screens but it wasn’t, I think I clench my jaw when I’m stressed”*. The participant further stated *“Everyone is like self-care you need to look after yourself but it’s like yeah but I need to do all these overtime hours”*.

Lack of supervision was another organisational stressor identified among participants which appeared to increased their vulnerability and cause distress. The findings revealed six participants did not receive supervision which significantly impacted their emotional well-being. When participants were asked about their support systems, many suggested they would talk with friends, family, and colleagues. However, some participants mentioned talking with family and friends was difficult due to their lack of understanding of the job as well as not wanting to burden

friends with traumatic information. For example, participant 11 stated “*I think because it’s difficult for other people in your life to understand sometimes the extent of the work you often have feelings that people won’t understand at home or in your outside friend group about what you do and why you do it and so there’s not much point in bringing that up or you feel guilty about landing that heavy stuff on somebody else*”. Another participant mentioned they would talk with friends as a way to debrief and process the emotions they were feeling because they did not have a supervisor. The participant explained “*I think because a lot of the time youth workers are supposed to have supervisors, but I’ve never had that so it’s hard to not have someone to vent to*”. Similar to this another participant mentioned the difficulty of having no supervision. When asked if they had enough resources to cope with the work demands, the participant responded “*No way not at all, they didn’t even offer supervision. Every two weeks we had an office day and we would have an external group supervisor come in and she was hopeless she had no idea what she was doing it was worse than nothing because everyone just ended up venting and it was really unproductive and demoralising, I felt like it was worse than not having any supervision*”.

Additionally, two other participants also identified having no supervision. One participant who had been called to a suicide incident stated they did not receive supervision “*I was thrown in the deep end and even after that there was no real supervision even to this day. My boss at the time, amazing guy, but there was no real supervision. That’s the expectation, to carry on, back to work*”. The participant questioned “*if something does happen, will we get that support afterwards?*”.

Contrasting with this, another participant stated the difficulty of talking with managers about problems they were having as they did not receive the support they needed. The participant explained “*sometimes when you say things it does get shut down but it can be useful to let them know, they are really quite understanding about your workload so they acknowledge it as being really hard but this is just the way it is.*”

The answers from the respondents suggests lack of supervision and support contributed to increased vulnerability of decreased emotional

well-being and STS and may be correlated with emotional exhaustion and suppression. This highlights the importance of having regular supervision to ensure youth workers are provided with the support they need to prevent negative emotional disturbances from occurring.

Boundaries and barriers. Another factor which increased vulnerability included boundaries and barriers. The results revealed five participants had limited boundaries between themselves and youth. This included being on call 24/7 and taking youth home. Three participants mentioned being on call 24/7 which increased elements of burnout, exhaustion, and depletion. One participant explained *“we tell our kids you’re allowed 24/7 access so that’s to reach us on our phones and stuff, we don’t care about after 5pm we turn our phones off, it’s not like that so I guess a lot of your work transcends into your personal life”*. A further participant explained *“For me personally I live with one of my friends and he owns a gym so we live in the gym and he has a son who we live with, so his mates and a lot of the kids I work with come to the gym because it’s a social hub for them. I train some kids I train some of their parents as well so the kids are always around and since I live at the gym they’re always there so I don’t really have a place to relax”*. As a result, these participants had minimal professional boundaries which may have increased elements of burnout and exhaustion.

Another professional barrier that was crossed included taking youth home. One participant mentioned taking kids home because they had no place to go or it wasn’t safe at home. The participant mentioned other youth workers did the same. They explained *“I have two girls I work closely with they’ve become super close to me and even close with my family like we’re not actually supposed to take them home but they come home with me”*. The participant further explained *“one of the general managers ended up doing it and now they are really close, that boy sees him as his father because he’s the only father figure he’s ever been brought up. Once with a youth worker before me she took a girl home who used to live on the streets she took her home to her family. It’s kind of like a pattern with the girls I work with they were just given a crap hand at life and I think for us we just gave them back what they wanted and needed at*

them time". From crossing this boundary, it appeared this may have contributed to the participant having a break down as they were burnt-out and may not have taken proper time for self-care.

Similar to this, another participant identified going out in the middle of the night to check on youth if there had been news reports of an incident near her neighbourhood. The participant stated "*Midnight one night there was an accident outside my house. Before I heard the bang me and my husband were running down the street in our dressing gowns. But I ended up saying call the police I'll be back later and police arrived, neighbours were around, but I went around to make sure all the kids I was working with were at home*". The participant also reported being called during the night about a young person who had requested to see them "*Quite often I'll get calls two, three in the morning. Police have picked someone up, saying they don't want their parents they want you to come down, and I say ok I'm picking coffee up on the way*". The answer from this respondent demonstrates how closely connected youth workers are with youth, which can exacerbate vulnerability.

Personal responsibility, questioning your ability and lack of time for one's self. Lastly, other themes which increased vulnerability included personal responsibility, questioning your ability, and lack of time for oneself. Personal responsibility appeared to increase vulnerability as participants felt personally responsible for the well-being and safety of youth. This led to some participants questioning their ability. For example, one participant who was involved in child removal stated "*you can't avoid to a degree feeling personally responsible and second guessing yourself and wondering if you could have done it differently, would it have been better*". Similar to this, another participant who had learned their client self-harmed also questioned their ability and appeared to feel personally responsible. They explained "*Mostly it turned to what I could have done differently. You know was I doing all that I could to prevent things getting as far as they did*". The effect of feeling responsible could have caused elements of distress and burnout which may have led to further negative emotional disturbances. Additionally, another participant who appeared to carry personal responsibility for the safety of their youth stated "*makes you*

question is what I'm doing is it enough? But I'm already overloaded with other things so what else can you do".

Lack of time for oneself was also prominent among participants which also contributed to increased vulnerability as this led to diminished self-care. One participant described sacrificing relationships because they had no time to commit to someone else, and their full energy was put into being a youth worker. The participant explained *"I think personally I have sacrificed quite a lot for the role, even in terms of relationships with friends and personal relationships because I will always be doing something with camps and it takes up so much of our time that I don't have time for anyone else"*. Another participant explained *"my love life has gone out the door"*. One participant mentioned not having enough time for self-care due to the overtime hours and increased workload. As a result, participants were not taking the time they need to look after themselves which could have further exacerbated vulnerability.

Reviewing the findings, it has revealed numerous themes which contributed to increased vulnerability and correlated with elements of decreased emotional well-being and experiencing symptoms of STS. From the results, it appears symptoms could have been minimised if participants took time for self-care and were given support from their organisations to reduce stress. Further care and consideration is needed to ensure youth workers are protected from the psychological implications of working with traumatised youth.

Factors Protecting Youth Workers from Vulnerability: Supervision and Coping Strategies

Contrasting with the previous section, this section outlines the factors which decreased vulnerability, including supervision and coping strategies. In terms of supervision five participants identified having regular supervision. Participants explained supervision was important to be able to mitigate distress and talk through distressing incidents. One participant explained how their organisation provided a lot of supervision and access to supervisors. They explained *"It's always open so if you need more time with supervisors you can have more"*. A further participant identified having weekly supervision meetings as well as a team meeting.

The participant also had internal and external supervision and personal counselling.

However, participants who did not receive supervision, discussed confiding in their colleagues or having an external counsellor. One participant stated *“I went and got a counsellor to go catch up with and process stuff and that was really helpful and a bunch of us advocated pretty hard for supervision so basically I just controlled my own support”*. Another participant identified getting personal counselling because they did not want to burden their manager with their difficulties: *“We have supervision so that’s every two weeks but because I don’t want to put my problems on my manager I get counselling here to so that helps”*.

Contrasting with supervision, when participants were asked what type of coping strategies they utilised, many suggested they distracted themselves from thinking about work by watching movies, listening to music, exercise, cooking, and socialising with friends. One participant wrote poetry to process their emotions and thoughts *“I really like to write I write a tonne to try process everything and poetry, so looking at what I’m anxious about, what I’m worried about, and what I’m looking forward to”*. The participant also mentioned using non-western meditation as a coping strategy *“I like to do non-western meditation so it’s less clearing your mind and more focusing in”*. A further participant identified using a breathing technique to centre themselves before seeing clients and after seeing clients as well as making sure they had quiet time at home and at work. Another participant identified the use of painting which helped them to destress. They explained *“so normally what I’ll do is I’ll try to finish a bit earlier than normal if it’s been a really bad day so I can get an hour of painting in before I pick up my daughter”*. The participant stated they have introduced this in their youth programme and has seen how it calms the youth.

Furthermore, another participant identified a few key coping strategies they employed such as connecting with other youth workers outside of their own organisation. They stated *“What was useful was finding other kind of youth work colleagues outside of my own organisation and just hearing their experiences and strategies that worked which were*

a little bit different to mine at times and kind of sharing that and having the channels to share, that was quite important just to know you weren't or it wasn't unique to your own situation and wasn't something that you or the organisation were doing, it was just knowing these are the challenges of youth work and having that broad sense". The participant also identified two other coping strategies which included *"learning to be able to leave work at work"* and *"finding ways to socialise with colleagues outside of work that didn't involve work and have that come up as a topic of conversation"*. The participant also learned the importance of leaving work at work and having a life outside of work which was important for their emotional health and connecting with other people *"I think what I did learn was to build enough distance between who I was at work and who I was outside of work and there would be differences as to what I could put on display and show, as well as keeping some things for home and friends"*. Overall, it seemed this was important to create distance and boundaries between work and personal life to minimise the effects of working with traumatised youth.

Conclusion of Results

The results of this study are imperative to understanding the effects of working with traumatised youth in New Zealand. Youth workers who participated in the study provided essential information which highlighted the sensitivity of working in this area. Each participant provided unique experiences, identifying clear similarities and themes. The themes were diverse which demonstrated the obstacles of working with traumatised youth, and highlighted the emotional cost of trauma work. From reviewing the results, it was clear there were numerous elements which contributed to decreased emotional well-being including anger and sadness, helplessness and resources to cope, emotional detachment and suppression, burnout, and emotional exhaustion. There were also several symptoms which correlated with STS such as difficulty sleeping, decreased energy, and avoidance. The symptoms identified appeared to increase the participants' vulnerability of developing STS and decreased emotional well-being along with organisational stressors, lack of supervision, boundaries and barriers, countertransference, and empathic

engagement. These findings stress the need for implementation of intervention procedures to ensure the psychological effects associated with trauma work are prevented and minimised.

DISCUSSION

This chapter will discuss the findings revealed in the results of the study and how they relate to existing literature on emotional well-being and STS. The section will begin by revisiting literature on emotional well-being and STS, and highlight the key components which endorse these conditions. A discussion comparing the findings with existing literature will follow, demonstrating the importance of key elements and their significance to development of both conditions. The last stage will provide recommendations for decreasing prevalence of both conditions, as well as discussing the limitations and conclusions of the study.

This qualitative study explored the conditions of emotional well-being and STS among New Zealand youth workers. The purpose of this study was to fill the gap in literature about the impact of working with traumatised youth and to establish how youth work is associated with decreased emotional well-being and STS. The second aim of the study sought to identify the symptoms and causes of decreased emotional well-being and STS. Lastly, the third aim of the study explored how decreased emotional well-being related to the development of STS. The results suggested 82% of participants experienced moderate levels of decreased emotional well-being, with 72% experiencing at least one symptom associated with STS. Importantly, it appeared symptoms correlated with decreased emotional well-being increased vulnerability of developing STS. Overall, the findings suggest emotional well-being and STS are a noteworthy phenomenon which requires further attention and intervention.

To reiterate the definition of emotional well-being, Kahneman and Deaton (2010) described it as the “emotional quality of everyday experiences and the frequency of joy, stress, sadness, anger and affection” (p.16489). Phelps et al., (2009) elaborated on this definition by explaining it as “a state of emotional and social well-being in which the individual can cope with the normal stresses of life and achieve his or her

potential” (p.34). STS, according to Figley (1978), is defined as a secondary form of trauma where the individual becomes indirectly traumatised from hearing about a traumatic incident. Symptoms of STS are congruent with symptoms of PTSD which include avoidance, re-experiencing the traumatic incident, hypervigilance, nightmares, sleeplessness, agitation, and physiological reactions (Ivicic & Motta, 2016; Barford & Whelton, 2010).

Prevalence

STS is a condition prevalent among social workers, child welfare workers, counsellors, and psychologists, due to their repeated encounters with victims of trauma. These helping professionals have been identified through research as being prime candidates susceptible to developing STS which causes behavioural and emotional disturbances. Specifically, child welfare workers were highlighted as being increasingly vulnerable to the effects of STS from interacting with traumatised children which exposes them to the cruel truths of the world (Menashe et al., 2014). Child welfare workers are similar to youth workers as both professions are exposed to children and youth who may have experienced traumatic ordeals. However, as there is limited research which focuses specifically on youth workers, studies on child welfare workers have been utilised in this research to represent the effects of working with traumatised children and youth.

In the current study, it was revealed 82% of participants had experienced emotional disturbances during their time as a youth worker which appeared to decrease their emotional well-being. The findings also suggested 72% of participants experienced at least one symptom associated with STS suggesting there is a correlation between youth work, emotional well-being, and STS. The second research aim was to identify symptoms and causes of decreased emotional well-being and STS. The most prominent emotional disturbances experienced by the participants included: anger and sadness; emotional exhaustion; distress and depletion; dysfunctional emotional regulation; as well as emotional detachment, and suppression. These results appear to be consistent with research by Bride, et al. (2008); Dane (2000); Hatcher et al. (2011);

Cornille and Meyers (1999); and Billieux et al. (2014) studies on STS. Alongside emotional disturbances, participants identified several symptoms associated with STS. These symptoms consisted of difficulty sleeping, changes in appetite, and social withdrawal, which were also consistent with studies by Menashe et al. (2014); Bercier & Maynard (2015); Osofsky et al. (2008). Interestingly, the participants noted many of their symptoms occurred because of work stress related to high caseloads, minimal supervision and support. Given this explanation, it is difficult to determine whether the symptoms were caused by trauma exposure, or a mixture of both elements (trauma exposure and work related stress). This will be discussed later to gauge the nature of these symptoms and provide explanations. Risk factors which appeared to increase vulnerability of STS and decreased emotional well-being included countertransference and empathic engagement, organisational stress, boundaries and barriers, and personal responsibility.

When comparing the results of the current study with existing research, several studies had similar results in terms of emotional and behavioural disturbances associated with STS. In Bride, et al.'s (2008) study, 92% of participants (n=172) experienced at least one symptom associated with STS when working with traumatised children. Participants revealed high caseloads, personal trauma, and intent to remain employed, were highly correlated with symptoms of STS. In the current study, high caseloads were highlighted as being a significant factor which increased stress and vulnerability of developing STS and decreased emotional well-being. In terms of emotions some participants expressed feelings of sadness which is consistent with Dane (2000) study. All the participants in Dane (2000) study described feeling sad as a result of working with traumatised children, as well as feelings of detachment and blaming themselves for situations which they couldn't possibly have been responsible for. A few participants in the current study appeared to experience elements of self-blame, particularly for youth who had self-harmed. Further studies by Hatcher et al. (2011) and Cornille and Meyers (1999) found emotional and behavioural disturbances were a common symptom reported by individuals who worked with traumatised victims. In

Hatcher et al.'s (2011) study, 44.8% of participants experienced emotional numbing, and 35.5% of participants experienced detachment from others. In Cornille and Meyers (1999) study 37% of participants experienced clinical levels of emotional distress associated with STS. The emotional disturbances found in both these studies are consistent with the results in the current study. Other symptoms prominent in the current study, which were also highlighted in previous research, included emotional suppression and regulation. Cornille and Meyers (1999) and Billieux et al. (2014) explained emotional suppression and dysfunctional emotional regulation had been identified as symptoms commonly found in individuals who worked with trauma victims, which appeared to increase the effects of STS.

Theory of STS and Emotional Well-Being

As noted by Figley (2002) in the etiological model the impact of trauma on emotional well-being is formed when the driving forces of empathy and emotional energy are exhausted. When therapists engage in empathic response with their clients, it puts them in a vulnerable position of becoming indirectly traumatised. Therefore, as the therapist becomes more empathetic, this can decrease emotional energy causing fatigue. This process was termed 'emotional contagion' and is formed when therapists are exposed to frequent and distressing trauma experiences. The results found in this study parallel Figley's (2002) theory, as participants displayed several emotional disturbances as a result of their empathic engagement with youth. The most prominent emotional disturbances included exhaustion, distress, depletion, detachment, and suppression, which were all cited in the literature review as significant effects of working with traumatised clients. These emotional disturbances were an expected result given the emotional energy needed to cope with the demands of the job, and as Figley (2002) pointed out, excessive use of emotional energy causes dramatic fatigue. Based on Figley's (2002) theory, it appeared participants experienced emotional disturbances as a result of the emotional energy needed to provide support and empathy, which resulted in exhaustion and depletion.

To expand on exhaustion, Figley (2002) described it as being a key component in the development of compassionate fatigue and therefore it was expected participants would display elements of compassionate fatigue. However, the results suggest emotional exhaustion was associated with elements of burnout, consistent with Adams et al. (2006) and Maslach, Jackson, and Leiter (1996) studies. These studies explained individuals could suffer emotional drain and burnout from providing emotional support which is congruent with Figley's (2002) etiological model. Figley (2002) provided a definition for burnout and its association with mental and physical exhaustion which were highlighted in the current study. Figley (2002) described burnout as "a state of physical, emotional and mental exhaustion" (p.1436) caused by involvement with clients needing emotional support. Figley suggested those who engage with trauma victims are susceptible to experiencing burnout given the emotional energy needed in demanding situations. Alternatively, Maslach, Jackson, and Leiter (1996) identified three dimensions of burnout including emotional exhaustion, depersonalisation, and feelings of incompetence. The researchers explained symptoms of burnout consist of physical and emotional exhaustion, self-esteem, feelings of helplessness and hopelessness, and depression. The results of the present study support both theories because they demonstrate youth workers can become emotionally exhausted, distressed, and depleted, as a result of burnout from providing emotional support to the youth, which consequently leads to feelings of helplessness.

A second theory which appeared to align with participants' responses was the theory of empathic engagement and its effect on helping professionals. As highlighted in the literature review, individuals who are most susceptible to experiencing STS and decreased emotional well-being are helping professionals who work closely with traumatised clients. These professionals are vulnerable to the effects of decreased emotional well-being and STS, due to the therapeutic alliance with clients and creating empathic engagement. Empathy plays an important part when creating effective bonds with clients as it involves the process of understanding the thoughts, feelings, and emotional states of others

(Wagaman et al., 2015). Empathic engagement is an essential part of the therapeutic relationship and helps to meet the needs of traumatised individuals (Nelson-Gardell & Harris, 2003). Demonstrating empathy enables the therapist to understand clients' needs, and their experiences of trauma (Figley, 1999). Studies (Nelson-Gardell & Harris 2003; Phelps et al., 2009; Hatcher et al., 2011) which have examined the effect of empathic engagement when working with traumatised clients have found therapists can become indirectly traumatised. In these studies, the more successful empathic engagement is with a client, the more susceptible they are in developing STS (Nelson-Gardell & Harris, 2003). Despite empathy being crucial in the therapeutic relationship, it increases vulnerability as the professional can become emotionally impacted by caring too much. The results from this study support this claim as the participants displayed strong connections and empathic engagements with youth, which caused participants to cross boundaries, diminish their self-care, and burnout. The youth workers invested a great amount of time and emotional energy to help youth by providing emotional support which caused participants to become emotionally exhausted, depleted, and distressed. It also appeared participants had difficulty with emotional regulation, causing dysfunction and may have contributed to emotional suppression. Figley (1995a) stated there is a cost to caring and professionals who hear about the fear, pain, and suffering of others, will indirectly feel a similar fear, pain, and suffering. This was demonstrated in this study.

The next section will discuss the symptoms correlated with emotional well-being and compare the results with previous research.

Emotional Well-Being

As noted in the literature review, individuals exposed to trauma can experience emotional disturbances such as distress, exhaustion, and suppression. Many studies (Bercier & Maynard, 2015; Hatcher et al., 2011; Osofsky et al., 2008; Cornille & Meyers, 1999) have cited emotions of fear, anger, sadness, irritability, and helplessness, as being key emotional responses when working with traumatised victims which causes severe psychological implications such as depression and anxiety. In the

present study, 82% of participants experienced emotional disturbances during their time as a youth worker which caused disruption to their life. Anger and sadness were a prominent emotion expressed by four participants as a result of working with youth and six participants experienced elements of exhaustion, distress, depletion, and burnout. Given these results, it was apparent participants were experiencing elements of decreased emotional well-being, which was expected given the vast amount of research indicating the psychological impact of trauma.

Osofsky et al., (2008) noted signs and symptoms of STS to include cynicism, anger, or irritability, as well as sadness and depression. Alongside this, David, Ceschi, Billieux, & Van Der Linden (2008) revealed traumatic events have a close connection with cognitive affective symptoms including sadness and self-dislike. These studies claimed sadness, anger, and irritability, are prominent features when identifying if an individual is experiencing elements of STS and are common emotional disturbances. In the current study, it was revealed some participants were experiencing anger and sadness, however there was a vast amount of other emotional disturbances which occurred such as exhaustion, depletion, and suppression, which contributed to decreased emotional well-being and may have been correlated with STS. Participants experienced these symptoms as a result of trauma exposure as well as job stress, lack of self-care, and support. Overall these elements appeared to combine and undermine emotional well-being.

Anger and sadness. As previously mentioned four participants experienced aspects of anger and sadness. Research has proposed individuals exposed to trauma can experience arousal symptoms of irritability and outbursts of anger in response to distressing information (Hatcher et al., 2011). The responses occurred as a result of emotional, behavioural and cognitive disruptions, caused by exposure to trauma (Bercier & Maynard, 2015). Bercier and Maynard (2015) stated when trauma is introduced, individuals could expect to endure several disturbances which may include nightmares, intrusive thoughts, anger, sadness, and anxiety. Bercier and Maynard (2015) also explained, trauma workers were susceptible to experiencing psychological distress which is

marked by distressing emotions, numbing, sleep disturbances, somatic complaints, avoidance symptoms, and impairment of day-to-day functioning in social and personal roles. The results of the present study support Hatcher et al.'s (2011) and Bercier and Maynard (2015) claims. From hearing about the pain and suffering of others youth workers endured their own emotional pain in response to information which caused emotional disturbances. Participants stated anger was in response to certain situations youths' experienced which caused them to be angry at families or individuals who inflicted pain. Participants also experienced anger against communities and society for not preventing harm from occurring. Consequently, this left the participants feeling sad and empathetic towards youth. Youth workers also had trouble sleeping and had somatic complaints, which overall impaired day to day functioning. Importantly, though the results align with Hatcher et al.'s (2011) and Bercier and Maynard (2015) claims, it appeared participants also experienced anger and sadness because of job stress, lack of self-care, and support.

Helplessness. Another prominent feature which contributed to decreased emotional well-being was feelings of helplessness. Previous research (Bercier & Maynard, 2015; Salston & Figley, 2003; Dutton, 1992) had suggested helplessness was a symptom correlated with trauma exposure and therefore it was not surprising to see some participants experience this symptom. Bercier and Maynard (2015) explained individuals could experience cognitive changes when exposed to trauma which causes changes in dependence and trust. From this, individuals could endure an extreme sense of helplessness and loss of personal control and freedom. Interestingly, Dutton (1992) revealed individuals experience a sense of helplessness in response to countertransference and over identifying with the client. In the current study, helplessness appeared to occur when participants felt there was not enough they could do for the youth, which led to feelings of guilt and questioning their ability. Therefore, it could be suggested helplessness occurred as a result of countertransference supporting Dutton's theory.

The findings suggest seven participants experienced a sense of helplessness. The participants identified feeling helpless in their ability to help youth which was informed by not having enough resources as well as being able cope with the workload demands which took time away from youth. Participants exclaimed they felt most helpless when youth would reveal information such as not having enough food at home, or not having anyone at home who supported them and were being physically and verbally abused. Participants felt there was nothing they could do within the realms of their professional boundaries which perhaps overwhelmed them and created a sense of helplessness. Participants explained they wanted to do more to help youth out of these tragic situations and show life would get better, but found it was difficult to provide youth with the positive outcomes they needed. Existing research has suggested when helping professionals hear about violent and graphic stories, the individual can become overwhelmed by feelings of grief or helplessness, which appeared to occur in this study (Salston & Figley, 2003).

Adding to this, Salston and Figley (2003) suggested helplessness may be associated with the effects of burnout when working with traumatised individuals which increases a sense of helplessness and hopelessness as workers feel they cannot do enough to help their client. The findings suggested as workers felt helpless, they began to question their ability and took personal responsibility which may have caused emotional exhaustion, leading to elements of burnout. For example, some participants questioned if what they were doing was enough particularly in situations of suicide and self-harm. This led to participants feeling angry and sad with themselves, people, and society. Salston and Figley's (2003) theory appears to align with the results of the current study, as participants felt helpless in their ability to help youth and may have correlated with feeling exhausted and burnout. It may be suggested helplessness was a precursor for burnout, as well as decreased emotional well-being, which negatively impacted participants causing a great deal of distress.

Emotion regulation. As highlighted in the literature review individuals who can regulate their emotions are best able to protect themselves from being negatively impacted when working with

traumatised individuals. Dysfunctional emotion regulation increases vulnerability of developing STS and decreased emotional well-being as participants are not able to cope with an abundance of overwhelming emotions which exceed their capabilities. As found in the current study, when participants had difficulty regulating/processing their emotions they lost personal control which contributed to emotional distress and symptoms of exhaustion, depletion, suppression, and withdrawal.

Existing research has found dysfunctional emotional regulation occurs as trauma exposure modifies impulsive behaviour which changes implementation of regulation (Billieux et al., 2014). This can be related back to Mc Cann and Pearlman's (1999) constructivist self-development theory which explained how trauma impacted the self which is associated with how individuals see and interpret the world (Pryce et al., 2007). As the theory explained, when trauma is introduced, it disrupts previously determined cognitive schemas and changes how people react to situations. Cognitive schemas are important for controlling how individuals act emotionally and rationally, however, when schemas are disrupted it affects the regulation of emotions and how people react and behave. When trauma exceeds psychological capabilities the resources to cope with new situations and the ability to control emotions is disrupted resulting in dysfunctional emotional regulation. In the current study, two participants appeared to have difficulty regulating their emotions which manifested in excessive crying and an inability to cope with their emotions. Another participant identified having a break down which was caused by accumulation of emotions and an inability to manage them. Though only two participants identified having an inability to regulate their emotions, most participants who had experienced elements of decreased emotional well-being may have also experienced aspects of dysfunctional regulation.

According to Billieux et al. (2014) a correlation between trauma exposure and general distress exists, which is formed via regulation strategies. Regulation strategies are crucial when adapting to stressful life events (Billieux et al., 2014) as dysfunction in the ability to implement regulation strategies which control behaviour and emotions, may increase emotional distress (Billieux et al., 2014). Billieux et al. (2014) explained,

emotional regulation strategies have been found to mediate the relationship between trauma and emotional distress, and moderate the relationship between stressful life events and resilience. In comparison to the current study, it appeared participants may have had some difficulties in regulating their emotions which could have contributed to symptoms of exhaustion, depletion, burnout, and suppression. However, Billieux et al., (2014) also found functional emotional regulation can work as a mediator to deflect emotional distress, which may possibly explain why some participants could manage and cope with their emotions compared with others as they could appropriately manage and regulate their emotions. Participants who were able to regulate their emotions were better able to protect themselves from experiencing components of decreased emotional well-being as they deflected emotional distress. Therefore, this highlights emotional regulation as being crucial to protecting individuals from experiencing negative psychological implications associated with trauma work as being able to process emotions can protect oneself from psychological problems such as decreased emotional well-being and STS. Contrasting with this, an inability to regulate emotions can increase the vulnerability of developing emotional disturbances. In the current study, it appeared participants were having difficulty regulating their emotions and may be a reason why participants were experiencing high levels of decreased emotional well-being.

Burnout, emotional exhaustion, and emotional depletion. In the current study, six participants experienced elements of burnout, exhaustion, and depletion, which appeared to decrease emotional well-being and increase vulnerability of STS. Participants who were identified as having experienced elements of burnout and depletion were those whose jobs were exceptionally demanding both mentally and physically. As discussed in the literature review STS and burnout are used interchangeably given the symptoms are similar, however both conditions are very different in terms of development and causation. Research has explained burnout is a consequence of STS and compassion fatigue which causes participants to feel both physically and emotionally exhausted (Adams et al., 2006). Several participants in the current study identified

themselves as feeling exhausted both physically and emotionally which was caused by shift work, not having enough time off, and the emotional demands of the job. Figley, (2002) described burnout as being marked by physical, emotional, and mental exhaustion, and is formed via long-term emotional involvement. Given the circumstances youth workers found themselves in, and the emotional energy needed to support youth, it was expected participants would display some elements of exhaustion and depletion. One participant explained there was a point where they could no longer do the “frontline stuff” which involved going into youths’ homes and working directly with youth who had self-harmed or been abused. The participant stated it had come to a point where their “tank was empty” and had no more energy or emotion to give. The participant suggested they experienced elements of burnout during their time as a youth worker. Several other participants were also identified as experiencing elements of burnout from being exposed to distressing and traumatic experiences.

In contrast to the emotional demands of the job, which caused burnout and exhaustion, the findings also suggested organisational stressors were a key component which intensified burnout. Two participants identified having a break down from being completely burnt out which was caused by organisational stressors, as well as not having the ability to regulate their emotions. Research has suggested burnout can occur as a result of working with any client group, but is in response to stressors in the organisational environment (Nelson-Gardell & Harris, 2003). Typically, burnout is associated with elements of working long hours, poor supervision, and in-experience (Phelps et al., 2009). Beaton and Murphy (1995) stated increased client contact and large caseloads also predicted burnout as well as poor psychological well-being which could result in emotional depletion. In the current study, organisational stressors included being overworked, having little support, and increased paper work. This resulted in participants not being able to achieve and manage their workload accordingly. Participants explained it was hard to keep up with the workload within their working hours which also took time away from the youth. To accommodate this, participants were taking work home which led to overtime hours and diminished self-care. By doing this,

participants became stressed, tired, and exhausted. Additionally, participants also explained the impact of having minimal support from the organisation in terms of supervision, which was a major contributor to stress and influenced how participants managed their emotions. Research has suggested professional support and supervision are occupational factors commonly identified as influencing stress and burnout (Phelps et al., 2009). Several participants mentioned having no supervision or help with their workload which increased distress and affected their ability to regulate emotions. Participants explained that having little or no supervision was difficult as they didn't have the option to debrief with someone and were left to process their emotions and deal with difficult cases on their own. This may have contributed to aspects of emotional suppression, exhaustion, and depletion. Thus, some participants sought out their own personal counselling to help manage their emotions and deal with the confronting work they do. However, they mentioned supervision would be highly beneficial.

Another aspect which may have caused burnout is lack of experience. Previous research found individuals who are in-experienced reported higher levels of burnout, particularly in younger employees (Barford & Whelton, 2010). Younger employees appeared to be more vulnerable to burnout, as when they entered the industry they had high expectations of wanting to help make changes to youths lives instantly (Barford & Whelton, 2010). Unfortunately, after learning and being in the job for a while younger employees often became disenfranchised and had diminished hopes when the job did not meet their expectations (Barford & Whelton, 2010). This was the case of one participant in the current study who mentioned they thought their company was "this amazing organisation who helped youth" but they have come to realise how difficult it was to create change quickly, particularly with a lack of resources and funding, and the demands of the job. Van hook & Rothenberg (2009) explained high levels of burnout in younger therapists may be associated with their inability to deal with vulnerable populations which exposed them to cruelty in the world within a short time frame. In the current study, several participants revealed they experienced elements of exhaustion

and burnout during their first few years as a youth worker with some explaining they had break downs during their first few years. However, compared with participants who had been working in the industry for years it appeared these participants had developed better coping mechanisms and were able to effectively manage their emotions and work load which decreased their susceptibility of developing burnout. Van hook & Rothenberg's (2009) theory may help to explain why youth workers in the current study experienced levels of burnout, exhaustion, and depletion, given how quickly they were exposed to the harsh realities of the world, which they perhaps were not prepared or trained for.

Emotion suppression and emotion detachment. As noted in the literature review, individuals exposed to traumatic information could experience elements of emotional suppression and detachment, which are marked as emotional disturbances of STS. Research has outlined signs and symptoms of STS include: emotional disturbances such as emotional detachment; a sense of numbness; depersonalisation; sadness and depression (Osofsky et al., 2008). Figley (2002), highlighted individuals who examine the pain of others could experience emotional disturbances such as detachment and suppression as a result of numbing oneself from emotional pain. In the current study, one participant explained they suppressed and detached from their emotions so much it accumulated and led to their eventual breakdown. It may be suggested individuals used these mechanisms as a way to avoid dealing with the ramifications of emotions they were experiencing as they did not have the capabilities to process emotions. Therefore, individuals chose to suppress and detach/avoid.

Research has suggested (Osofsky et al., 2008; Cornille & Meyers, 1999; Hesse, 2002) detachment is an emotional disturbance correlated with STS which is marked by the symptom of avoidance. Avoidance is a prominent symptom associated with STS which involves the individual avoiding situations, people, or places, which would remind them of the traumatic event (Hatcher et al., 2011). Emotional disturbances associated with avoidance includes detachment and numbness, which was supported by the results of the current study. Several participants identified feeling

emotionally detached and suppressed their emotions which may have been caused by dysfunctional emotion regulation. Other participants mentioned it was difficult to process emotions and incidents which impacted them as they did not have a supervisor or someone to debrief and discuss incidents with. Participants also mentioned, by detaching and suppressing their emotions it helped them to move forward with the job. By distancing themselves and ignoring their own emotional responses, they were better able to provide support to the youth. However, it could be suggested detachment and suppression were used as unhealthy coping mechanisms to manage the emotional demands of the job as research has suggested individuals use numbing and distancing as a way to intervene in a traumatic situation to provide help and support (Pryce et al., 2007). This was identified in one participant who explained that on occasion they would detach from their emotions to help youth, and identified it as an unhealthy coping mechanism.

Several other studies have identified suppression of emotions as being a further symptom of STS which created emotional disturbance. Research has revealed, individuals who hear about stories or re-enactments of traumatic incidents could experience suppression of emotions (Cornille & Meyers, 1999; Adams et al., 2006) and may also be seen as an unhealthy coping mechanism. As noted in the previous paragraph, suppression was used as a way to move forward and provide emotional support to youth. One participant mentioned they would put their own emotions aside so they could provide emotional support to youth. However, this then led to months of emotion suppression and detachment, which caused the participant to have a breakdown. Unfortunately, research has yet to fully explain why individuals exposed to trauma suppress their emotions. However, it may be explained within the same realms of detachment, where suppression is an avoidance mechanism that occurs due to dysfunctional emotional regulation. The current study suggests individuals suppressed their emotions as a way to cope with the emotional demands of the job and provide emotional support to youth. Alongside this, it seemed participants suppressed emotions as a way to avoid their own emotional pain and process their own difficulties.

Desensitisation. An interesting finding in the current study was the symptom of desensitisation which appeared to be a negative emotional reaction to trauma exposure. According to Figley's (2002) etiological model on managing compassionate fatigue, when individuals are exposed to frequent amounts of traumatic information it is possible they can become desensitised. Desensitisation is used as a way to manage how helping professionals react to hearing traumatic information, which helps them to build resilience. Findings in the current study found three participants had become desensitised due to increased exposure to traumatic incidents. One participant stated the effect of becoming desensitised meant they had to try harder to connect with others pain and brokenness, while the other two participants identified it made them more willing to step into risky situations. The findings appear to support Figley's (2002) theory that desensitisation removes part of the initial emotional reactions to trauma, and gives individuals the confidence to be able to move forward in supporting the traumatised person. However, one participant said they found it hard to connect with others. This could be seen as a negative emotional reaction of trauma exposure which could have further implications. This finding requires further investigation before a conclusion can be made.

Overall, the current study suggested emotional disturbances were significantly correlated with being exposed to traumatised youth and was supported by previous research. It may be suggested the emotional impact of working in this area could be mitigated if helping professionals were provided with support and educated on how to reduce and regulate emotional reactions. Despite this, it is clear youth workers experienced adverse emotional effects which may have increased vulnerability of STS. The following section will discuss the symptoms correlated with STS and compare the results of the current study with previous research.

Secondary Traumatic Stress Disorder

STS is defined as a natural consequent of behaviours and emotions resulting from hearing or knowing about a traumatic event experienced by another person (Cornille & Meyers, 1999). The syndrome is similar to PTSD, however the person who experiences STS hears about the trauma

indirectly rather than experiencing it first-hand. Research (Wagaman et al., 2015; Osofsky et al., 2008; Hensel et al., 2015; Hatcher et al., 2011) on STS has found those who work with trauma victims can experience an array of behavioural, emotional, and cognitive disturbances, as a result of hearing about the details of a traumatic event. Research has been able to reveal a direct relationship between STS and helping professionals who work directly with trauma victims which causes psychological problems. Helping professionals may be unaware they are experiencing symptoms of STS and, according to Pearlman and Saakvitne, if STS goes unacknowledged it can cause harm to clients by creating distance between the individual, their family, and friends. Individuals can become unfocused and inattentive to the needs of others which can lead to feelings of helplessness, withdrawal, and cynicism.

Emotional, behavioural, and cognitive symptoms, associated with STS includes: difficulty sleeping, flashbacks, avoidance, re-experiencing the traumatic event, anxiety, sadness, depression, depersonalisation, emotion detachment, social withdrawal, changes in world view, diminished self-care, and intrusive thoughts. In the current study 71% of participants displayed symptoms of STS which were associated with the effects of trauma exposure. Participants experienced changes in appetite, difficulty sleeping, irritability, changes in worldview, social withdrawal, and decreased energy. The results supported findings in Wagaman et al. (2015), Bercier and Maynard (2015), Osofsky et al. (2008) and Menashe et al. (2014) studies which revealed participants who worked with trauma victims had difficulty sleeping and social withdrawal. An important finding of the study revealed organisational stressors were a major component which increased vulnerability of STS and decreased emotional well-being. This was marked by lack of support and supervision, increased work/client load, shift work, and paper work. Organisational demands of the job caused participants to experience difficulty sleeping and changes in their appetite due to stress and was also associated with elements of burnout. Results of the current study support research by Osofsky et al., (2008) which found organisational factors such as high case load, lack of support and supervision, inadequate resources to meet demands, excessive paper

work, shift work and sleep deprivation increased susceptibility of STS. In summary, it is difficult to determine if the symptoms participants experienced were associated with hearing about traumatic incidents, or were a result of organisational stressors. Therefore, the research is unable to determine if symptoms were a result of STS.

The next section discusses the symptoms associated with STS including: sleep deprivation, social withdrawal, decreased sense of energy, eating disturbances, and changes in worldview.

Symptoms of secondary traumatic stress. Research has shown sleep disturbance is an indicator of psychological distress (Bercier & Maynard, 2015) which can impair day-to-day functioning. Hatcher et al. (2011) explained sleep disturbances are an arousal symptom of STS that involves difficulty falling or staying asleep. Participants in the current study noted sleep disturbance as being a major problem, with one stating they could not sleep as they would worry about the safety of youth and the situation they were currently in. Other participants mentioned having trouble falling asleep as they would ruminate on the shift they had just finished which may have required intense behavioural management. Increased workload also contributed to lack of sleep with one participant stating they would wake in the night to complete work because they could not stop thinking about it. This appeared to increase elements of burnout as workers became exhausted and also contributed to sleep deprivation. One participant mentioned how they would always feel tired even after 12 hours of sleep which may be correlated with burnout and psychological distress.

Other symptoms of STS included social withdrawal, decreased energy, and changes in appetite. Research has suggested individuals who work with child abuse cases typically experience feelings of alienation, sadness, loneliness, and hopelessness, which can lead to a desire to withdraw and distance oneself from others (Dane, 2000). In the current study, some participants identified not having the time or enough energy to give to friends and family, or did not have the energy to participate in activities. Two participants identified losing a connection with their friends and family and did not participate in social activities. However, they were

aware they needed to find a way to increase contact and connection. Furthermore, one participant indicated they withdrew from activities they used to enjoy because they did not have enough time or energy to give. Others experienced decreased energy because of the emotional demands of the job as well as shift work and lack of time off which corresponds with Figley's (2002) theory. Figley (2002) identified that the emotional demands of providing support to trauma victims could lead to a sense of fatigue and increase vulnerability of STS.

Changes in appetite were also a prominent feature amongst participants which appeared to be related to work stress. The participants who noted changes in their appetite explained it occurred for many employees, with one participant stating they were a stress eater. Follette, Poulsny, and Millbeck (1994) suggested eating disturbances were correlated with assessment of general psychological functioning and argued it is a trauma symptom. The findings in the present study suggested eating was correlated with feelings of distress and impairment of general functioning.

Lastly, changes in worldview were revealed in two participants who reported viewing the world as an unsafe place after learning about the harsh conditions some youth had to endure. Previous research suggested individuals who were exposed to traumatic incidents were also exposed to harsh realities of the world, which changed how people viewed society (Menashe et al., 2014; Pryce et al., 2007; Ben-Porat & Itzhaky, 2009; Clemans, 2004; Salston & Figley, 2003). One participant stated "the world sucks" and appeared to be disenfranchised that people could be so cruel. Based on the constructivist self-development theory which demonstrates how trauma can change our 'self' and cognitive schemas, the theory identifies how preconceived beliefs about the world, people, and situations are altered which changes thought patterns and awareness. Previous research has found participants experience changes in their own beliefs about the world when exposed to trauma, whereas previously they viewed it as a just and safe world with good people (Salston & Figley, 2003). However, when learning about violent encounters, individuals

preconceived beliefs were altered. Additionally, some individuals could become desensitised to cruelty due to increased exposure.

A study by Cunningham (1999,2003) revealed participants viewed the world as threatening after working with victims of family violence and were more suspicious of people around them. Participants noted how their beliefs about society and people were changed where they became more cautious and judgemental of others. Furthermore, research has found individuals could experience negative changes in their spousal relationships due to their work with family violence victims, which could also change their views on humanity and the world (Ben-Porat & Itzhaky, 2009). In Ben-Porat and Itzhaky (2009) study, participants stated they viewed the world through a grey lens, and that their faith in people, humanity, and the world, had been undermined as a result of their work. Participants explained they felt society was evil, aggressive, and malicious, and saw the world as unsafe. The results of the current study supported these findings as participants had similar views.

Though only a few symptoms of STS were found in the current study, it suggested participants were impacted via trauma exposure and highlights the risk of working with traumatised individuals. To discuss further elements which appeared to increase vulnerability, the next section discusses themes which appeared to increase vulnerability of decreased emotional well-being and STS.

Risk Factors Increasing Vulnerability

The next section discusses risk related factors which appeared to increase vulnerability of decreased emotional well-being and STS. Components consisted of countertransference, empathic engagement, organisational stressors, supervision, and personal trauma.

Countertransference. Countertransference and empathic engagement were components which appeared to increase susceptibility of STS and decreased emotional well-being. By engaging in these conditions, it appeared professional boundaries were minimised as participants felt personally responsible for their clients, and would step over professional boundaries to help them.

Previous research has found countertransference is a common feature associated with the development of STS and vicarious trauma (Nelson-Gardell & Harris, 2003; Ben-Porat & Itzhaky, 2009) and is considered a risk factor that increases susceptibility and vulnerability. Countertransference occurs when a helping professional over identifies with a client, sees themselves within the client, or tries to meet the needs of the client (2002). During this process, helping professionals experience severe emotional reactions which undermine the therapeutic relationship and increases risk (2002). In the current study, two participants appeared to be experiencing elements of countertransference which occurred when the participant would see themselves within their client, or relate to their experience. Both participants identified having similar problems to their clients which may have caused over identification as a result of seeing themselves within the client. Both participants identified their own biases and acknowledged they were experiencing a connection with the client, and were aware of the steps to minimise transference. Cerney (1985) suggested countertransference is the therapist's unconscious responses toward a client resulting from unresolved issues they are experiencing within themselves. Cerney's (1985) theory may help to explain why the participants reacted in this way.

Additionally, research has found therapists can without knowledge, experience countertransference as a result of emotional reactions towards a client's ordeal which occurs unconsciously, as therapists/helping professionals are heavily influenced by strong polarising responses from clients (Tosone et al., 2012). Through engagement with clients and connecting with their emotions about a tragic ordeal, helping professionals can experience strong emotional reactions which threaten professional boundaries and cause a multitude of emotional consequences (Tosone et al., 2012). This was identified in the current study where many participants revealed experiencing emotional reactions from hearing about the stress youth experienced. For example, one participant said it was difficult to separate your own emotions from the youth's emotions. The participant explained it was "hard to not take on the youth's emotions as your own", and said it was "important to distinguish what was your feelings and what

was their feelings". Throughout the study it appeared that majority of the participants would take on the youth's emotions as their own which led to feelings of helplessness as discussed earlier.

Research has also determined when helping professionals experience countertransference it is difficult to remain within professional emotional boundaries, and therefore helping professionals start to take on the stress of their clients (Tosone et al., 2012). Within this process boundaries are threatened, and in the current study it appeared many boundaries were broken between youth and youth workers due to strong emotional reactions. For example, in the current study it was revealed some participants had 24/7 contact with their youth and another participant mentioned taking a young person home. The professional boundaries between some participants and their clients appeared obscure. However, the participants noted it was important to have this connection so that youth felt as though they had someone who cared about them and were available whenever they needed them. One participant mentioned "suicide does not happen between the hours of 9 – 5". Consequently, by having these emotional connections and lack of professional boundaries, it may be suggested this correlated with participants feeling emotionally exhausted, distressed, depleted, and burnt-out.

Empathic engagement. Empathic engagement also follows similar lines to countertransference and may provide a further explanation for strong emotional reactions and connections between participants and youth. Research has revealed the importance of being empathetic towards clients and has explained it is vital in the therapeutic relationship to understand and relate to the distress of clients (Phelps et al., 2009). However, research has also suggested individuals who engage empathically with trauma victims are vulnerable to the emotional implications of STS (Osofsky et al., 2008).

Bride, et al. (2008) explained that when creating an empathic relationship with clients to help them overcome distressing ordeals, the helping professional could experience their own emotional disturbances from taking on the emotions and trauma of their clients. The findings in the current study support Bride, et al. (2008) claim, as participants identified

becoming very upset from hearing about incidents their clients had endured which prompted a sense of personal responsibility and wanting to do more for youth. The majority of participants identified being emotionally impacted by at least one case during their time as a youth worker, with a few stating there were a multitude of times they were significantly affected. These incidents may have contributed to participants experiencing sleepless nights from worrying about a young person's safety as well as experiencing emotional disturbances including distress, exhaustion, burnout, and depletion. Empathic engagement may have increased susceptibility of STS and decreased emotional well-being from stress over wanting to help provide positive opportunities for youth.

Furthermore, research by Figley (2002) suggested empathic responses are responsible for causing compassion fatigue which highlighted the impact empathic engagement could have on psychological well-being. In Figley's (2002) etiological model, he noted empathic ability, empathic concern, and empathic response, were all components which manifested compassion fatigue. Findings from the current study supported this theory as participants experienced elements of emotional exhaustion, distress, and depletion, which may have been a result of empathic engagement. One respondent explained it was "important to empathise and engage with the youth as a way to connect and build a strong relationship" and as such gain a deeper level of understanding. This highlights how crucial empathic engagement is with youth. The downside of this relationship is explained by Figley (2002) which stated that being compassionate and empathetic towards trauma victims can come at an emotional cost and could result in emotional exhaustion. This appears to have occurred in the current study which increased vulnerability and risk of developing STS and decreased emotional well-being.

Organisational stressors. Organisational stressors were identified in the study which appeared to increase vulnerability of decreased emotional well-being and STS. Numerous studies (Osofsky et al., 2008; Phelps et al., 2009) have discovered organisational stressors enhanced susceptibility of STS which causes distress and burnout. In the current

study eight participants highlighted organisational stressors as being a prominent problem which had a significant impact on emotional well-being.

A vast amount of research (Adams et al., 2004; Collins & Long, 2003a; Figley, 1995a; Sabin-Farrell & Turpin, 2003) has recognised organisational stressors as being a strong predictor of poor psychological well-being amongst helping professionals which increases vulnerability of STS. In the current study organisational problems which were identified as the most troublesome included: minimal supervision and support, high caseload, shift work, increased paper work, lack of resources, and working overtime. Osofsky et al., (2008) revealed that organisational factors which strongly influence the onset of STS included high case load, little support, conflicting roles, lack of peer support, inadequate resources to meet demands, excessive workload of paper work, shift work, sleep deprivation, and physical risks, or concerns about safety. Most of these elements were revealed as significant stressors in the current study, which participants explained caused a great deal of distress.

Adding to this, Beaton and Murphy (1995) discovered a combination of working long hours and increased client contact manifested the onset of burnout and poor psychological well-being. Similarly, MarMar, Weiss, Metzler, and Delucchi (1996) also identified workload, traumatic information, and the amount of training, as being correlated with stress related problems. The findings of the current study supported this theory as findings suggested organisational problems contributed to stress and burnout. Participants highlighted it was difficult for them to do their job effectively given the amount of stress which was correlated with an inability to manage work load, long hours, lack of personal time, and minimal help, and supervision. Many participants explained it was difficult to manage their workload due to large amounts of paperwork and having limited time and resources to keep up. As a result, this took time away from youth which then prompted overtime hours to ensure youth would still get their allocated contact time. For example, one participant mentioned waking up in the middle of the night stressed about the amount of paperwork which was due, and decided to get up at 2am to be able to

finish it. It could be suggested, this contributed to elements of stress, exhaustion, exaggerated emotional responses, and burnout.

Shift work was also mentioned as causing problems for participants which led to unhealthy eating habits, sleep deprivation, and broken social lives. Participants who worked night shift explained it would take hours to wind down after a shift particularly when intense behavioural intervention was required. Others explained how shift work interfered with socialising as they were too tired during the day to socialise, and would be working till late at night.

Overall as the research suggested, organisational stressors could have a major impact on the psychological functioning of individuals which could cause stress related problems. This result was found in the current study which suggested organisational stressors were a major contributor to elements of exhaustion, distress, and burnout, which increased vulnerability of decreased emotional well-being and STS.

Supervision. Along with the vast amount of organisational stressors which appeared to influence elements of burnout, distress, and emotional disturbances, a significant problem in the study appeared to be supervision. Professional support and supervision have been pinpointed as an organisational factor which influences the level of stress and burnout experienced by helping professionals and is regarded as a strong factor which increases vulnerability and risk (Adams et al., 2004; Phelps et al., 2009; Craun & Bourke, 2015; Ivicic & Motta, 2016).

Supervision has been described as an effective tool which can protect helping professionals from the harmful effects of working with traumatised individuals (Salston & Figley, 2003; Wagaman et al., 2015). This can mitigate the effects of STS (Ivicic & Motta, 2016). Research has noted that without supervision helping professionals are at risk of developing emotional disturbances and can become dehumanised (Phelps et al., 2009). Lack of supervision has been cited as a critical issue when working with victims of trauma as it negatively influences the psychological well-being of helping professionals (Ivicic & Motta, 2016; Phelps et al., 2009). In the current study, supervision was a common theme revealed in the findings as some participants identified having no supervision or

support during their time as a youth worker. One participant explained how they were at the scene of a suicide, and years on the participant has yet to receive supervision about the incident which may have contributed to elements of PTSD. Interestingly, participants who did not receive supervision appeared to have experienced several emotional disturbances, compared with participants who did receive supervision.

Respondents of the study outlined supervision worked to mitigate emotional stress and therefore was the most important part of being able to cope with the effects of the job. Some stated it would have been beneficial to receive supervision as they needed support to process painful emotional reactions and overcome other problems they were experiencing. Contrasting this, the participants who did receive supervision highlighted how important and crucial supervision was for them as it enabled them to debrief and discuss cases they were having difficulty with.

When trying to minimise the effects of STS and alleviate emotional implications when working as a helping professional, research has recognised support and supervision are key (Pryce et al., 2007). Previous research has explained the behavioural, emotional, and cognitive effects of STS could be ameliorated if helping professionals had regular supervision, or sought consultation (Salston & Figley, 2003). Several participants in the current study who did not have access to supervision recognised the need to be able to talk to someone about their emotional and behavioural reactions and therefore sought personal counselling. One participant identified having weekly supervision internally and externally, and also received personal counselling. Other respondents identified utilising the free counselling within their organisation. Alternatively, some participants would turn to colleagues for support or find other people from different organisations who shared similar work experiences.

Personal Trauma. Previous research has suggested personal trauma is a factor which can increase susceptibility of STS (Cornille & Meyers, 1999; Pryce et al., 2007; Ivicic & Motta, 2016). Pryce et al. (2007) explained individuals who have experienced their own personal trauma may be more vulnerable to the effects of STS, particularly when a client's

trauma is similar to their own. This can occur when the professional has unresolved conflicts relating to their personal trauma, exacerbating the effects of STS. In the current study, several participants identified having experienced their own personal trauma. When participants were faced with hearing about traumatic incidents which were similar to their own, the participants acknowledged it was difficult to hear but were able to manage this accordingly. It appeared that by going through the same situation this encouraged participants to act and provide support for the young person as they knew what to do. Participants explained they were more compassionate and understanding of the young person's situation, which gave them the confidence to step in and manage the situation effectively. However, there was one participant who recognised they needed to be careful about their own triggers which could have potentially set off emotional responses. The participant noted having been abused themselves as a child and identified there was a risk of being adversely affected by working with traumatised youth. Given the contrasting responses from different participants, the findings of the current study appear to be inconclusive when determining if personal trauma increased vulnerability of STS. It may be suggested individuals with different personality traits react to trauma in different ways and whether individuals have unresolved conflicts.

Conclusion of Discussion

In summary, the findings of the current study have yielded interesting results which suggests youth work is associated with the effects of STS and decreased emotional well-being. The results of the study appeared to be consistent with previous research on STS which highlighted helping professionals can experience several emotional and behavioural disturbances when with working with trauma victims.

Several theories were supported by this study which included Figley's emotional contagion and empathic engagement theory. Both theories suggest individuals can experience emotional disturbances as a result of empathic engagement with traumatised clients, which increases their risk of experiencing negative emotional disturbances of burnout, exhaustion, detachment, suppression, distress, and STS.

Reflecting on the results, participants experienced several emotional disturbances associated with decreased emotional well-being which included anger and sadness, helplessness, dysfunctional emotion regulation, burnout, suppression, detachment, depletion, and desensitisation. These findings were consistent with previous research by Bercier & Maynard (2015), Hatcher et al., (2011), Osofsky et al., (2008), and Cornille & Meyers, (1999) which highlighted individuals working with traumatised victims can experience an abundance of emotional implications causing psychological distress. It appeared participants experienced these symptoms from being exposed to traumatic information as well as job stress, lack of self-care, and support. This caused participants to become angry with families and society and feel helpless in their ability to help youth and provide positive outcomes within their professional boundaries. Thus, participants became exhausted and distressed, which led to some participants experiencing burnout. Additionally, the emotional demands of the job caused some participants to experience desensitisation, detachment, and suppression, which appeared to be caused by dysfunctional emotion regulation. Importantly, dysfunctional emotion regulation played a crucial role in the development of emotional disturbances which decreased their emotional well-being as participant's psychological capabilities were exceeded causing psychological implications.

Alongside decreased emotional well-being, participants experienced several symptoms associated with STS including changes in appetite, difficulty sleeping, irritability, changes in worldview, social withdrawal, and decreased energy, which was consistent with research by Menashe et al. (2014), Bercier & Maynard (2015), and Osofsky et al. (2008). However, it was unclear whether participants experienced these symptoms a result of trauma exposure or organisational stressors. The most prominent organisational stressors which caused distress included lack of support and supervision, increased workload, shift work, and increased paperwork. Previous research had suggested these elements can play a major role in the development of STS as participants are vulnerable to distress. This was displayed in the current study which

contributed to participants experiencing elements of burnout and exhaustion. Lastly, other items which were revealed as increasing risk included countertransference, empathic engagement, lack of supervision, and personal trauma. Countertransference and empathic engagement increased risk and vulnerability as participants would cross professional boundaries to help youth due to strong unconscious emotional reactions towards a young person's situation. Consequently, this contributed to elements of burnout, distress, exhaustion, and depletion. This was consistent with research by Bride, et al. (2008). Supervision was also a prominent problem participants experienced as many participants lacked support and supervision which research noted is important for mitigating emotional stress and allows helping professionals to cope with the effects of the job. The results suggested lack of supervision contributed to emotional disturbances.

Overall, all the themes outlined in the discussion had a major contribution to the psychological functioning of participants which highlights the need for intervention and prevention to minimise harm from occurring. The following chapter will provide a conclusion of the thesis highlighting the key findings and discuss recommendations for minimising the effects of decreased emotional well-being and STS. Lastly, the strengths and limitations of the study will be outlined and conclude the thesis.

CONCLUSION

The current study reveals a cycle where helping professionals are becoming increasingly vulnerable to STS and decreased emotional well-being. Reflecting on the literature review, Figley (1995a) identified STS is caused when individuals are exposed to trauma indirectly and experience emotional distress caused by extreme empathy. Consequently, this leads to severe stressor like symptoms and occurs for individuals who are repeatedly exposed to traumatic events. Previous research highlighted psychologists, counsellors, social workers, and mental health workers, were increasingly vulnerable to developing STS, however there was little knowledge about other professions who were also at risk. Additionally,

there was also little knowledge about the emotional impact of trauma work and how this affects helping professionals without the presence of STS. Given these results one objective of this study was to conduct research with youth workers to create awareness and recognise the effects this type of work can have. Youth workers are exposed to the same realities as social workers, counsellors, and psychologists, but are on the front line bearing most of the brunt associated with abuse and neglect. Therefore, this informed the decision to conduct research with youth workers and identify if they were at risk of STS.

Alongside this, another objective of the study was to identify the emotional effects of trauma work and if this decreased emotional well-being. Several studies had been conducted on helping professionals which focused on the effect of STS, however knowledge about the emotional effects of trauma work without the presence of STS was not fully understood and therefore displayed a gap in the literature. Due to limited knowledge, this study sought to fill the gap in literature and conduct a qualitative study which would provide real life experiences about working with traumatised individuals and the emotional costs of trauma work. This informed the decision to frame the study from a phenomenological perspective to provide the lived experiences of participants and determine the true nature of trauma work.

Overall findings of the study suggested individuals experienced changes in their cognitive schemas which caused participants to experience emotional and behavioural disturbances as their psychological capabilities were exceeded which reflects McCann and Pearlman's constructivist self-development theory. As they suggested, the self is made up of cognitive schemas which shape how individuals see the world and themselves in it. When trauma is introduced the psychological growth of cognitive schemas are disrupted and psychological capabilities are exceeded. This appeared to occur in the current study.

Reflecting on the results, it is clear youth work is associated with STS and decreased emotional well-being which was correlated with several emotional and behavioural disturbances. The participants experienced several emotional disturbances associated with being

exposed to traumatised youth which significantly implicated their personal lives, demonstrating they are not immune to the effects of trauma work. Prominent findings of the study included emotional disturbances of detachment, suppression, burnout, exhaustion, emotional regulation dysfunction, and depletion, which was in accordance with Figley's (2002) research. Majority of participants experienced emotional disturbances during their time as a youth worker, which severely impacted and disrupted their personal and professional lives. However, despite detachment and suppression being prominent emotional disturbances in the current study, minimal research has explored the effects of these emotional disturbances, highlighting the need for further research to fully understand the development and maintenance of these symptoms. Importantly, emotional regulation dysfunction played an important role in how participants controlled and processed their emotions and it is clear participants experienced emotional regulation dysfunction which led to psychological implications. This result was similar with research by Billieux et al., 2014 identifying dysfunctional emotional regulation occurs as trauma exposure modifies impulsive behaviour and changes implementation of regulation.

Aside from emotional disturbances, participants experienced several symptoms associated with STS including difficulty sleeping, irritability, changes in worldview, social withdrawal, and decreased energy, which was highlighted in research by Hatcher et al. (2011) and Dane (2000). Despite these symptoms being correlated with STS, it was unclear whether the participants experienced these symptoms as a result of trauma exposure or as a result of organisational stressors, though it may have been a combination of both. In the literature review, Osofsky et al., (2008) found organisational stressors including high case load, lack of support and supervision, inadequate resources to meet demands, excessive paper work, shift work and sleep deprivation, can increase susceptibility of STS. The findings in the current study support Osofsky et al., (2008) findings as several factors were recognised as increasing vulnerability and risk and may have caused participants to experience symptoms correlated with STS. This was a prominent finding of the study.

Lastly, the findings revealed numerous factors which increased participants' vulnerability of developing STS as well as decreased emotional well-being and included lack of self-care, minimal professional boundaries, and organisational stressors, increased work load, lack of supervision and resources. Other factors which also contributed to increased vulnerability were countertransference, empathic engagement and personal trauma, which was consistent with research outlined in the literature review.

The findings of the study are comparatively similar to previous research on STS but have also highlighted there are clear emotional disturbances associated with trauma work without the presence of STS which requires further research and investigation. Not only this, but the study has shown that this sample of helping professionals lack the resources, support, and help they need to avoid the adverse emotional consequences of trauma work, and consequently, are experiencing psychological implications. This highlights the need for intervention and prevention to mitigate the psychological implications of trauma work and recognise it as a serious problem to ensure helping professionals are protected. Although it is difficult to completely eliminate the effects associated with trauma work, it is crucial steps are taken which help to build resilience and ensure overall health and well-being is maintained. Further research is required in this area to establish how large the problem is, while individuals working in this area need more education on how to prevent the effects of trauma work.

Recommendations for Minimising Effects

As documented in the previous sections, it is clear working with traumatised young people has emotional, behavioural, and cognitive implications. Research has revealed there are ways to mitigate the effects of trauma work, which can help to decrease vulnerability and reduce risk. In the current study, participants suggested several coping strategies which they employed to help relieve stress symptoms and manage their emotions. These included self-care, taking time to relax or participate in an enjoyable activity, exercise, meditation, cooking, and reading. Research (Osofsky et al., 2008) has suggested there are two ways to implement

prevention; personal and organisational. Personally, individuals can try and recognise symptoms related to STS and try to reduce or prevent the symptoms from escalating. From an organisational perspective, this may involve implementing strategies or procedures which help to minimise and prevent the effects of STS for staff which may be achieved through education programmes, workshops, and supervision. The next section will discuss recommendations for minimising the effects of STS and decreased emotional well-being from a personal and organisational perspective.

Personal Implications. Self-care is a central part of being an effective worker and is crucial in the helping professional setting (Figley, 2002). Negative health related problems can affect psychological well-being as noted throughout the study and if unrecognised can cause long-term adverse effects. Several participants in the study noted coping strategies which helped to mitigate emotional distress and comprised of exercise, taking time off work, and meditation. Figley (2002) recommended several self-care strategies to maintain overall health which included regular exercise, healthy eating, social activities, and regular sleeping patterns. A supportive network was also considered crucial such as having personal connections with a supervisor or colleague and, as revealed in the findings of the current study, lack of supervision and support was a key factor which increased vulnerability and risk. Wagaman et al. (2015) suggested individuals may find it useful to address and identify one's own familial, emotional, and spiritual needs, to help maintain overall health. The authors also stressed the importance of finding a balance within life. For example, a balance between home, work, self, and others; and a balance between physical self, emotional self, and spiritual self. The researchers also recommended various other techniques for self-care such as: progressive relaxation, physical activity, journaling dreams, imagery, appropriate diet, and seeking involvement in activities which bring pleasure.

Research has suggested therapy and education can also help to reduce and prevent the harmful effects of working with traumatised individuals (Bercier & Maynard, 2015, Hatcher et al., 2011; Osofsky et al.,

2008; Wagaman et al., 2015). Therapy has been identified as a prevention strategy which helps individuals manage and process emotions or stress related symptoms associated with the effects of STS. Therapy can be conducted on an individual basis or through group therapy which incorporates interpersonal psychotherapy, cognitive behavioural, and psychoeducation (Bercier & Maynard, 2015). Participants in the study mentioned personal counselling helped to reduce emotional distress and enabled them to work through the difficulties of working with youth who were traumatised. Aside from therapy, education about the effects of working with trauma victims has been noted as particularly useful for individuals to understand the triggers and signs of STS. Research has suggested training individuals to recognise the signs and symptoms associated with STS helped to reduce manifestation and development (Hatcher et al., 2011). This is because as individuals became more aware and educated about the risk factors associated with STS they could become self-aware, and get help sooner rather than later.

Osofsky et al., (2008) has suggested a self-administered check list may also be beneficial to assess ones exposure to stressors. The researchers explained the check list was used as a tool to examine the degree to which the individual experiences symptoms correlated with STS and at what level they were experiencing these reactions. The check list helped the individual to recognise what effects are expected when exposed to trauma settings and could encourage individuals to seek help sooner (Osofsky et al., 2008).

Organisational implications. One of the main problems revealed in the current study which increased vulnerability and risk was organisational stressors. Organisational stressors were associated with the development of negative emotional consequences which influenced elements of burnout, exhaustion, and distress. Research (Wagaman et al., 2015; Salston & Figley, 2003; Pryce et al., 2007) revealed organisational implications had a significant effect on the vulnerability of individuals and their susceptibility in developing negative psychological responses such as burnout and STS. Various suggestions have been provided from previous research to help decrease stress caused through the organisational

environment. These include supervision, a supportive culture, and workshops.

As identified in the previous section, supervision was a significant problem which appeared to influence emotional well-being and increase the risk of STS. Supervision within an organisation is noted as a crucial element which would dramatically prevent negative psychological responses (Salston & Figley, 2003). Supervisors help to identify signs and symptoms of distress, and help employees to build resilience to prevent the development of negative psychological effects. Supervision is also important for building a strong supportive culture which has been suggested by research as a crucial way to minimise harm and risk (Bercier & Maynard, 2015; Hatcher et al., 2011). Having a supportive environment has been found to increase the health and happiness of employees and prevents stress (Adams et al., 2004; Leiter & Maslach, 2000).

Aside from supervision and a supportive culture, further implications include addressing shift work and employing workshops. Shift work and workload were recognised in the study as being common problems which increased elements of burnout and distress. Nelson-Gardell and Harris (2003) recommended rotating work assignments and decreasing workloads to reduce stress, as well as encouraging workers to take regular time off for self-care. As recommended by Wagaman et al. (2015) finding a balance between home, work, self, and others, helps to maintain overall health, and if organisations supported this by decreasing workloads and rotating assignments fairly, it would be beneficial to staff and reduce negative emotional consequences. Lastly, organisations could also employ workshops which have been demonstrated as an effective way to deliver trauma therapy (Bercier & Maynard, 2015; Hatcher et al., 2011). Workshops teach individuals how to recognise signs or triggers of STS, as well as methods to prevent STS symptoms, and other psychological conditions.

Strengths and Limitations

The qualitative design of this study incorporated semi-structured questioning to enable participants to give a real representation of the hardships when working with vulnerable youth. The information gathered

recognised the difficulties of working in a fragile environment and the vulnerability of helping professionals. The results yield somewhat bleak findings but recognised more support was needed to protect helping professionals, who are a particularly vulnerable segment of New Zealand's work force. Previous research has found STS is hard to measure, but have noted qualitative studies are able to better represent the effects of working with traumatised individuals.

Strengths. Strengths of the study include using a qualitative approach to demonstrate the effects of working with vulnerable youth, which provided a clear picture of the implications of trauma work. The findings in the current study were supported by previous research and add value to the study of STS. The study recognised there are severe implications when working with a traumatised population and highlighted how this affected psychological well-being.

Another strength of the study was working with a population group where research had yet to be conducted, as well as exploring emotional well-being. To date, it appears there have been minimal studies which focus specifically on the emotional effects of trauma work which are not induced by STS and therefore filled a gap in the literature. The study found emotional effects occurred without the presence of STS, and was a prominent feature noted in majority of the participants. This adds value to the knowledge of emotional well-being and its correlation with trauma work.

Another strength included educating participants on the harmful effects of working with a vulnerable population and recognising youth work as being worthy of research. Several participants acknowledged being grateful research was being conducted in their area as they explained youth workers felt they were often overlooked. Others mentioned they did not know about STS and were now aware of it occurring. Furthermore, participants appeared to appreciate the time to be able to talk about their difficulties and felt their voice was being heard. Lastly, another strength of the study was having participants from four different organisations, as this better represented the general population.

Limitations. The study may have been limited by the nature of questions, which potentially hindered the participant's responses and therefore results. Semi-structured questioning was utilised in the study as this enabled participants to express themselves freely without interference from the researcher. However, on several occasions participants would go off topic, and struggled to provide a relevant answer. This may have happened as the questions were not specific enough and therefore may have prevented certain information being revealed. Questions that participants found most difficult were those focused on STS symptoms. Their responses often failed to identify symptoms which may have been related to STS. Reasons for this could be lack of awareness about the condition, or not recognising their behaviours as being unusual. Questions which were more specific may have possibly provided more concrete answers, however this may have gone against the concept of qualitative research and semi structured questioning.

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APPENDICES:
Appendix A: Ethics Approval

School of Psychology
The University of Waikato
Private Bag 3105
Hamilton, New Zealand

Phone DDI +64-7-856 2889
Facsimile 64-7-858 5132



24 August 2016

Amber Takhar-Stapleton
24A Ludlow Terrace
Totara Vale
Auckland

Dear Amber

Ethics Approval Application – # 16:48

Title: Emotional Well-being and Secondary Trauma in New Zealand Youth Workers

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

Please note that approval is for three years.

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



Prof. Linda Nikora
Acting Convenor
Psychology Research and Ethics Committee
School of Psychology
University of Waikato

Appendix B: Email to Organisations

To Whom It May Concern

My name is Amber Stapleton and I am in the final year of my Masters of Psychology degree at Waikato University. As part of my Master's degree I am required to conduct a small research project to complete the thesis component of my degree. For my thesis I am interested in exploring the topic of emotional well-being and secondary traumatic stress for child/youth workers in New Zealand. The research would seek to identify symptoms of decreased emotional well-being and secondary traumatic stress as well as possible causes. Participants would be asked to discuss their experiences as a youth worker which would reveal possible symptoms and causes of either of the two conditions being researched. Interviews will be semi-structured meaning the participant is the narrator of their own story.

To perform this research, it would be profoundly beneficial if an organisation such as yours would participate. If you would be willing to do so, a recruitment flyer would be provided to your organisation which could be put up in a common area (e.g. staff room) to seek participants for this study. It would be greatly appreciated if the flyer could also be emailed to staff or mentioned in a staff meeting. What I require from the participants is to meet for a one on one interview to discuss the topics of emotional well-being and secondary traumatic stress which would involve a series of semi-structured questions. Information from the interviews would be collected and analysed, and findings will be reported in a thesis document. I would be happy to supply a report of the findings to your organisation.

To perform the interview, I would need a space where the participants feel comfortable which may be at home or at work. If they would like to meet with me at their place of work, I would require a room that is private and free from interruptions. It would be greatly appreciated if you would be willing to lend me a space if needed. But I can understand if this is a limited resource.

The reason why I chose to contact your agency is based on your passion and commitment to vulnerable children. Staff are committed to supporting children, young offenders and their families, demonstrating

their passion for the job which is something I would be privileged to explore. This research does not intend to evaluate the performance of any organisations, but to explore the experiences of youth workers in general.

Ethically, it is important that possible participants not feel obligated to take part. Therefore, I will not report the names of any participants to their employers. If interviews are conducted at their workplace, it might be possible that employers observe who participates. However, the interview can take place at another venue mutually agreed by the participant and researcher


If you are interested in this research, I would be happy to discuss this further with you, in person or via phone or email. Alternatively, if you feel you have all the information you need, I would be happy to post you print-outs of the flyers for you to distribute. If I do not hear from you again I'll assume you don't think you're able to assist with this research, but I thank you for taking the time to read this

I look forward to your response.


Yours Sincerely,

Amber Stapleton

Appendix C: Recruitment Flyer




Participants Needed for Research on Emotional Well-Being and Secondary Trauma in Youth Workers



About The Researcher

My name is Amber Stapleton and I am a Masters student at Waikato University. I am currently completing the thesis component of my degree which requires me to do a small research project.



Participation

Participants needed for this study are youth workers who would be interested in talking about their work related experiences and problems they may have faced or overcome. You may think you haven't experienced any of the above descriptions, but if you have ever felt distressed after interacting with a young person who has experienced trauma, I would appreciate the opportunity to discuss this further.

Why research these topics?

The goal of this study is not to diagnose, but is aimed at exploring emotional well-being and secondary trauma among youth workers. The aim is to identify if symptoms of either condition are present, and examine possible causes. The research may also help to recognise other population groups susceptible to developing secondary traumatic stress, and what impact youth work can have on emotional well-being. By identifying symptoms and causes related to decreased emotional well-being and secondary traumatic stress, individuals may be helped to build resilience and learn to develop protective and coping strategies.

What is required

If you are interested in being a participant in this study, I would like to meet with you for an hour, to discuss your experiences as a youth worker. Your participation can be anonymous and your identity in the study confidential. For your time, you will receive a \$20 Warehouse voucher.

If you are interested please contact me on
0273936757 or e-mail
amber-stapleton@hotmail.com

What is the research about?

Helping others through difficult times can be rewarding but it can also take its toll. Sometimes we aren't aware of how our work can really affect us and what it does to our psychological functioning. Youth workers play a pivotal role in helping children and youth have better opportunities. They become a mentor, a role model and even a friend. Having such close contact with our most vulnerable individuals, can expose youth workers to harsh truths and realities.

Working with children/youth who have experienced trauma or come from backgrounds which have caused them distress, exposes youth workers to the potential harms of decreased emotional well-being and secondary trauma.

This research does not intend to evaluate the performance of any organisations, but to explore the experiences of youth workers in general.

Appendix D: Information Sheet

Participant Information Sheet

Emotional Well-Being and Secondary Trauma Research

My name is Amber Stapleton and I am a student at Waikato University currently completing the thesis component of my Master's Degree in Psychology. I am interested in learning more about trauma and the impact it has on those working with individuals who have may have experienced trauma.

Working with individuals who have experienced trauma can cause problems for the people who are helping them. Working with youth who have experienced trauma or come from backgrounds which have caused them distress, exposes youth workers to the potential harms of decreased emotional well-being and secondary trauma. ***Emotional well-being*** refers to our thoughts and feelings about ourselves and the world. It is an important function of positive well-being and mental health. ***Secondary Traumatic Stress*** is the emotional distress an individual feels from hearing about the first-hand trauma experience of another.

The goal of this research is to identify if youth work is associated with decreased emotional well-being and secondary trauma. I will be looking for symptoms, causes and experiences which would lead to decreased emotional well-being or secondary traumatic stress.

Participation

Participants will meet with me to discuss the topics of emotional well-being and secondary trauma as they relate to youth work. It is expected the interview will require 1 hour, but this depends on the individual's experience. The interview will take place at a time and place convenient for you. All information gathered will be anonymised and only I will have access to raw data. Interviews will be recorded and written notes will be taken.

Please be assured all information will be confidential, and it is your right to abandon the interview at any time

Ethically, it is important possible participants not feel obligated to take part. Therefore, I will not report names of any participants to their

employers. If interviews are conducted at their workplace, it might be possible that employers observe who participates. However, the interview can take place at another venue mutually agreed by myself and the participant.

Risks

Throughout the interview, I am determined to keep risks at minimum. However, it is important you understand the interview will explore the topics of emotional well-being, secondary traumatic stress and experiences you have encountered. I do not want to cause you any harm or discomfort and I understand the topics being discussed can be quite confronting and hard to talk about. You may find it comforting to bring a support person along with you. Please let me know beforehand if you wish to do this.

Throughout the interview you can refuse to answer any question, and stop the interview if you feel uncomfortable. You have the right to withdraw your participation and the information from the interview up to three weeks after the interview takes place.

Benefits

Benefits include being part of a study which may help future youth workers build resilience or protective factors against the development of secondary traumatic stress and decreased emotional well-being. This study may help your organisation, and other organisations working in this industry to recognise the beginning stages/symptoms of either conditions and prevent them from developing.

The study may also help you to understand the feelings you may be experiencing, or help to prevent problems from occurring in the future.

Further Information

For your time, you will receive a \$20 Warehouse voucher as a thank you for being part of this study. You will also be provided a written copy of the information from your interview and if you wish, a summary of the findings from the study.

A consent form will be provided at the beginning of the interview outlining what you need to know about the research and your rights

throughout. This will obtain your consent to be part of the study. A copy of the consent form will be given to you.

If you wish to contact the supervisors over-seeing this research study, please find their details below:

Primary Supervisor	Secondary
Supervisor	
Dr Cate Curtis	Armon
Tamatea	
Email: ccurtis@waikato.ac.nz	
Email: tamatea@waikato.ac.nz	
DDI: 07 837 9207	DDI 7 858 5157

This research has been approved by the University of Waikato, School of Psychology Ethics Committee. If you have any concerns please contact Dr Rebecca Sargisson, phone: 07 557 8673, email: rebeccas@waikato.ac.nz

Help Services

If you find discussing the topics through the interview to be upsetting, I encourage you to please contact any of the services below

Counselling	24/7 Help Line 0800 543 354 http://www.lifeline.org.nz/corp_Home_378_2001.aspx
Depression	Helpline freephone 0800 111 757 http://www.depression.org.nz/waythrough/help+services
Anxiety	0800 ANXIETY (2694 389) http://www.depression.org.nz/waythrough/help+services

If you have any queries or concerns, please raise this with me before your commitment to the study. This can be done by phone (0273936757) or via email (amber-stapleton@hotmail.com)

Appendix E: Consent Form



CONSENT FORM

Research Project: Emotional Well-Being and Secondary Trauma in New Zealand Youth Workers

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 within three weeks after the interview takes place		
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.		
7. I understand the interview will be recorded and anything I say during the interview may be used within the study, unless otherwise specified.		
8. I am happy for the researcher to take notes during the interview		
9. 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.		
10. I wish to receive a copy of the findings		
11. 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 (Dr Rebecca Sargisson, phone 07 557 8673, email: rebeccas@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 F: Interview Procedure

Interview Procedure

Emotional Well-Being and Secondary Trauma – Research Procedure Overview

The interview involves a series of sections to cover all aims of the study, this helps to guide the structure of the interview, while still allowing the participant to narrate their own story.

Sections will include the following:

Section A: Extent of participant work and difficult Youth.

Section B: Work related experiences/lingering effects

Section C: Symptoms of Emotional Well-Being, Symptoms of Secondary Trauma, Timeline of symptoms, intrusive thinking

Section D: Disruption to home life

Section E: Coping Strategies/Protective Factors

Interview Procedure

The researcher conducting the interviews will have had previous contact with the participants through email or a phone call. During this time the researcher would have briefly discussed the purpose of the research and provided an information sheet. Before any interviewing occurs, the researcher will ensure every participant was given an information sheet, and answers all questions and queries.

Interview Proceedings

The interviews will be audio recorded and written notes may be taken. Permission for these proceedings is outlined in the consent form (Appendix B).

Step 1: As the participant arrives, introductions are made and the participant is offered a seat and water.

Step 2: The researcher will go over the goals of the study and reiterate the right to withdraw from the study within a three-week time frame of the interview taking place. The researcher will also highlight the participants right to refuse answering of any questions.

Step 3: A written consent form will be given to the participant to read and sign.

Step 4: Once consent is given, the researcher will ask the participant if they are ready to begin. Upon permission to start the interview, audio recording devices (laptop and mobile phone) will be turned on.

Interview Begins:

“As you saw in the information sheet I emailed you when you first contacted me and the research aims we just discussed, this study is concerned with emotional well-being and secondary trauma in New Zealand youth workers. I choose this group because there appears to be minimal knowledge about the impact youth work has on employees, particularly emotional well-being and secondary trauma. Previous research that has explored these areas have done so with counsellors, psychologists and social workers, so there is a gap on other groups who could experience these conditions which brings me here today and I really appreciate your willingness to be part of this. This interview is not me asking you a series of yes or no questions, instead is more of a discussion and conversation about the work you do here and experiences you have had. It is more of a general overview of being a youth worker, and you are not required to discuss any emotions or reveal details about specific youth in depth. Please be aware, I am not a trained clinical psychologist or counsellor.

Section A

“So to start with tell me about the work you do here? For example what role you play in helping them and so forth.”

Section B

“There are different causes for decreased emotional well-being and secondary trauma, you may have experienced some symptoms of these conditions without realising. So what experiences have you had as a youth worker which you think have had an emotional impact on yourself? These could be things such as particular young people you have come across where you have learnt things about them, or they have told you about themselves/their lives or past which may have affected you.

Prompts

“And what did you feel when you heard about this?”

Section C

“From the experiences you have discussed can you tell me about the impact on your life?”

Prompts

“Did you feel this way for a long time?”

“when did you start to experiencing these feelings?”

“Did it get worse with time or slowly disappear?”

Section D

“Through your time as a youth worker, have there been times where work has effected your personal life? For example, not wanting to socialize with friends or decreased sense of energy, social withdrawal difficulty sleeping, or changes in appetite”

Section E

“When things get a bit tough or you had a hard day how do you cope with this? Is there anything you do at work or at home to cope with tough situations or coping strategies you may use? “

Prompt

“Tell me about your support system personally and professionally? “

“From when you started as a youth worker, to now, have you noticed any changes in yourself?”

Closing the interview

“Ok it seems as though we have covered everything, I really appreciate you discussing all this with me it has been very helpful. Is there anything else you would like to say?”

Present voucher to participant, and sign for it. Let the participant know they are welcome to a copy of the interview notes and get contact details for sending.

Turn off all audio devices, thank and finish.