Vicarious Trauma and the Role of Professional Supervision: Strategy for Historic Claims Staff

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Abstract

The Historic Claims process of the Ministry of Social Development in Aotearoa New Zealand aims to settle claims from adult survivors who experienced serious abuse whilst in State Care. The Historic Claims staff hear, support and assess the claims of claimants. Their roles involve listening to details of traumatic experiences of physical, mental, emotional, and sexual abuse. The purpose of this research was to explore the role of professional supervision in potentially preventing or mitigating vicarious trauma for Historic Claims staff. This research set out to answer the question of whether Historic Claims staff experience vicarious trauma as part of their professional duties. Additionally, this research explored the role of professional supervision as a support procedure to mitigate against vicarious trauma for Historic Claims staff.

A rapid narrative literature review was conducted to determine the potential impacts of consistent staff exposure to sensitive and disturbing historic claims of abuse. This research also investigated whether this impact could be defined as vicarious trauma, the benefits of professional supervision for Historic Claims staff as well as alternative and similar measures to mitigate the harms of vicarious trauma. A total of 86 articles were reviewed for this research with a condensed format that typically summarises the content of each article. Articles were inductively grouped together to present key findings.

Key findings included interchangeable definitions and use of vicarious trauma, secondary traumatic stress, and burnout. Findings from this research hypothesised that Historic Claims staff are more likely to experience vicarious trauma due to increased exposure to graphic details of traumatic experiences as reported by claimants. Empathic listening and witnessing claimant distress as they retell their experiences of emotional, mental, physical and/or sexual abuse can also have disturbing and upsetting impacts for Historic Claims staff. Several factors have been identified in this study that mitigate vicarious trauma along with the benefits of professional supervision to include cultural supervision.

Implications: The research has important implications for Māori and Pacifica people who are over-represented as claimants. Cultural supervision is an important factor in Aotearoa as well as areas to improve the effectiveness of professional supervision. Māori and Pacific models of trauma and health were also explored in the context of Aotearoa New Zealand. Traditional western focused approaches do not consider well enough Māori and Pacific ideologies of health and the historical context. Cultural competence and context are critical for trauma work, specifically for Historic Claims staff where the majority of claimants identify

as Māori and/or Pacific Island descent. More research is needed to explore and protect trauma workers from undergoing psychological trauma that potentially affects client care.

Approaches to manage vicarious trauma included debriefing, accepting support from each other, engaging in more energy-fulfilling activities, eating well, staying hydrated and prioritizing sleep hygiene. Measures to guard against vicarious trauma included awareness and education, increasing self-awareness to prevent burnout, organisational support and professional supervision.

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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signed:

Teagan Martha Marieta Tunupopo Date: 8th April 2022

Fa'asinomaga – Identity

"O le tagata ma lona aiga, o le tagata ma lona fa'asinomaga"

Every person belongs to an aiga (family) and every aiga belongs to a person

- Alagāupu (Samoan proverb)

My father is Neville Moore and hails from the villages of Vaivase and Faleāpuna in Samoa. His father is Leniu James 'Jim' Moore, and his mother is Muliagatele Georgina Thomsen – they are Samoan and also of mixed Irish and German heritage.

My mother is Joan Kasileta Gabriel and hails from the villages of Alamagoto and Falelima. Her father is Alphonse 'Lucky' Gabriel, and her mother is Palepa Pereira Gabriel who are Samoan and have mixed German, Tokelauan and Tuvaluan heritage.

I was born in Samoa and raised in west Auckland, and I am the eldest of four – my siblings are James, married to Kristine with their son Avery, and the youngest siblings Thomsen then Gabrielle.

As well as my family and culture, my faith is a core component of my identity.

"I have been crucified with Christ and I no longer live, but Christ lives in me. The life I now live in the body, I live by faith in the Son of God, who loved me and gave Himself for me" – Galatians 2:20 (New International Version).

Acknowledgements

E fa'afo'i uma le vi'iga i le Atua – all the praise goes back to the Lord God Almighty - and my Lord and Saviour Jesus Christ. Thank the Lord for being the ultimate healer and protector.

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Thank you to my Peace Chapel West church family – thank you for your prayers and for the privilege of serving alongside you.

Fa'afetai tele lava to my siblings James, Kristine, Tj & Gabrielle for your testimony and inspiring hustle – alofa tele atu – much love to you all.

I would like to acknowledge my beloved grandparents especially my inspiring Mama Gina and late prayer warrior Mama Palepa for their sacrifice, faith and drive.

Grateful to my Mama Gina for paving your own way and encouraging us to take on every opportunity – this next one will be for you Mama. You are the captain of your ship, and master of your fate in the Lord.

To my parents Neville and Joan for your hard work, sacrifice, and selfless love. For raising me to dream big and persevere – fa'afetai tele lava – thank you so much, mai le taele a lo'u fatu – from the bottom of my heart.

And to my fui husband Nathan for your never-ending prayers, support and inspiration – just like our name is on this paper. we did it pele. Through Him. Thank you, my love.

Chapter 1: Introduction

Se'i fono le pa'a ma ona vae.

Let the crab take counsel with its legs.

- This alagāupu (Samoan proverb) advises us to think things through before we take action; let the people talk first before a decision is made.

Historic Claims staff in Aotearoa New Zealand (hereafter referred to as New Zealand) hear and assess the claims of those who have been abused in State Care – with details of physical, emotional, mental, and/or sexual abuse. Historic Claims staff alike interview, hear and assess claimant's recounts of traumatic experiences with empathy, compassion and theoretically varying degrees of responsibility, helplessness and control (Winter, 2018). For the purposes of this research, a parallel will be drawn between social workers, therapists, trauma workers and Historic Claims staff. The highlighted similarities in the nature of their work with vulnerable communities will allow research on vicarious trauma with social workers, therapists, and trauma workers to be reviewed and utilised. There is little research on Historic Claims staff in New Zealand to review and build on in this specific area and thus a call for more research to be done in this area.

This research set out to review contemporary discussion of supervision as a form of staff development and how it may provide support, training, monitoring and evaluation to Historic Claims staff. It also set out to investigate how professional supervision may help to address and/or prevent vicarious trauma in the related fields. Originally this research was going to address the following questions:

I. Is there an impact on Historic Claims staff as a result of interviewing claimants about the abuse they experienced in State Care?
II. Could this impact be defined as vicarious trauma?
III. Would professional supervision better support staff wellbeing in their roles, as assessors and claimant support, at Historic Claims?

Unfortunately, the planned qualitative semi-structured interviews with Historic Claims staff could not go ahead. There is sensitivity around the nature of the work with claimants especially as Historic Claims sits with the New Zealand government's Ministry of Social Development (MSD). Initial approval to interview staff was withdrawn by the Historic Claims management following heightened and numerous public calls for changes within the MSD system. This may likely have included the work of the Royal Commission of Inquiry into

Abuse in Care. There is a Royal Commission of Inquiry looking into what happened to children, young people and vulnerable adults in State and faith-based care in Aotearoa New Zealand between the years 1950 – 1999. The Royal Commission will make recommendations to the Governor-General in 2023 on how New Zealand can better care for children, young people and vulnerable adults. In addition, findings from the Waitangi Tribunal's WAI 2575 report (2019) concerning Te Tiriti o Waitangi will further inform processes for Historic Claims at the Ministry of Social Development in the future.

After a miscommunication in the unit, the planned interviews with staff could not proceed and an application for ethics approval was withdrawn as a consequence. Due to these unforeseen circumstances, the research approach and questions were reframed and addressed by completing a rapid narrative literature review. A rapid narrative literature review was chosen due to the time constraints and time remaining to complete the research. By completing a rapid narrative literature review, the identified research issue refocused its attention on the literature as an investigation method.

In what manner could Historic Claims staff experience vicarious trauma as a result of consistent exposure to interviewing and assessing claimants who experienced abuse in State Care?

What are the potential benefits of professional supervision and similar measures for Historic Claims support staff in their roles as assessors and claimant support?

After the researcher's interest in the topic and position is discussed, the key terms of trauma, vicarious trauma and professional supervision will be defined and introduced here before they are explored further in this research.

Researchers interest in the topic and positioning

My interest in the topic has come about because of both my professional and personal life experiences. I was fortunate to work with vulnerable youth communities as I studied at and after I graduated from university. While working with youth for Police it was mandatory that I have professional supervision from someone externally qualified to do so. I found this immensely helpful with practical strategies and coping mechanisms. Professional supervision helped me to not take work home and balance my personal life with work life stressors. I had worked as a Claimant Support Specialist for Historic Claims at the Ministry of Social Development for approximately a year and a half. I was keen to research if there was any potential vicarious trauma experienced by Historic Claims staff and the role professional supervision may have in mitigating or reducing vicarious trauma. I was born in

Samoa and raised in West Auckland, so I am also interested in finding out if there is any research or literature on Pacific and Māori models of trauma.

I am a female Pacific Islander with mixed European heritage who has worked in the trauma space and personally experienced trauma. When I was working for Historic Claims, I began receiving professional supervision halfway through my time there. By stating this I know that any bias, presumptions, or conflict of interest can be stated clearly for the readers knowledge. Bias has been defined as the lack of objectivity and can be seen as a threat to a study's credibility, as an ethical issue and as potentially hidden from a researcher's knowledge of self (Roulston & Shelton, 2015). This bias will be managed by examining my subjectivity and reflecting on how this shapes the research process (Preissle, 2008, as cited in Roulston & Shelton, 2015). Such reflection on practice and self-examination throughout the life of this research is thought to constitute what has widely been conceptualized as 'reflexivity' (Roulston & Shelton, 2015). Critical self-reflection has taken place of the ways in which my social background, assumptions, positioning, and behaviour may impact on the research process (Roulston & Shelton, 2015). This process and learning of critical self-reflection were aided and implemented by my professional supervision received while at Historic Claims as well as my supervision with Dr Alayne Mikahere-Hall as my academic supervisor for the research.

Gilgun (2008) shares how her working definition of reflexivity involves the idea of awareness – those researchers are reflexive when they consider the influences, they have on research processes and how those same research processes affect them and their research. Reflexive engagement while planning, conducting, and writing about research promotes an ongoing, recursive relationship between the researcher's subjective responses and the intersubjective dynamics of the research process itself (Probst, 2015). The term 'reflexive' is used to denote actions that direct attention back to the self and foster a circular relationship between subject and object (Probst, 2015). Research found the benefits of reflexivity included accountability, trustworthiness, richness, clarity, ethics, support and personal growth – beneficial for the integrity of the research process and the quality of the knowledge generated (Probst, 2015).

To be self-aware has provided a framework for processing, renewing, and gaining insight both into the research and oneself (Probst, 2015). Self-awareness during the research process was aided by keeping my beliefs and a journal of my experiences, discussing my research in professional supervision through my place of employment as well as discussions with my primary supervisor from the university. These techniques also helped me to reflect as a researcher and ensure reflexivity to be able to remain critical of the research. Reflexivity

has also proven to be a useful tool for managing the research experience as it serves as a way to work through surprising or upsetting issues and thus, I can avoid becoming side-tracked or emotionally depleted – a way to normalize one's reactions by putting them into context (Probst, 2015). These surprising issues in the research process included changing academic supervisors, having to reframe the research questions, withdrawing the ethics application that was approved conditionally and not being able to officially present findings to the Ministry of Social Development. Practicing reflexivity and self-awareness has aided me significantly and ensured that the research and its process has maintained integrity and balanced perspective.

Trauma

As outlined in a traditional approach to a trauma-informed service system, trauma is usually understood as a single event with profound impact (Harris & Fallot, 2001). This single event labelled as trauma involves actual or threatened death, serious injury, serious harm, or a threat to one's personal integrity (Harris & Fallot, 2001). Multiple definitions of trauma have been generated by decades of work in the field of trauma and SAMHSA (Substance Abuse and Mental Health Services Administration, 2014) have combed through this work to develop an inventory of trauma definitions. Subtle nuances and differences in these definitions were recognized but an overall definition of trauma includes the lasting adverse effects on a person's functioning and mental, physical, social, emotional, or spiritual wellbeing, caused by event's (SAMHSA, 2014). 'The Three "E's" of Trauma' have been outlined as including events, experience of events and effect (SAMHSA, 2014). Events and circumstances may include the actual or extreme threat of physical or psychological harm and may occur as a single occurrence or repeatedly over time (SAMHSA, 2014). The individual's experience of these events or circumstances helps to determine whether it is a traumatic event, and the long-lasting adverse effects of the event are a critical component of trauma (SAMHSA, 2014).

Although the SAMHSA definition of trauma has been widely used in the literature, it needs further consideration within a New Zealand context as trauma experiences may also include a collective response, particularly for Māori people (Pihama et al., 2014; Te Pou o te Whakaaro Nui, 2018). A more inclusive definition of trauma was therefore put forward as the lasting adverse effect on a person's or collective's functioning and mental, physical, social, emotional or spiritual wellbeing, caused by events, circumstances or intergenerational historical traumatic experiences (Te Pou o te Whakaaro Nui, 2018). Pihama et al. (2014) found that in the past decade there had been a growth in the use of historical trauma theory in New Zealand while also noting that Māori are grossly over-represented in New Zealand's trauma profiles. The impacts of colonisation have resulted in historical trauma for Māori

people and have been transmitted through generations and are associated with negative health disparities experienced by many whānau (extended family), hapū (sub-tribes), and iwi (tribes) (Pihama et al., 2014; Te Pou o te Whakaaro Nui, 2018). The New Zealand context for trauma will be explored further in this research when looking at Māori models of trauma.

General population studies have shown that a large proportion of people in developed countries have been exposed to at least one traumatic event in their lifetime with estimates from 28 to 90 per cent (Benjet et al., 2016). Exposure to traumatic events is a common experience worldwide with over two-thirds of individuals reporting a lifetime traumatic event (Benjet et al., 2016). The types of events leading to a potential trauma response are varied and research across 20 countries (Stein et al., 2010) indicates common traumatic events include: the death of a loved one (31 per cent), witnessing violence to others (22 per cent), and experiencing interpersonal violence (19 per cent) (Te Pou o te Whakaaro Nui, 2018). Throughout developed countries, other traumatic events such as automobile accidents and natural disasters, appear to be quite similar throughout developed countries (SAMHSA, 2014; Te Pou o te Whakaaro Nui, 2018). Research has also found that exposure to a traumatic event does not occur randomly in the population but varies according to country of residence, sociodemographic characteristics, and history of prior traumatic event exposure (Benjet et al., 2016).

More and more clinicians will be exposed to the demands of providing such services due to the increased prevalence of psychological trauma and the consequent growing needs for support for such clients (Coleman, Chouliara & Currie, 2018). There is a significant impact on clinicians as a result of working with complex trauma as it has been shown to be personally and relationally demanding on clinicians (Coleman, Chouliara & Currie, 2018). Due to war and conflict, people are forced to flee and additionally the unexpected movement of populations as a consequence of extreme weather conditions can be environmentally and psychologically devastating, it can be stated that we live in an increasingly traumatogenic world and thus it is expected that professionals will be increasingly called to respond to individuals and groups suffering from complex psychological trauma (Coleman, Chouliara & Currie, 2018). In those working therapeutically with complex trauma, the risk for vicarious traumatisation is higher (Coleman, Chouliara & Currie, 2018). This highlights the need for a workforce who is trauma-sensitive, trauma aware and trauma-focused as well as the need for a framework for good practice and self-care to support those people charged with the responsibilities and duties of care.

Vicarious Trauma

Vicarious trauma can develop when a practitioner is exposed to the retelling of a traumatic event by a client and it can be much like the experience of a direct trauma (Pirelli et al., 2020). The process of vicarious traumatization has been termed as the persons working with victims then themselves experiencing profound psychological effects that can be disruptive and painful for the helper and can persist for months or years after work with traumatized people (McCann & Pearlman, 1990). Another definition of a vicarious trauma response has been outlined as 'a process in which a clinician experiences adverse alterations in her/his person and professional life as a result of empathic connection with trauma survivors' (Rohan, 2005; Joubert, Hocking & Hampson, 2013). "Victimization has a ripple effect, spreading the damage in waves out from victims to all those with whom they have intimate contact" (Remer & Ferguson, 1995, p. 407).

A thorough review of the impact of trauma on social workers was undertaken using the work of McCann and Pearlman and it was stated: 'As the therapist experiences trauma second-hand, defences such as denial, intellectualization, isolation of affect, dissociation, and projection are employed. These defences serve to protect the self from harmful material, but can also seriously alter a therapist's identity, world view, and sense of spirituality' (Hesse, 2002; Joubert, Hocking & Hampson, 2013). Alterations in schemas and core beliefs resulting from exposure to the trauma of others is what is considered to be vicarious trauma (Ireland & Huxley, 2018). Vicarious trauma has also been defined as what results from empathic engagement with trauma survivors and their trauma material as the negative transformation in the helper, combined with a commitment or responsibility to help the survivors (Pearlman & Cairangi, 2013 as cited in Ashley-Binge & Cousins, 2020). Vicarious trauma will be explored further in the literature review part of this research inclusive of the theoretical conceptualization of the term and process.

Professional supervision

Supervision is considered a central component of professional practice and the importance of supervision has been well documented in social work literature (Joubert, Hocking, & Hampson, 2013). The aim of professional supervision is to provide an on-going opportunity for critical reflection and learning that takes into account the political, organisational, professional, practical, administration and cultural contexts of practice (Beddoe & Egan, 2009). Consideration of the emotional impact of social work practice on the worker is integral to this process of critical reflection (Beddoe & Egan, 2009). Supervision is central to both the development and maintenance of high standards in social work practice (Joubert, Hocking, & Hampson, 2013). There is a focus on both short-term which aligns with the critical long-term objective of providing clients with the most effective and efficient service that the agency is

mandated to offer (Kadushin & Harkness, 2002, as cited in Joubert, Hocking, & Hampson, 2013).

Social Work and Historic Claims

Social work is both a rewarding and a stressful occupation as every day social workers tackle the issues that many of the general public prefer to ignore (Chiller & Crisp, 2012). Also, social workers are often required to work with individuals who do not wish to be helped and who can be aggressive or even violent towards them (Coffey, Didgill, & Tattersall, 2009, as cited in Chiller & Crisp, 2012). This ongoing exposure to trauma and hardship can make social work an emotionally draining and demanding profession (Dollard, Winefield, & Winefield, 2001; Chiller & Crisp, 2012). The Historic Claims staff at the Ministry of Social Development in New Zealand also face ongoing exposure to trauma and hardship as they hear the claimants' experiences of abuse in State Care – physical, mental, emotional and sexual abuse (Winter, 2018). Research will be explored in the literature review part of this dissertation in relation to the Historic Claims process in New Zealand and the parallels that can be drawn between social workers and Historic Claims staff.

Rationale for the study

Reflecting on her investigation into the impact of secondary trauma, Hesse (2002) concluded that for therapists, organizations, and institutions, the key to successfully working with trauma victims is to understanding secondary trauma and the risks associated with hearing traumatic material and finding ways to process and cope with it. Addressing secondary or vicarious trauma is without a doubt, in the best interests of the recipients of our services – our clients (Hesse, 2002). The rationale of the study is the highlighted importance of the effects vicarious trauma can have on trauma workers as well as their colleagues, employees and most importantly – their clients. To gauge how many clients Historic Claims staff in Aotearoa New Zealand would be working with, research by Winter (2018) states that as of 31 December 2017, the Ministry of Social Development had closed 1632 claims and paid 1315 settlements. Professional supervision and similar aspects of the research are explored to find out what may be able to mitigate or prevent vicarious trauma. The literature has been focussed on social workers, therapists and trauma workers alike as there has not been sufficient research on Historic Claims staff in this specific area. The importance of this research is to understand vicarious trauma in relation to Historic Claims staff and formulate a strategy to protect staff in order to also best serve their clients – the claimants.

Purpose of the study

The original purpose of this study was to find out if there was an impact on Historic Claims staff as a result of hearing and/or assessing claimants who experienced abuse in State

Care. The original research questions asked if this impact could be defined as vicarious trauma and whether professional supervision could prevent or address vicarious trauma from the point of view of Historic Claims staff. Unfortunately, research interviews could not be carried out with Historic Claims staff as planned. A rapid narrative literature review has been completed instead to explore the definition of vicarious trauma, secondary traumatic stress, burnout and compassion fatigue. The purpose of the study is to now ascertain from seminal and recent research if vicarious trauma could be what is experienced by Historic Claims staff if their roles are to be likened to social workers and trauma workers. The role of professional supervision and similar related practices in the literature is also explored to find out whether it may mitigate or address vicarious trauma.

Chapter 2: Literature Review

Historic Claims

The New Zealand state reportedly took more than 100,000 children into care between 1950 and 1980 (Human Rights Commission, 2017; Winter, 2018). Those children were placed by the state in a variety of residences including orphanages, group homes, foster care and borstals (Stanley, 2016, as cited in Winter, 2018). Many adult survivors who experienced serious abuse whilst in care are now lodging claims for monetary redress (Winter, 2018). The Ministry of Social Development had settled 1,315 claims as of 31 December 2017 (Ministry of Social Development, 2018, as cited in Winter, 2018). It was observed by the United Nations Committee on the Elimination of Racial Discrimination that the historic claims process “fail[s] to expose the systemic problems’ inherent in the over-representation of Māori, who make up more than half of all survivors” (Winter, 2018, p. 2). It is for this reason and line of thinking that Māori and Pacific models of trauma will be explored as well in this research to better address and serve the claimants in the most effective way possible.

The Historic Claims process

A person can make a claim of abuse or neglect if they were in the care, custody, guardianship, or came to the notice of the Child Welfare Division, the Department of Social Welfare, the New Zealand Children and Young Persons Service or Child, Youth and Family before 1 April 2017 and believe they were harmed as a result of abuse or neglect while in care (Ministry of Social Development, n.d.). A person can start the claim process by writing to the Ministry of Social Development, calling the Historic Claims duty phone line and speaking with a Claimant Support Specialist, completing a form online to register their claim or emailing Historic Claims (Ministry of Social Development, n.d.). The Historic Claims staff compiles relevant information including the period the claimant was in care, locations of abuse and the general nature of any abuse (Winter, 2018). A claimant without legal representation contacts the ministry directly otherwise they can choose to be represented by

a lawyer (Winter, 2018). When a person first makes a claim, staff will go through the claims process with them and answer any questions before putting a request through for their personal files if that is something they would like access to (Ministry of Social Development, n.d.).

The first meeting that takes place between the claimant and Historic Claims staff is for the claimant to tell the Ministry about their experience at a time and place that works for them (Ministry of Social Development, n.d.). These interviews are audio-recorded and can often take several hours (Winter, 2018). The Ministry of Social Development (n.d.) acknowledges that talking about difficult things that have happened in the past can be upsetting so endeavour to make the conversation as simple as possible and maintain respect for the culture and values of the claimants. Claimants are welcome to bring support persons with them to the interview and will be given an idea of how long the claim will take (Ministry of Social Development, n.d.). New claims are addressed chronologically and placed on a waitlist prior to investigation where the object of the ministerial investigation is to establish whether the Ministry had legal responsibility for the claimant's welfare when they experienced abuse (Winter, 2018). The general feedback gathered from reviewing the claimant's file will be given when the assessment is finished and a payment offer may be discussed (Ministry of Social Development, n.d.). Claimants are encouraged to seek legal advice if they wish to do so and an apology from the Chief Executive may be discussed (Winter, 2018). If the offer is accepted by the claimant and included a payment, the claim will be closed once payment has been made whereas if the offer is not accepted, a review of the decision will be carried out (Ministry of Social Development, n.d.).

Through a process that is designed to be equitable, caring and personal, New Zealand's programme helps many survivors obtain a remedy for their injuries (Winter, 2018). Historic Claims staff are committed to being sensitive and helpful and each claim is addressed holistically with a highly individuated approach (Winter, 2018). It is very likely that New Zealand's survivor population is disproportionately affected by poverty, psychological illness and other disadvantages; therefore, it is with good reason to minimise the costs of settlement for survivors (Winter, 2018). Also, while some survivors find that testimony is helpful and therapeutic, many experience exposing very private elements of their personal lives to be arduous and difficult (Winter, 2018). As the historic claims process requires individual and holistic information, survivors must 'relive' past abuse in detail, sometimes on multiple occasions, and this can cause re-traumatisation (Winter, 2018). One interviewee stressed the difficulties involved with the historic claims process, "you've got to articulate all the different things, remember what happened, remember how you felt at that time, the circumstances. Yes, it's awful; very traumatizing" (Winter, 2018, p.16). The problem of re-

traumatization was found in the models in both Ireland and New Zealand, however the process in Ireland was quicker and survivors had more support (Winter, 2018). Staff in New Zealand attempt to make the process congenial and informal to develop a personal relationship with claimants to help address any psychological difficulties, but delays inhibit that relationship and there are fewer external provisions for support (Winter, 2018).

At the time this research was carried out on the Historic Claims process in New Zealand, many of the Historic Claim's staff had social work backgrounds (Winter, 2018). A parallel will be drawn for the purposes of this current research between Historic Claims staff and social workers as to the potential vicarious trauma they may experience. Historic Claims staff support a vulnerable group of people drawing similarities to the vulnerable people social workers support as well. In hearing the traumatic experiences of the abuse claimants suffered while in state care, Historic Claims staff find common ground with social workers who can also be exposed to hearing the traumatic experiences of the people they work with. Historic Claims staff offer support to claimants throughout the process of their claim, which can take a considerable amount of time (Ministry of Social Development, n.d.). The support offered to claimants draws similarities to the support social workers offer to those that they work with. Parallels have been drawn between social workers, trauma workers and Historic Claims staff for the purposes of utilizing research done on social workers in the area of vicarious trauma. There has been no further research done on Historic Claims staff in New Zealand; especially in the area as to whether Historic Claims may experience vicarious trauma in their professional roles.

Social Work and Trauma Related Work

Social workers work with the most vulnerable of clients who are suffering from the effects of trauma and working with these clients can also be painful for the social workers trying to help them (Dombo & Gray, 2013). Social workers in protective services aim to help maintain the welfare of clients from vulnerable populations as they fulfil vital roles in our society to do so (Singer et al., 2020). Vulnerable populations include adults, elderly, children, and intellectually and developmentally disabled. Protective service workers are susceptible to experiencing burnout, secondary traumatic stress and vicarious trauma as a result of interacting with clients who have experienced some form of trauma (Newell & MacNeil, 2010; Singer et al., 2020). As such, protective service workers for adults, elders and children are exposed to the traumatic event(s) their clients experience, repeatedly hearing the victims' account of the event(s) (Singer et al., 2020). Individuals might experience secondary traumatic stress and vicarious trauma as the psychological responses upon indirect exposure to another person's traumatic event, for example hearing about a traumatic event (Versola-Russo, 2008). This posits that workers in in the trauma field including the Historic

Claims support and assessment staff are vulnerable to experience vicarious trauma as they hear more than once the details of another person's traumatic event(s). Historic Claims staff repeatedly hear the victims' account of the event(s) and may experience vicarious trauma upon indirect exposure to another person's traumatic event as suggested by research (Versola-Russo, 2008).

Vicarious Trauma

The term 'vicarious trauma' first appeared in McCann and Pearlman's seminal article in 1990 as the concept became increasingly accepted and used (Ashley-Binge & Cousins, 2020). A framework for understanding the effect of trauma work on the practitioner and on the student is what is provided by the concept of vicarious traumatization (Cunningham, 2004) and it is for this reason this seminal article has been included in this research. It was from the empirical study of secondary trauma amongst disaster workers, firefighters, and family members of trauma victims that this concept evolved and developed theoretically with considerable empirical support (Cunningham, 2004; Schauben & Frazier, 1995). McCann and Pearlman (1990) stated that despite practitioners having advanced degrees and training, they are not immune to the painful images, thoughts and feelings associated with exposure to their clients' traumatic memories. These reactions can occur as a short-term reaction to working with particular clients or long-term alteration in the practitioner's own cognitive schemas, beliefs, expectations and assumptions about self and others (McCann & Pearlman, 1990). Persons who work with victims and are exposed to their traumatic experiences may themselves experience profound psychological effects and McCann and Pearlman (1990) termed this process 'vicarious traumatization'.

It is stated that there is a constructivist foundation that the cognitive portion of the theory is built upon with the underlying premise that human beings construct their own personal realities through the development of complex cognitive structures used to interpret events (Epstein, 1989, as cited in McCann & Pearlman, 1990). As individuals interact with their meaningful environment, these cognitive structures evolve and become increasingly complex (McCann & Pearlman, 1990). These cognitive structures were described as schemas and include beliefs, assumptions and expectations about self and world that enable people to make sense of their experience (Piaget, 1971, as cited in McCann & Pearlman, 1990). An extensive review of the literature on adaptation to trauma and later elaborations of this work revealed fundamental psychological needs: safety, dependency/trust, power, esteem, intimacy, independence and frame of reference (McCann & Pearlman, 1990). The cognitive manifestations of psychological needs are schemas and McCann and Pearlman (1990) hypothesized that trauma can disrupt these schemas and the unique way trauma is experienced depends on which schemas are central for the individual.

Dependency/Trust

Therapists who work with victims are exposed to the many cruel ways that people violate the trust of other individuals, and as if often the case with child victims, the ways people can undermine those who depend upon them (McCann & Pearlman, 1990). This may well disrupt the therapist's schemas about trust and as a result, they may become suspicious of other people's motives, more cynical, or distrustful (McCann & Pearlman, 1990).

Safety

Images involving a loss of safety may challenge the therapist's schemas within this area and this will be particularly disruptive if the helper has strong needs for security (McCann & Pearlman, 1990). Therapists who work with victims of rape or other crime may experience a greater need to take precautions against such a violation and clinicians may experience a heightened sense of vulnerability and an enhanced awareness of the fragility of life (McCann & Pearlman, 1990).

Power

Persons who have been victimized often find themselves in situations of extreme helplessness and vulnerability (McCann & Pearlman, 1990). Exposure to these traumatic situations through the client's memories may evoke concerns about the therapist's own sense of power in the world (McCann & Pearlman, 1990). In extreme cases, a therapist may find himself or herself experiencing feelings of helplessness, depression, or despair about the uncontrollable forces of nature or human violence (McCann & Pearlman, 1990).

Independence

Trauma survivors often experience a disruption in their need for independence, such as restriction in their freedom of movement (McCann & Pearlman, 1990). For the therapist with strong needs for independence, the identification with clients who have lost a sense of personal control and freedom can be especially painful (McCann & Pearlman, 1990).

Esteem

We use esteem to refer to the need to perceive others as benevolent and worthy of respect (McCann & Pearlman, 1990). Persons who are violated or harmed through the uncaring or cruel intentions and acts of others may experience diminished esteem for other people (McCann & Pearlman, 1990). The helper may also find his or her own view of human nature becoming more cynical or pessimistic (McCann & Pearlman, 1990).

Intimacy

Trauma victims often experience a profound sense of alienation from other people and from the world in general (McCann & Pearlman, 1990).

Frame of Reference

The need to develop a meaningful frame of reference for experience is a

fundamental human need (Epstein, 1989 as cited in McCann & Pearlman, 1990). This need is represented cognitively in part in schemas related to causality, or individuals' attributions about why events occur (McCann & Pearlman, 1990). Similarly, therapists may try to understand why an individual experienced a traumatic event (McCann and Pearlman, 1990). This can become destructive if it takes the form of victim-blaming (McCann & Pearlman, 1990).

Vicarious traumatization is a result of the nature of the material presented by the client and the personality of the practitioner, including their own vulnerability to being affected and the workplace setting (Cunningham, 2004). As outlined above with the different fundamental psychological needs, McCann and Pearlman (1990) stated that the hallmark of vicarious traumatization is the disruption of the clinician's worldview. Exposure to clients' traumatic material over time can challenge the clinician's belief system just as trauma disrupts the sense of meaning one has in the world (McCann & Pearlman, 1990). Pearlman and Saakvitne (1995, as cited in Way et al., 2004) state that perhaps the most distressing aspect of vicarious traumatization is the disruptions in one's worldview as it may affect one's sense of trust, raise concerns about personal safety, result in avoidance of stimuli reminiscent of the trauma and diminish one's view of human nature (Cunningham, 2004). An important part of clinical work is the genuine emotional reactions, and it is the empathic connection with the client that makes the clinician vulnerable to vicarious traumatization (Pearlman & Saakvitne, 1995, as cited in Way et al., 2004; Cunningham, 2004). Some studies have found that the more empathetic therapists have a higher risk of developing vicarious trauma (Ireland & Huxley, 2018). The level of empathic concern may be a factor, but it is about getting the balance correct that is important (Ireland & Huxley, 2018). Vicarious traumatization can be reduced and addressed, although it is an inevitable part of trauma work, thereby protecting workers and ensuring effective clinical practice with trauma survivors (Pearlman & Saakvitne, 1995, as cited in Way et al., 2004).

Research has found that therapists who work with traumatized clients over an extended period may begin experiencing similar symptoms to their clients (Ireland and Huxley, 2018). These symptoms include intrusive thoughts, nightmares, difficulty in managing intense emotions and feeling helpless and vulnerable (Ireland & Huxley, 2018). There have also been reports of physical symptoms by therapists such as headaches, nausea, body aches as well as psychological symptoms, such as emotional numbing, hypervigilance and feeling discouraged and cynical (Ireland &Huxley, 2018). Some others report that they begin to feel shame as they experience negative symptoms of vicarious trauma, losing trust in their own ability (Ireland & Huxley, 2018). As theorized initially as well, some therapists report

disruptions in their own schemas, such as viewing the world as less safe (Ireland &Huxley, 2018). The likelihood of experiencing symptoms of vicarious trauma can increase if therapists are exposed to trauma material that was vivid or graphic, or the therapist shares traumatic re-enactments with clients (Ireland &Huxley, 2018; Weaks, 1999). The presence of any continued threat to the client, the extent to which the traumatic event violated the therapist's existing schemas, and the predictability, or unpredictability of the event, are all factors that could increase the individual's likelihood of developing symptoms if those factors are present (Weaks, 1999, as cited in Ireland & Huxley, 2018).

These symptoms were found to consequently impact on both personal and work relationships (Weaks, 1999, as cited in Ireland & Huxley, 2018). It was noted that therapists with child clients who have been sexually abused became more protective of their own children, and experienced intense fear of sexual abuse occurring in their family (Lonergan et al., 2004, as cited in Ireland and Huxley, 2018). Brady et al. (1999) found that at the description of cruelty of some human behaviour, the faith and own sense of meaning and hope for the therapist can be challenged and this damage is considered to be one of the more dangerous threats to the individual's wellbeing. Vicarious trauma can also have organisational effects. Vicarious trauma that goes unaddressed can lead to short-term and long-term emotional and physical effects, strains on relationships, substance abuse, burnout and shortened careers (Weaks, 1999, as cited in Ireland & Huxley, 2018). As staff become unable to give the quality of care needed these effects can negatively impact the organisation as a whole (Ireland & Huxley, 2018). Burnout also leads to a high staff turnover which means organisations continuously look for replacements and have to train new staff (Ireland & Huxley, 2018).

A qualitative study explored the impact of working with domestic violence on clinicians who treat high numbers of such clients (Iliffe & Steed, 2000, as cited in Canfield, 2005). Although health professionals have the qualifications and training for trauma counselling, researchers concluded that those health professionals are not immune to the effects of hearing about peoples' traumatic experiences (Canfield, 2005). All study participants reported feeling horrified at times by what they had heard, almost half felt they were no longer shockable having heard so many disturbing stories of interpersonal violence and most experienced visual imagery of what they had heard (Canfield, 2005). Nearly all of the participants reported that they think visual images of severe violent incidents heard in their work will stay with them forever (Canfield, 2005). There was a range of physical responses including a general feeling of heaviness, churning stomachs, nausea and feeling shaken, while others felt sadness and anger (Canfield, 2005). Participants reported that it was particularly difficult

to hear about violence when children were involved (Iliffe & Steed, 2000, as cited in Canfield, 2005).

Trauma History

Research indicates that a high proportion of mental health practitioners have a personal history of trauma (Elliot and Guy, 1993, as cited in Cunningham, 2004). Maltreatment history (including any maltreatment, physical abuse, neglect and emotional neglect) in the therapists themselves was significantly associated with increased disruptions of schemas (VanDeusen and Way, 2006, as cited in Ireland and Huxley, 2018). However, a factor in this may be whether they have resolved any personal distress that may link to this opposed to their own experiences of maltreatment as it was noted that emotional neglect in the clinicians was particularly associated with more disruptions in cognitions about intimacy with others (VanDeusen and Way, 2006, as cited in Ireland and Huxley, 2018). However, contradictory results have been found, and some researchers conclude that clinicians with maltreatment history in and of itself was not significantly associated with vicarious trauma (Creamer and Liddle, 2005; Way et al., 2004) and other factors may be if such history continues to be a stressor or not (Ireland and Huxley, 2018).

Based on the framework by McCann and Pearlman (1990), cognitive schemas necessary to adapt to the traumatic material might already be altered and more susceptible to the development of vicarious trauma if social workers have their own personal trauma history (Michalopoulos and Aparicio, 2012). According to the framework, if similar client traumatic material may bring up unresolved issues for clinicians and they are not prepared, self-schemas will be disrupted and they will feel helpless with an increased sense of vulnerability in relation to both the client's and his or her own trauma history (Michalopoulos and Aparicio, 2012). This is expected to have serious consequences on the social worker's well-being as well as on the therapeutic relationship and will result in the development of vicarious trauma (Michalopoulos and Aparicio, 2012). Conversely, social workers without a trauma history will be less at risk for developing vicarious trauma symptoms as they are able to successfully integrate their client's traumatic material because their self-schemas of power and control as well as safety and trust are not disrupted (McCann and Pearlman, 1990; Michalopoulos and Aparicio, 2012).

Māori models of Trauma

Māori models of trauma and the historical context of Māori in Aotearoa New Zealand is very important in and of itself, but also because of the over-representation of Māori who constitute

more than half of all survivors in Historic Claims (Committee on the Rights of the Child, 2016, as cited in Winter, 2018). Māori models of trauma would be significant to explore and implement as well as the historical context of Māori in Aotearoa New Zealand. Research by Winter (2018) found that at the time there were no Māori staff in the Historic Claims unit, yet despite advisors holding interviews on marae and incorporating Māori tikanga in interviews, the overall process lacked Māori input and character. The individualistic and legalistic character of the process is likely to be incompatible with the whanaungatanga of some Māori survivors and was the subject of a 2017 complaint to the Waitangi Tribunal (Winter, 2018; Te Mata Law, 2017).

Historical Trauma Theory is unique in that it focuses on the collective and multigenerational trauma of colonisation from an Indigenous worldview as it conceptualises Indigenous distress in response to colonisation (McGregor, 2020). Contemporary Indigenous health disparities is linked to the process of colonisation through biological, psychological, and socio-political pathways with the Historical Trauma Theory (McGregor, 2020). The Historical Trauma Theory was developed by Maria Yellow Horse Brave Heart and DeBruyn (1998) and was informed by literature that examined the trauma experiences of Jewish Holocaust survivors. Historical trauma has clinical features similar to post-traumatic stress disorder (PTSD) but which are built upon three unique features; collective-felt trauma, intergenerational transmission of trauma, and unresolved grief and loss (Brave Heart & DeBruyn, 1998). As set out by Braveheart (2000 | 2003) five assumptions that underpin Historical Trauma Theory were identified:

1. The trauma is inflicted intentionally by the dominant group;
2. The trauma was inflicted for individual and collective gain;
3. Traumatic processes are sustained over a long period of time and often condoned on a socio-political level;
4. The trauma is experienced as a collective over multi-generations and is exhibited as a collective response;
5. The trauma has significantly impacted the projected ‘life course’ of the affected population which is manifested in various domains in society

Puao Te Ata Tu (Day break) The Report of the Ministerial Advisory Committee on Māori Perspective for the Department of Social Welfare

This seminal piece of work has been selected and included for its commentary on the Māori Perspective for the Department of Social Welfare. The task of the Māori Perspective Advisory Committee was to advise the Minister of Social Welfare on the most appropriate

means to achieve the goal of an approach which would meet the needs of Māori in policy, planning and service delivery in the Department of Social Welfare (The Māori Perspective Advisory Committee, 1988). The Committee's report, Puao Te Ata Tu (day break) (1989) identified institutional racism reflected in the Department of Social Welfare and in society itself (Rangihau, Manuel, Hall, Brennan et al, 1989). The recommendation was to "attack all forms of cultural racism in New Zealand that result in the values and lifestyle of the dominant group being regarded as superior to those of other groups, especially Māori" (Rangihau et al., 1989).

They also identified a number of problem areas which included policy formation, service delivery, communication, racial imbalances in the staffing, appointment, promotion and training practices and suggested essential changes to be made urgently (Rangihau et al., 1989). The Department provides a social work service for individuals and families under stress, with particular emphasis on the care and control of children (Rangihau et al., 1989). At the time there were about 10,000 children either under guardianship or supervision by the Department and they also operated a wide variety of social work programmes, ranging from full-time residential care to preventive work with families and community groups (Rangihau et al., 1989). The Committee also studied policies and practices in the social work field and have commented on desirable changes in the Children and Young Persons Act (Rangihau et al., 1989). The Committee stated that at the heart of the issue is a profound misunderstanding or ignorance of the place of the child in Māori society and its relationship with whānau, hapu, iwi structures (Rangihau et al., 1989). Changes are equally important in the area of this legislation as well as in the operations of our courts, of our policies and practices for fostering and care of Māori children and of family case work for Māori clients (Rangihau et al., 1989).

The Department of Social Welfare, since its inception in its present form, has been concerned at the disproportionately high numbers of Māori in the welfare system compared with the general population (Rangihau et al., 1989). In 1975, the Joint Committee on Young Offenders found that the Māori were over-represented in lower socio-economic groups and other government and non-government reports in the space of a decade have demonstrated that the relative socio-economic status between Māori and non- Māori has remained unchanged for many decades (Rangihau et al., 1989). Educational and economic under achievement by Māori people has been reflected in increased crime rates, poor infant and life expectancy rates, high unemployment rates and low incomes (Rangihau et al., 1989). All these factors have led to increasing pressure on the Department of Social Welfare and on its benefits and social work programmes (Rangihau et al., 1989). Concern has grown at the

high numbers of young Māori in the Department's institutions and those who make up its social work caseloads (Rangihau et al., 1989).

The Committee decided to undertake their task by first listening to the community by travelling around the country to meet the Department's clients in a marae setting, believing that an oral approach to their work was the traditional approach of Māori people to which they would respond (Rangihau et al., 1989). Written submissions were also invited as a total of 65 meetings were held on marae, in institutions and Department offices were the Committee spoke to staff, to community workers, to young people and to judges who sat in the Children and Young Persons Court (Rangihau et al., 1989). The messages from the discussions and consultations were all the same – messages of frustration, anger and alienation though frequently flavoured with hope, unfulfilled expectations, pride and aroha (Rangihau et al., 1989). For example, key decisions have been made with little consultation with Māori people and inappropriate structures and Pākehā involvement in issues critical for Māori have worked to break down traditional Māori society (Rangihau et al., 1989). This has been done by weakening the base – the whānau, the happy, the iwi so it has been almost impossible for Māori to maintain tribal responsibility for their own people (Rangihau et al., 1989). In proposing a strategy to achieve a Māori perspective for the Department, the Committee believe they cannot ignore the lesson of history: that Māori must be involved in making decisions that affect their future and this means direct involvement in Social Welfare policy, planning and service delivery at the tribal and community level (Rangihau et al., 1989).

The Committee also grappled with the question of racism and considered its many faces, having considered historical issues and the events which gave rise to them (Rangihau et al., 1989). Racism is belief or practice based on the assumption that one race, culture or ethnic group is inherently superior or inferior to another and may be fuelled by fear, injustice, insecurity or religion (Rangihau et al., 1989). Racism may be propped up by economic advantage or simply age-old prejudice of one group against another group and in New Zealand it has been considered in three broad forms: personal racism, cultural racism and institutional racism (Rangihau et al., 1989). Personal racism manifested by attitude or action is the most obvious form and the one most easily confronted whereas cultural racism is manifested by negative attitudes to the culture and lifestyle of a minority culture or the domination of that culture and its efforts to define itself by a power culture (Rangihau et al., 1989). The most insidious and destructive form of racism is institutional racism as it is the outcome of monocultural institutions which simply ignore and freeze out the cultures of those who do not belong to the majority (Rangihau et al., 1989).

The Māori Perspective Advisory Committee (1988) sees Biculturalism as the appropriate policy direction for race relations in New Zealand as it is considered the essential prerequisite to the development of a multi-cultural society. When applied to the functioning of the Department of Social Welfare the Committee interpret biculturalism as the sharing of responsibility and authority for decisions with appropriate Māori people (Rangihau et al., 1989). Biculturalism involves understanding and sharing the values of another culture, as well as understanding and/or preserving another language and allowing people the choice of the language in which they communicate officially (Rangihau et al., 1989). The Māori Perspective Advisory Committee (1988) also stated that biculturalism means that an institution must be accountable to clients of all races for meeting their particular needs according to their cultural background, especially in the case of Māori.

In terms of institutions, the Committee noted that the great majority of residents of Social Welfare institutions are Māori, and a good number are of Pacific Island descent (The Māori Perspective Advisory Committee, 1988). The Māori Perspective Advisory Committee (1988) have a responsibility to make sure that the needs of children and young persons are properly catered for and that as many of them as possible are placed on the path to rehabilitation. The Committee have been impressed by the success of some institutions which have tackled their responsibilities by trying to re-establish the tribal identities of the young people under their care (The Māori Perspective Advisory Committee, 1988). The Committee think that the Department must respond to the challenge from the communities and be prepared to entrust them with more responsibility for the operation of the institutions and its resources (Rangihau et al., 1989). During their visits to the institutions, the Māori Perspective Advisory Committee (1988) were concerned to find that many of the young people there did not know their tribal identities and believe this is a matter that must be addressed urgently. When tribal identities have been established, the question of how many can be released to the care of their hapu can be examined and by directing resources at strengthening the hapu/iwi kinship ties then placements with direct kin will have a greater chance of success (Rangihau et al., 1989). Finally, the Committee also sees value in an institution establishing cultural enrichment programmes for young people in its care and it is important that such programmes should be appropriately funded so the young people can be taught about their heritage: history, culture, language and the nature of their tribal grounds (Rangihau et al., 1989).

The Meihana Model

The Meihana model was created using the foundations of the well-documented Māori health model, Te Whare Tapa Wha, it was initially published in 2007 and described six components of the model introducing a concept referred to as Māori beliefs, values and experiences which overlaid the six components (Pitama et al., 2014). The analogy of a waka hourua (double-hulled canoe) was developed to describe the elements of the Meihana model, their interactions and to assist with visual presentation of the model, see Figure 1 (Pitama et al., 2014).

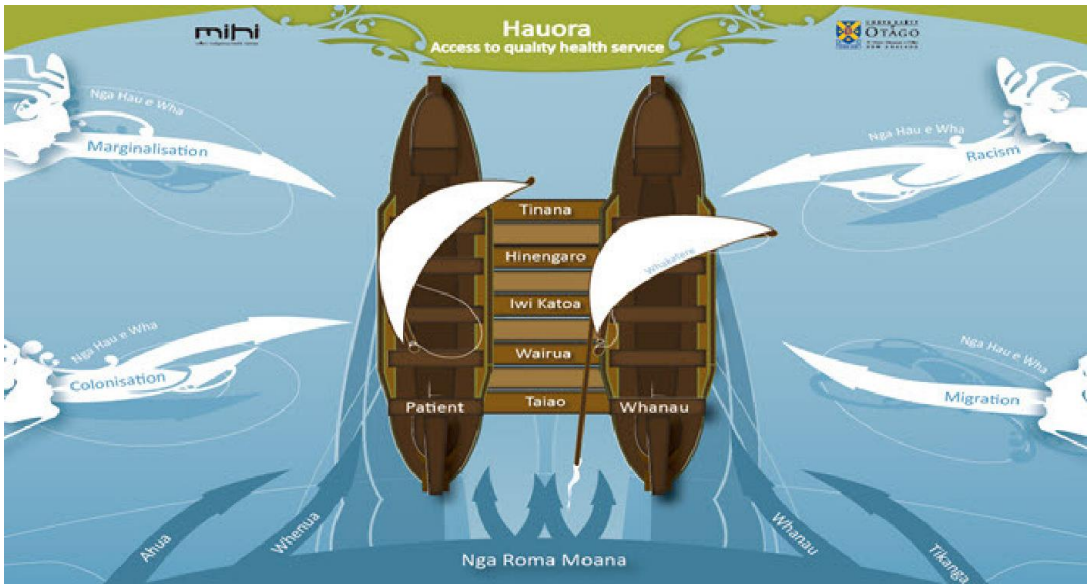

Figure 1. Diagram of the Meihana model. Reprinted from “Improving Māori health through clinical assessment (Pitama, Huria & Lacey, 2021): This development of the Meihana model uses the components of the waka hourua and factors that can affect this voyage to summarise the breadth of information that may be required to fully understand a Māori patient’s health status (Pitama et al., 2014). The waka hourua was the traditional mode of transport used in the migration of Māori from Hawaiki to Aotearoa New Zealand, therefore this analogy draws on a voyage of a waka hourua across the moana (ocean) from one destination to another (Pitama et al., 2014).

Figure 1 illustrates the two hiwi (hull) representing the patient and whānau are attached through aku (crossbeams), each voyage is charted towards a destination, for the waka hourua this involves the passage of attaining hauora (health/wellbeing), however the course can be influenced by nga hau e wha (the four winds of Tawhirimatea), nga roma moana (ocean currents) and whakatere (navigation) (Pitama et al., 2014).

Components of Meihana model - Waka hourua (double-hulled waka)

The waka hourua demonstrates the importance of considering both the patient and their whānau in assessment of health (Pitama et al., 2014). Additionally, it is a role of the health practitioner to get onto this waka hourua and become a part of the patient's support network (Kaupapa whānau) for a period of time (Pitama et al., 2014). Developing an understanding of the strength and weakness of each of the aku (cross beams) and its role in the patient's health will be included in assessing the health of a Māori patient (Pitama et al., 2014).

Patient

Defined as a patient identifying as Māori with ethnicity correctly confirmed within the clinical context (Pitama et al., 2014). It should become common places for all patients to be asked their ethnicity within clinical practice and to have this reviewed over time, because the more comfortable a patient becomes in the service, or the more a health practitioner demonstrates cultural competency and safety, the more likely a patient may feel willing to identify as Māori within the service (Pitama et al., 2014). The identification of Māori patients should ensure Māori health services and supports are offered to the patient (Pitama et al., 2014).

Whānau

Defined as support network(s) for the patient as whānau may refer to biological family (whakapapa whānau) and/or other key support people (Kaupapa whānau) who are stakeholders in the patient's health and well-being (Pitama et al., 2014). Whānau often have a key role in establishing collateral history and family medical history so the assessment should also include whana understanding of the patient's condition and their expectations around management and prognosis (Pitama et al., 2014).

Tinana

Defined as physical health and functioning of the patient – this component incorporates the assessment of a standard medical history to draw an accurate profile of the patient's physical status; both past and current functioning (Pitama et al., 2014).

Hinengaro

Defined as the psychological and emotional wellbeing of the patient – this component encourages health practitioners to explore psychological wellbeing but should also include assessment of the patient's concept and perception of their condition and the impact of this on their wellbeing (Pitama et al., 2014).

Wairua

Defined as beliefs regarding connectedness and spirituality – this component identifies the beliefs, values and priorities for the patient/whānau that may impact their engagement with the health system and/or their paradigm of health (Pitama et al., 2014). Health practitioners can begin to explore this by enquiring about spiritual-religious belief and attachments to

people, places and taonga (treasured items) as incorporating this component allows a conversation about religion, death and dying within an appropriate cultural context (Pitama et al., 2014). This is especially important in palliative care and in situations where a lack of connectedness may be a key risk factor (Pitama et al., 2014).

Taiao

Defined as the physical environment of the patient/whānau – this component identifies the importance of gaining a clear understanding of the physical environment of the patient/whānau (Pitama et al., 2014). This includes direct questions of the patient/whānau about their home environment, neighbourhood and workplace health and safety and involves critiquing the service or clinical environment that the patient/whānau are interacting with (Pitama et al., 2014).

Iwi Katoa

Defined as services and systems that provide support for patients/whānau within the health environment (Pitama et al., 2014). An integral part of the assessment process is to identify whether patients/whānau have had appropriate access to services and systems that can improve their broader health context and/or their engagement with the health environment (Pitama et al., 2014). This includes access to mainstream services such as NGOs, Work and Income, screening programmes, Plunket, other primary care services and/or specific Māori health services (Pitama et al., 2014). Exploring current barriers and enabler to accessing services allows the health practitioner to further tailor future care plans for the patient/whānau (Pitama et al., 2014).

Nga Hau e Wha – The four winds

In this analogy these winds impact the journey of the waka hourua to Hauora (wellbeing) as the four winds signify historical and societal influences on Māori as the indigenous peoples of Aotearoa New Zealand (Pitama et al., 2014). Knowledge and understanding of these winds assist in providing the appropriate context for Māori health in a colonised society and encourages the health practitioner to reflect on how these winds have influenced their perception of Māori patients/whānau /community (Pitama et al., 2014).

Colonisation

Defined as both historical and on-going, occurs through the loss of land, political re-organisation and dehumanisation of Māori patients and/or community (Pitama et al., 2014). This component of the model challenges health practitioners to explore poverty, socioeconomic status, employment conditions, access to quality education opportunities, appropriate housing and financial ability to engage in the health system (Pitama et al., 2014). Health practitioners should also consider the context of contemporary political events, which

foster the inclusion or alienation of Māori communities in the development and implementation of services that may contribute to Māori health gains (Pitama et al., 2014).

Racism

Defined as understanding of the impact of institutional, interpersonal and internalised racism on a patient's presenting complaint/wellbeing (Pitama et al., 2014). Racism has consistently been identified as a key determinant of health as this component encourages the health practitioner to explore the patient's experiences of living in a racialised society, including questions around experiences in which they or their whānau have been discriminated against because they are Māori – this may have occurred in education, health, or community settings (Pitama et al., 2014). Exploring racism with patients requires sensitivity (Pitama et al., 2014).

Migration

Defined as understanding internal migration of Māori from traditional iwi land to other regions within Aotearoa New Zealand, tracking of possible external migration and establishing where their support networks are located (Pitama et al., 2014). This assists the health practitioner to explore connections to whenua (land), where current support networks are located, reasons behind migration and how such events have engaged or disabled access to quality healthcare (Pitama et al., 2014).

Marginalisation

Defined as knowledge of health information which identifies current Māori health status, including health disparities and health gains – it is the knowledge of current Māori incidence, prevalence, morbidity and mortality rates that can influence clinical assessment and practice (Pitama et al., 2014).

Nga Roma Moana – Ocean Currents

Māori navigators understood how the currents influenced seafaring voyages and familiarity with the current influenced the timing of voyages and assisted to plot the course required to reach the destination (Pitama et al., 2014). There are four specific ocean currents around the two larger islands of New Zealand, and these are used in this model to represent four specific components from Te Ao Māori (the Māori world view) that may influence Māori patients/whānau in clinical settings (Pitama et al., 2014).

Ahua

Defined as personal indicators of Te Ao Māori that are important to the patient/whānau – the identification of personalised indicators of Te Ao Māori that are important to the patient and whānau are opportunities to develop meaningful whakawhanaugatanga with the patient and whānau (Pitama et al., 2014). Enquiry of this component helps health practitioners to facilitate patients and whānau sharing more about themselves and validates the patient and whānau as Māori in the clinical setting (Pitama et al., 2014).

Tikanga

Defined as Māori cultural principles – this requires the health practitioner to become familiar with specific cultural principles and how these are enacted by the patient and/or whānau, and how these might be integrated with clinical investigations and practices (Pitama et al., 2014).

Whānau

Defined as the relationships, roles and responsibilities of the patient within Te Ao Māori, including whānau, hapu, iwi and other organisations – identifying the patient and/or whānau role and responsibility in the wider whānau may assist the health practitioner to understand the patient's priorities, values and beliefs (Pitama et al., 2014).

Whenua

Defined as specific genealogical or spiritual connection between patient and/or whānau and land (Pitama et al., 2014). When asking Māori patients where they are from, Māori may respond with the region where they have whakapapa (genealogical connections) rather than the place they currently reside and this place may be a key component of the patient and whānau identity and provides and opportunity to explore with the patient where they are from (Pitama et al., 2014).

Pacific models of Trauma

Constructs related to trauma, traumatic stress, and trauma-based interventions historically have failed to consider the influence of intersectional identities in trauma treatment and recovery as they are largely embedded in European perspectives (Litam, 2020). Post-traumatic stress disorder (PTSD) has been identified in most cultures (Koenen et al., 2017, as cited in Hansford & Jobson, 2021). Despite this, models of PTSD and current psychological treatment approaches have predominantly been developed in Western cultural contexts and emphasize Western cultural norms, beliefs, and values (Jobson, 2009, as cited in Hansford & Jobson, 2021).Understanding trauma and its effects on an individual within their sociocultural context is necessary as this shapes the focus of clinical interventions (Kirmayer et al., 2010, as cited in Hansford & Jobson, 2021) and adaptive responses to trauma may differ across cultural contexts (Pederson, 2015, as cited in Hansford & Jobson, 2021).

Culture is defined as shared learned behaviour and meanings that are socially transmitted in various life-activity settings for purposes of individual and collective adjustment and adaptation (Marsella, 2005, as cited in Hansford & Jobson, 2021). For example, those from individualistic cultures, such as Australia, United Kingdom, United States, perceive the self as independent, unique, valuing individual personal goals and prioritizing self-esteem and

positive emotional states (Hansford & Jobson, 2021). In contrast, there are those from collectivist cultures, such as Asian, South American and African cultural backgrounds, perceive the self as interdependent, related and interconnected with others, valuing loyalty and group harmony, prioritize maintaining connections and building mutual resilience (Hofstede, 2011, as cited in Hansford & Jobson, 2021). Although all people have both independent and interdependent aspects of the self, the dominant self-construal domain is driven by cultural context (Markus & Kitayama, 2010, as cited in Hansford & Jobson, 2021).

Racial trauma refers to the events or danger related to real or perceived experiences of racial discrimination (Carter, 2007, as cited in Litam, 2020). These experiences include threats of harm and injury, humiliating and shameful events, and witnessing harm to other people of colour and indigenous groups (POCI) because of real or perceived racism (Carter 2007, as cited in Litam, 2020). The effects of racial trauma parallel symptoms of other trauma-based disorders and POCI may experience hypervigilance, avoidance, flashbacks and nightmares related to the events of racial discrimination (Comas-Diaz et al., 2019, as cited in Litam, 2020). Healing race-based trauma requires counsellors to consider the intersectional identities that uniquely influence experiences of oppression and discrimination for marginalized groups (Litam, 2020). The nature of discrimination lies within sociocultural contexts because POCI experience race-based stress throughout their lives (Gee & Verissimo, 2016, as cited in Litam, 2020; Comas-Diaz et al., 2019, as cited in Litam, 2020), therefore healing these racial wounds can be difficult.

Secondary Traumatic Stress, Burnout and Compassion Fatigue

The transfer and acquisition of negative affective and dysfunctional cognitive states occurring due to prolonged and extended contact with traumatised individuals is defined as secondary traumatic stress (STS) (Motta, 2012). Secondary trauma has also been defined as a worker's trauma reactions that are secondary to their exposure to clients' traumatic experiences and as the natural behaviours and emotions that arise from knowing about a traumatizing event experienced by a significant other – the stress resulting from wanting to help a traumatized person (Figley, 1995, as cited in Roberts, 2020). Some researchers define this term as differing from the concept of vicarious trauma, yet they are increasingly being used interchangeably, along with compassion fatigue (Creamer and Liddle, 2005). Mental health workers are considered susceptible to secondary traumatic stress and burnout as they are exposed to highly stressful environments (Wagaman et al., 2015). Mental health workers would fit the STS criteria in that they are exposed to client's traumatic experiences, emotions arise, and they may be stressed wanting to help the traumatized persons. The mental health professionals' experiences and the impact of being exposed to the trauma and

distressed responses of their clients is referred to as secondary traumatic stress (Harker et al., 2016; Dinkel, 2020).

Feelings such as exhaustion, frustration, anger and depression characterise burnout and can be defined as feelings of hopelessness and difficulties in dealing with work or in doing your job effectively (Stamm, 2010, as cited in Roberts, 2020). Burnout has also been described as a general emotional exhaustion that professionals may develop over time as a result of various work-related stressors (Way et al., 2004; Ireland & Huxley, 2018). Burnout has also been defined as having three dimensions: emotional exhaustion, depersonalization, and a diminished sense of personal accomplishment (Singer et al., 2020; Newell & MacNeil, 2010). The classification of burnout is a syndrome that is experienced by the professionals through a set of associated symptoms that consistently occur together (Puig et al., 2014; Dinkel, 2020). The individuals' stress experiences from chronic emotional and interpersonal tension that negatively influences the quality of their service delivery is another definition of burnout (Rupert, Miller, & Dorociak, 2015; Dinkel, 2020).

Exhaustion, anger and irritability, negative coping behaviours, reduced ability to feel sympathy and empathy, a diminished sense of enjoyment or satisfaction with work, increased absenteeism, and an impaired ability to care for patients and make decisions characterise compassion fatigue (LeMaster & Zall, 1983, as cited in Roberts, 2020). Compassion fatigue refers to the diminished capacity of mental health professionals to share compassion and empathy for their clients' challenges (Dinkel, 2020; Turgoose & Maddox, 2017). It stems from a lack of fulfilment in serving a clientele resulting in long-term physical and emotional fatigue (Figley, 1995; Singer et al., 2020; Newell & MacNeil, 2010).

Professional Supervision

Research stated in 2011 (O'Donoghue & Tsui) that there had been a growing awareness of the importance of supervision in social service organisations in New Zealand during the last decade. This had been characterized within social service organisations by the development and implementation of supervision policy statements (O'Donoghue & Tsui, 2011). The New Zealand government passed the Social Workers Registration Act in 2003 establishing a system of voluntary state regulations for social workers (O'Donoghue & Tsui, 2011). The Act acknowledges that supervision plays a significant role in the attainment of registration and the maintenance of a registered social worker's practising certificate and proficiency (Hutchings, 2008, as cited in O'Donoghue & Tsui, 2011). According to the social workers policy statement, practitioners must receive at least monthly supervision to maintain a certificate of competence (Social Workers Registration Board (SWRB), 2007, as cited in O'Donoghue & Tsui, 2011). The SWRB's Code of Conduct and Guidelines states that

supervision is so fundamental to providing competent social work services that all employers must provide supervision, even if it requires them to look outside of their own organization for supervisors (SWRB, 2006, as cited in O'Donoghue & Tsui, 2011).

Professional supervision has long been regarded as having three distinct functions that involve management, support, and professional development and generally involve a less experienced supervisee and more experienced supervisor, who meet to discuss the work of the former (Davys & Beddoe, 2010, as cited in Chiller & Crisp, 2012). Supervision can be challenging to define, as many terms – including both professional and clinical supervision – are used interchangeably in the literature (Ducat & Kumar, 2015). Supervision is multidimensional and includes normative, formative and supportive activities including face-to-face sessions, on-site supervision incorporating goal setting, reflective practice, peer support and sharing good practice as well as telephone-based sessions (Ducat & Kumar, 2015). Supervision was mentioned by research participants as being vital and important for their wellbeing, either throughout their careers or at particular points (Chiller & Crisp, 2012). For example, one participant spoke of a growing appreciation of supervision from initially being an addition to her work, to the current time when it has become an integral prioritised part of her practice (Chiller & Crisp, 2012). Early mentors or early learning experiences, or both, were still positively guiding and influencing the practice of participants as some shared how they still remember and utilize advice they had received from early supervisors (Chiller & Crisp, 2012).

Focus group participants of oncology social workers identified the importance of professional supervision in supporting them in their professional practice (Joubert, Hocking & Hampson, 2013). Within an oncology service, social workers work with individuals and families who are confronted with the challenges of a cancer diagnosis and treatment regimes (Joubert, Hocking & Hampson, 2013). As a result of this specialized type of social work, the work with patients and their families has the potential to impact on both professional and personal functioning (Joubert, Hocking & Hampson, 2013). One of the two key components of supervision that were highly valued was supervision that focused on practice with individual patients and their families, and the linking of this to professional social work theories and frameworks (Joubert, Hocking & Hampson, 2013). The guidance provided by supervision to manage the emotional impact of the work on the social worker and support to manage caseloads and organizational challenges was of equal importance (Joubert, Hocking & Hampson, 2013). This research highlights the significance and value social workers place on professional supervision to assist them in their professional practice.

Vicarious trauma was defined by participants of the study as the cumulative effect of their clients' emotional issues on their social work practice and personal lives by their taking on the trauma of their clients' experience (Joubert, Hocking & Hampson, 2013). The results from the study confirmed there is stress associated with the social work role within a cancer service however there was also a high level of job satisfaction from helping and connectedness to others (Joubert, Hocking & Hampson, 2013). The results showed that the social workers in this small sample did not demonstrate they were suffering from PTSD but they reported experiencing transient traumatic emotions in relation to their workplace which included intrusive thoughts, avoidance, numbing and arousal (Joubert, Hocking and Hampson, 2013). All participants in the study acknowledged the importance of regular supervision sessions as professional supervision was seen as an integral component of social work practice (Joubert, Hocking & Hampson, 2013). Reasons for this view included professional supervision providing opportunities for case discussion and reflection, support, and professional development (Joubert, Hocking & Hampson, 2013).

Cultural Supervision

Outside of New Zealand, the term cultural supervision usually refers to cross-cultural supervision, the supervision of supervisees by a person of another culture (Eketone, 2012). A focus on the need for culturally appropriate supervision has been more common in the New Zealand context (Eketone, 2012). In his study of supervision in the community probation service, O'Donoghue (2000, as cited in Eketone, 2012) identified four functions of New Zealand supervision:

- The maintenance of boundaries and ethics
- Protection from unsafe practices
- A form of quality assurance
- Providing reassurance to clients that the people seeing them were competent and accountable

Although he does not mention cultural supervision directly, he did identify those traditional supervisory approaches were not suitable for all social workers (Eketone, 2012).

Pacific social workers are one group who have sought to have their needs, culture and values upheld in supervision (Eketone, 2012). Auatagavaia (2000, as cited in Eketone, 2012) is critical of supervision by Palagi of Pacific peoples but argues that an inclusive model of cross-cultural supervision can come about by the creation of a relationship based on trust and dialogue. A number of Māori writers have also called for culturally appropriate supervision that meets the cultural needs of Māori social workers (Eketone, 2012). Bradley, Jacob & Bradley (1993, p.3, as cited in Eketone, 2012) stated that 'the vital imperatives of

Māori supervision are drawn from a Māori world view – he says that Māori have a set of key cultural values and principles that underpins Māori practice methods and therefore workers need supervisors who are conversant and confident with these values. Recently there has been advocacy for what has become known as a Kaupapa Māori approach to cultural supervision as Tapiata-Walsh and Webster (2004, as cited in Eketone, 2012) advocate for a Kaupapa Māori supervisory approach to ensure the safety, accountability and professionalism of kaimahi Māori that also provides learning opportunities and ensure that social workers are accountable, ethical and professional in their practice.

The Māori social workers said cultural supervision involved someone questioning the cultural appropriateness of your practice and service delivery, looking at how you could have done things better – a time when someone is holding you accountable for cultural safety and it is a place to discuss Māori theories and methodologies (Eketone, 2012). The Māori social worker participants in this research also said that cultural supervision is somewhere where you can get cultural advice for your own protection, a place where you are being encouraged and someone is looking out for you and questioning whether your needs are being met, a place where what you share is heard on a deeper level, from the wairua (Eketone, 2012). The Māori managers said that they saw cultural supervision as a place to ensure the safety of the workers and the clients; a place where staff develop their practice to work more appropriately with clients so that it is safe for whānau and safe for individuals (Eketone, 2012).

The Pākehā managers identified three types of supervision: administrative, professional and cultural (Eketone, 2012). They had a list of what they expected cultural supervision to do that fell into three categories with the first related to the work done with the client – that the client was being treated in an appropriate safe manner, and that issues about the client were being spoken to by someone who understood the cultural relevance and meanings (Eketone, 2012). The second category of expectations was to do with the support and management of the worker as it was seen as a mediation process, where they can vent off frustrations in a safe place, a place to prevent conflicts of being Māori and working with Māori (Eketone, 2012). The third category of expectations for cultural supervision was to help the agency deal with internal conflict in the agency, including liaison over issues of racism within the organisation (Eketone, 2012). They also wanted cultural supervision to uphold the organisation's values and deal with conflict over allegiance to the organisation (Eketone, 2012).

The Māori social workers said that firstly cultural supervision should be available to anyone working with Māori clients; they said that if a Pākehā worker is working with Māori clients

there must be something to make them accountable to make sure what they are doing is appropriate (Eketone, 2012).The Māori managers also said that anyone who wants cultural supervision should be able to get it, with a priority for new social workers so that they learn good practice as they too saw cultural supervision as not only being important for Māori, but anyone working cross-culturally and as essential for people working in the health and justice fields (Eketone, 2012). The Pākehā managers agreed that it should be available for anyone who wants it (Eketone, 2012). All participants saw the primary role of cultural supervision as ensuring the safety of staff and clients (Eketone, 2012).

From the literature and the research Eketone (2012) identified four separate types of cultural supervision, they are:

1. Cross-cultural supervision where supervision takes place between two people of differing cultures
2. Culturally appropriate supervision or generic cultural supervision where supervision takes place with workers working with clients from a different culture than themselves
3. Culturally competent supervision where supervision takes place between people of the same culture (in this case Māori) using that culture's world view, models and frameworks in a manner that is consistent with the context. It examines the approach of the worker in a way that is itself culturally appropriate
4. Culturally effective supervision where the purpose is to support, educate and to protect the worker, looking at the environment and their practice so that they in turn work in an appropriate and safe way with the client

Kaupapa Māori supervision became a natural outcome of specialised professional supervision once the term cultural supervision was recognised as professional supervision and will be explored more in the Findings chapter of this research (Elkington, 2014).

Chapter 3: Methodology and methods

Methodology

The purpose of a literature review is to objectively report the current knowledge on a topic and base this summary on previously published research so the reader is provided with a comprehensive overview and helps place the current information into perspective (Green et al., 2006). Narrative overviews, also known as an unsystematic narrative review, are comprehensive narrative syntheses of previously published information (Green et al., 2006). This type of literature review reports the author's findings in a condensed format that typically summarizes the content of each article (Green et al., 2006). This research method has been selected for its usefulness in pulling many pieces of information together in a readable format and presenting a broad perspective on a topic (Green et al., 2006). The

essence of qualitative work concerns issues of meaning, truth, purpose and the significance of things (Jones, 2004). Narrative overviews are great papers to read to keep up to date, receive continuing education credits and challenge your way of thinking as they deal with more broader issues and constitute an important component in the literature base (Green et al., 2006).

The phenomenological nature of value and its various perspectives and viewpoints make it challenging to develop suitable measurement criteria for evaluation (Ukoha & Stranieri, 2019). This study is partly modelled after the narrative literature review of Ukoha & Stranieri (2019) and similarly tries to make sense of the different approaches and to make relevant recommendations accordingly. As is generally the case with narrative literature reviews, this research does not adopt methodological approaches that would answer specific quantitative questions but instead it uses qualitative methods, using headings and subheadings, to discuss the phenomenon that is the focus of this research (Ukoha & Stranieri, 2019). Exploring the literature in a narrative literature review has consisted of an intertwined combination of searching, evaluating, selecting, pre-analysing and reading the literature (Juntunen and Lehenkari, 2021). A narrative literature review process is iterative, non-structured and multi-layered (Juntunen and Lehenkari, 2021).

Methods

A rapid narrative literature review was conducted to determine the impact of interviewing and assessing historic claims of abuse in State Care on Historic Claims staff, whether this could be defined as vicarious trauma, and the benefits of professional supervision for Historic Claims staff as well as similar strategies to mitigate vicarious trauma. This research method was selected due to the limited timeframe to carry out the research. Much of the time was originally taken to have ethics approval complete for the initial planned interviews, but when that could not be completed this research method was selected to utilize the time and provide a background paper addressing the research issues.

A rapid narrative literature review is a literature review with the following limitations:

Rapid: The scope of search terms was narrowed to a specific set that would yield a manageable number of documents to review within the timeline (Deans, 2020).

Narrative: No meta-analysis of data was made and there is no table outlining all references - a narrative review describes and critically analyses the state of the science on the topic (Deans, 2020).

A working definition of rapid review is that it is a type of knowledge synthesis in which components of the systematic review process are simplified or omitted to produce

information in a short period of time (Tricco et al., 2015). Streamlined methods used in rapid reviews which were utilized for this research included limiting inclusion criteria by date and language and presenting the results as a narrative summary (Tricco et al., 2015).

Although it is not a requirement for narrative review articles to list the types of databases and methodological approaches used to conduct the review, this information is provided to ensure methodological transparency (Ukoha & Stranieri, 2019). A rapid narrative literature review was conducted using the databases from the AUT Library Search engine: Cochrane Library, EBSCO Health Databases, Health and Psychosocial Instruments, Humanities International Index, OVID Databases, PsycINFO, Sage Full Text Collections and Google Scholar.

Keywords in the search in April 2021 included ‘vicarious trauma’, ‘social work’ using ‘AND’ to combine both terms as well, also the keywords ‘professional supervision’, ‘historic claims’ using ‘AND’ with ‘New Zealand’. The search was limited to the English language and articles published between January 2000 and December 2021 to ensure the return of findings that were relevant and current. After each search, titles and abstracts were reviewed. Articles were pulled for full-text review if they reported on the key terms especially if professional supervision was researched regarding vicarious trauma or the social work or trauma work fields. Retrieved articles were culled so that only the articles that were specifically related to vicarious trauma, social work, trauma work and professional supervision remained (Ukoha & Stranieri, 2019). Seminal articles beyond the timeframe were included and utilized especially if they were the original research on the key terms of this research.

The search and screening processes are documented in Figure 2 (Prisma Diagram). The search returned 300 articles after duplicates were removed and abstracts were reviewed for their relevance to this rapid narrative literature review. A total of 86 articles were included in the synthesis. Articles were grouped inductively according to the type of information provided and these groups of articles were then organized accordingly in the findings section of this research: Interchangeable definitions, social workers and professionals in trauma work, social support as a mechanism to address vicarious trauma, factors that mitigate or decrease vicarious trauma, Historical Trauma Theory in Aotearoa, Cultural Trauma, Benefits of Professional Supervision, Cultural Supervision in Aotearoa, Retention of Social Workers and Areas to improve in professional supervision.

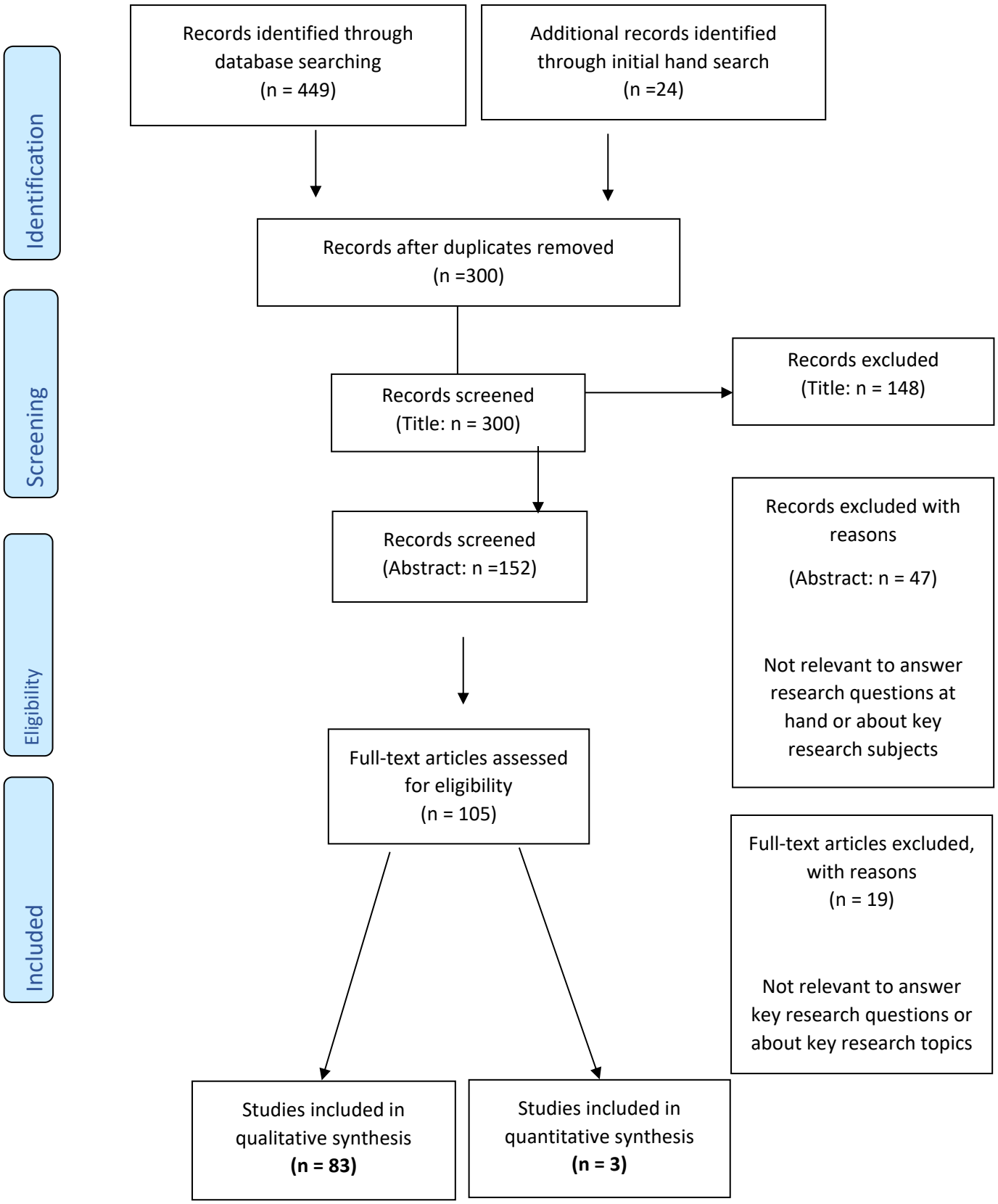

Figure 2. – Literature Prisma Flow Diagram. Reprinted from "Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement," by D. Moher, A. Liberati, J. Tetzlaff, D. G. Altman, The PRISMA Group, 2009, *PLoS Medicine, 6*(7), e1000097, p.3. Copyright 2021 by PLos Medicine

Chapter 4: Findings

Interchangeable definitions

A key finding and theme of this research is that the key terms are often used interchangeably. Vicarious trauma, secondary traumatic stress and burnout have common underlying themes and thus are often used interchangeably: they are psychological responses that stem from working with vulnerable populations and result in decreased productivity in one's professional life (Hayes, 2013; Singer et al., 2020). The conditions of compassion fatigue and secondary traumatic stress have considerable overlap in commonalities with burnout and have been identified as indicators of burnout (Dinkel, 2020). Compassion fatigue is said to sometimes be formerly known as secondary traumatic stress disorder (Figley & Kleber, 1995, as cited in Ashley-Binge & Cousins, 2020) as it refers to the negative though predictable and treatable psychological consequences of working with people who are suffering (Bloom, 2011, as cited in Ashley-Binge & Cousins, 2020). Research suggests that vicarious trauma is seen as a normal response to challenges, but a response that carries with it a cost for the professional (Baird & Kracen, 2006). Challenges for example, the belief in personal invulnerability that allows one to use public transportation at night, or the belief that the world is an orderly place, are challenged by the stories and experiences relayed by survivors of trauma (Baird & Kracen, 2006).

Research has found that due to being exposed to the trauma narratives reported by forcibly displaced peoples (FDP), those working with FDP also experience psychological effects, such as burnout, secondary trauma and compassion fatigue (Roberts, 2020). It is hard to identify in clinicians working within the field of complex trauma the exact prevalence of vicarious traumatization, burnout and compassion fatigue because of differences across countries and settings, differences in definitions and challenges in reporting (Coleman, Chouliara and Currie, 2018). The phenomenon of vicarious trauma has been increasingly researched, yet a more consistent use of the term could help future studies explore the effects on many professions (Versola-Russo, 2005). Secondary traumatic stress is the direct result of hearing emotionally shocking material from clients, while burnout can result from work with any client group (Canfield, 2005). A key aspect which distinguishes vicarious trauma from concepts of burnout or secondary trauma is that it does not reflect weakness or fault on the part of the worker but rather that 'vicarious trauma goes with the territory' (Ross & Halpern, 2012, as cited in Ashley-Binge & Cousins, 2020) and is an inevitable effect of compassionate engagement with others in distress.

Social workers and professionals in trauma work

Compassion fatigue as well as secondary traumatic stress and vicarious trauma is well-documented in child protective service workers and could be particularly relevant to social

workers as well (Singer et al., 2020). Most found in the human services and healthcare fields of the workforce is the concept of burnout and this indicates that mental health professionals are a vulnerable population for experiencing burnout (Parrish, 2017, as cited in Dinkel, 2020). The factors of emotional exhaustion, depersonalization and a diminished sense of personal accomplishment which make up burnout develop in persons employed in emotionally demanding work environments and reduce their capacity to perform their jobs (Wagaman et al., 2015). Compassion fatigue, burnout and secondary traumatic stress can lead to diminished abilities to provide high-quality services and result in impairment on the mental health professionals and thus the clients they serve (Dinkel, 2020). Although the susceptibility of social workers to higher rates of burnout, secondary traumatic stress and vicarious trauma is demonstrated by much research, less is known about how to protect these workers from undergoing psychological trauma that potentially affects client care (Singer et al., 2020). This is an area of research that this literature review tries to address and investigate and is one area that needs further research.

Working in environments where there is psychological trauma and/or mental health issues can be stressful, as some staff can in some instances be exposed to acts of violence (both physical and verbal) and other distressing events, including hearing distressing details regarding the past traumas of their clients (Weaks, 1999, as cited in Ireland & Huxley, 2018). When an individual listens empathically while someone shares the graphic details of their traumatic experience over an extended period of time, it is more likely that individual will experience symptoms similar to that of vicarious trauma or secondary trauma (VanDeusen & Way, 2006, as cited in Ireland & Huxley, 2018). According to the studies reviewed, vicarious trauma is a common experience amongst professionals working in the field of sexual violence and the effects of working with this population can be negative (Chouliara, Hutchison, & Karatzias, 2009). According to most of the reviewed studies, higher levels of vicarious trauma were associated with higher levels of exposure and lower levels of experience in working with survivors of sexual violence (Chouliara, Hutchison, & Karatzias, 2009; Way et al., 2004). A study suggested that counsellors who work with a higher percentage of sexual violence survivors report more disrupted beliefs about themselves and others and more vicarious trauma than counsellors who see fewer survivors (Schauben & Frazier, 1995). It is important to note that symptoms do appear to be vicarious as their symptomatology is related to the percentage of sexual violence survivors in their caseload but not to their own history of sexual victimization (Schauben & Frazier, 1995).

Research also describes empathic engagement with clients' traumatic material (McCann & Pearlman, 1990) as involving bearing witness to graphic descriptions of violent events from a victim's past, exposure to the realities of people's cruelty to one another, and involvement in

past and/or present trauma-related re-enactments (Canfield, 2005). Some reactions of grief, rage, and outrage grow over time as trauma workers hear repeatedly about the torture, humiliation, and betrayal people perpetrate against one another, often those they love the most (Canfield, 2005). Sorrow, numbing, and a deep sense of loss often follow these reactions and clients are not blamed for vicarious trauma, rather it is viewed as an occupational hazard and an inevitable effect of doing trauma work (Canfield, 2005). The Historic Claims process requires individual and holistic information, survivors must relive past abuse in detail, sometimes on multiple occasions and this can cause re-traumatisation (Winter, 2018). From this research and literature reviewed it can be hypothesised that Historic Claims staff may experience vicarious trauma due to listening empathically in graphic detail to the traumatic experiences of their claimants, which can include emotional, mental, physical and/or sexual abuse.

Social Support as a mechanism to address Vicarious Trauma

Researchers asserted that social support is an essential factor in determining one's ability to deal with stress following exposure to trauma (Lerias & Byrne, 2003, as cited in Michalopoulos & Aparicio, 2012). From this it was concluded that social support would predict fewer vicarious trauma symptoms among social workers who are exposed to traumatic material from their clients (Michalopoulos & Aparicio, 2012). In fact, research has indicated social support among trauma therapists is specifically a protective factor against the development of vicarious trauma (Way et al., 2004; Michalopoulos & Aparicio, 2012). However, few empirical studies have examined social support as a predictor of variation in vicarious trauma specifically among a sample of social workers (Michalopoulos & Aparicio, 2012). There was one of the few studies that found perceived social support had a negative relationship with vicarious trauma among a sample of social workers (Adams et al., 2001, as cited in Michalopoulos & Aparicio, 2012). According to McCann and Pearlman's (1990) constructivist self-development theory, and the framework developed by Regehr et al. (2004, as cited in Michalopoulos & Aparicio, 2012), relationships with friends, family, and significant others might prevent the disruption of self-schemas that occurs from chronic exposure to a client's trauma. This knowledge could assist Historic Claims staff to understand the value of their relationships with friends, family and significant others, including a health work-life balance, and how it may help as a protective factor against vicarious trauma.

Factors that mitigate or decrease vicarious trauma

It was asserted that if the clinician is unable to understand and make sense of the trauma their client has experienced using the clinician's existing frame for understanding the world, the clinician will develop vicarious traumatization (McCann and Pearlman, 1990; Michalopoulos and Aparicia, 2012). McCann and Pearlman (1990) went on to state that

chronic exposure to the client's traumatic material could disrupt the specific cognitive schemas that are necessary to adapting and integrating the trauma. Vicarious trauma could compromise the ability of social workers and clinicians alike to provide quality mental health care services to large groups of individuals and communities in need (Michalopoulos and Aparicia, 2012; Dinkel, 2020). The possibility of social workers and clinicians developing vicarious trauma has important public health implications in this regard (Michalopoulos and Aparicia, 2012). It is for this reason that it is critical to understand potential risk and protective factors in the development of vicarious trauma (Michaelopoulos and Aparicia, 2012).

Therapists indicate a key method to mitigate or reduce the potential for vicarious trauma is to educate themselves (Lonergan et al., 2004; Motta, 2012; Ireland and Huxley, 2018). Educating themselves about the field in general and, more specifically, about secondary traumatic stress, allows the trauma worker to understand that this is a common occurrence in the field, and reduces the stress of thinking they are not doing their job correctly if they are experiencing vicarious trauma (Lonergan et al., 2004; Ireland and Huxley, 2018). Training that focusses on self-awareness, emotional regulations, and affective response, both before entering the field and during their working career to mitigate secondary traumatic stress (Wagaman et al., 2015) is considered an effective approach (Ireland and Huxley, 2018). There is an urgent need for developing frameworks for practice that combine knowledge about trauma with the principles of anti-oppressive and emancipatory approaches for the therapists who engage with clients recovering from the aftermath of trauma (Pack, 2010). Self-care techniques, such as regular exercise, eating a healthy diet, taking vacations or taking breaks from work, setting appropriate limits on work time, diversifying their caseloads and limiting the number of particularly difficult cases are further recommended (Motta, 2012; Lonergan et al., 2004; Ireland and Huxley, 2018). Furthermore, having a fulfilling personal life and engaging in a healthy intimate relationship can safeguard the professional's mental health and provide additional support (Neuman and Gamble, 1995, as cited in Ireland and Huxley, 2018). Also, becoming involved in activities that restore a sense of meaning, connection and hope are beneficial (Neuman and Gamble, 1995, as cited in Ireland and Huxley, 2018) for instance, actively participating in religious services was found to predict lower burnout (Sprang et al., 2011, as cited in Ireland and Huxley, 2018).

Social workers with regular support from their superiors, peers and work teams, experienced lower levels of secondary traumatic stress (Choi, 2011, as cited in Ireland & Huxley, 2018). Research also suggests access to social support, both co-worker and supervisor support, may be especially important for an individual's ability and willingness to continue in a job that

takes a significant toll on personal resources (Stalker et al., 2006). Therapists reported that having dedicated time and supervision to discuss their experiences assisted them (Lonergan et al., 2004; Pistorius, 2006, as cited in Ireland and Huxley, 2018). By also offering personal therapy to their staff may give the employees an opportunity to discuss matters of their work and evaluate their own responses to their work and to certain clients (Pistorius, 2006, as cited in Ireland and Huxley, 2018). Another important way to mitigate or decrease vicarious trauma is that the organisation displays a willingness to regularly examine systemic issues that may factor into the likelihood of staff developing symptoms (Brady et al., 1999, as cited in Ireland & Huxley, 2018), and they should further aim to ensure their staff have a mixed caseload that is not too heavy with trauma clients (Pistorius, 2006, as cited in Ireland & Huxley, 2018). Employees should have a suitable work-life balance is a further recommendation (Pistorius, 2006, as cited in Ireland & Huxley, 2018).

Historical Trauma Theory in Aotearoa

Historical Trauma Theory literature is limited within the Aotearoa context (McGregor, 2020). "There is a lack of training programmes that specifically concentrate on cultural competencies and the issues of trauma from an Indigenous and Māori perspective that will increase workforce capability" (Mikahere-Hall, 2019, p. 50). However, Historical Trauma Theory is applicable to Māori experiences of colonisation and support core concepts of Kaupapa Māori Theory when conceptualised in an Aotearoa context (Pihama et al., 2014; McGregor, 2020). Historical Trauma Theory concepts resonate with the colonisation of Aotearoa such as grief for loss of life, land, language and culture, and ongoing systemic oppression which sustains historical loss for the Māori people (Pihama et al., 2014; McGregor, 2020). Pihama et al. (2014) argued that western psychiatry and psychology are unable to fully articulate the experience of colonisation for Indigenous people, but Historical Trauma Theory could (McGregor, 2020). Furthermore, Pihama et al. (2014) argued that Historical Trauma Theory aligns well with Kaupapa Māori Theory as both theories focus on the collective experience of colonisation and analyse historical trauma transmission over multiple generations (McGregor, 2020). In reference to historical trauma and contextualising it within Aotearoa, Hall states:

> “Trauma can be understood to have a whakapapa; this is where unresolved trauma remains nested in the whānau system, where underlying difficulties in everyday whānau life remain in the collective unconscious realities of whānau, hapū and iwi life” (2015, p. 72).

Cultural Trauma

Cultural trauma is a complex conceptual process as it refers to an experience that causes a dramatic loss of identity and meaning in the social fabric of a community; it generally affects groups of people who have already achieved some degree of social cohesion (Bith-Melander et al., 2017). Gomez (2012, as cited in Bith-Melander et al., 2017) developed cultural betrayal trauma theory (CBTT) with a specific focus on minority populations, it implicates societal trauma in the harm of interpersonal trauma. As a framework for examining trauma, CBTT builds upon ethnic minority trauma psychology that has highlighted the importance of incorporating context into examining trauma sequelae (Brown, 2008, as cited in Bith-Melander et al., 2017). CBTT suggests that cultural betrayal in trauma occurs in within-group trauma in minority populations and some minorities develop (intra)cultural trust with known and unknown fellow members of minority groups as a way to protect against societal trauma (Bith-Melander et al., 2017). Results showed the high prevalence of trauma victimization in this ethnic minority sample is in line with previous work that demonstrates that some ethnic minorities are at increased risk for victimization (Bith-Melander et al., 2017). Another study also used CBTT as a framework for comparing the impacts of between-group (interracial) and within-group (ethno-cultural betrayal) trauma on mental health outcomes for Asian American Pacific Islander college students at a predominantly white university (Gomez, 2019). There is compelling evidence for CBTT that adds to the theoretical and empirical work that suggests that cultural betrayal (perpetrator: same ethnicity) is a dimension of harm that can impact outcomes (Bith-Melander et al., 2017; Gomez, 2019).

The Pacific is a unique region characterised by small populations dispersed across island living in high urban density and remote rural villages, with limited human resources and medium to low human development (Phillips et al., 2020). Pacific island countries bear the double burden of non-communicable and communicable diseases, as well as a high rate of trauma and interpersonal violence (Phillips et al., 2020). Pacific Islanders are geographically grouped into three regions: Polynesia (Hawaii, Samoa, Tonga, Tahiti, Aotearoa, Tokelau), Micronesia (Guam, Mariana Islands, Saipan, Palau, Caroline Islands, Kosrae, Pohnpei, Chuuk, Yap, Marshall Islands, Kiribati), and Melanesia (Fiji, Papua New Guinea, Vanuatu, Solomon Islands) (Godinet, Vakalahi & Mokuau, 2019). A number of these Pacific islands and nations have political arrangements with the United States due to colonization and militarization of their home islands (Godinet, Vakalahi & Mokuau, 2019). The intersection of the immigration and colonization experiences has resulted in added complexities in Pacific Islanders' transnational identities, particularly with indigenous people who have been colonized and immigrants who have been treated as less than equal (Godinet, Vakalahi & Mokuau, 2019).

Benefits of Professional Supervision

Several common themes centring on why supervision is useful emerged from participants of this study, with the most pertinent being the ability for supervision to act as a medium through which stresses and concerns can be externalised and explored (Chiller & Crisp, 2012). Supervision was also thought to be an important forum for learning and useful in terms of facilitating critical reflection (Chiller & Crisp, 2012). Other common characteristics of helpful supervision included regularity, discussion, and support as well as being a medium for generating construction challenges and areas for improvement (Chiller & Crisp, 2012). A systematic review defined supervision as a professional development and support tool designed to enhance service delivery, professional practice, and client outcomes (Ducat & Kumar, 2015). Health practitioner professional supervision is one mechanism to support best practice that has been advocated and researched in recent years as it is a working alliance between two or more professional members in which the aim is to achieve a range of goals relating to a) organisational/administrative functions b) clinical practice and c) provision of personal support to the employee (Ducat & Kumar, 2015).

Systematic reviews previously within professional supervision and development literature have investigated supervision within the context of psychotherapists and counsellors, mental health nursing, medical education and social work (Ducat & Kumar, 2015). A key theme has emerged as these reviews generally report that supervision is perceived as positive however rigorous, primary research is needed (Ducat & Kumar, 2015). A recent systematic review identified the following supervision strategies as effective: giving feedback to the therapist, use of audio/video recordings of supervision, use of multi-modal methods of supervision, live demonstrations, use of an agenda and a collaborative approach (Ducat & Kumar, 2015). Other studies focused on individual satisfaction and relationship quality and have shown that clinicians find structured, regular participation where a supervisory relationship is marked by trust, empathy and genuine regard as optimal supervision characteristics (Ducat & Kumar, 2015). The importance of supervisee driven support has also been demonstrated, for example physiotherapists have reported the importance for both supervisee and supervisor to be clear about their purpose and link supervision to professional development and reflective practice (Ducat & Kumar, 2015).

Cultural Supervision in Aotearoa

Eketone (2012) concluded that all four of the identified types of cultural supervision have application for Māori social workers and their clients as cultural supervision is an important part of Māori social work practice. However, it is proposed that culturally effective supervision with its three purposes of the education and support of Māori workers with a focus on the cultural protection and safety of staff and their clients, is the form the most

closely aligns to what Māori practitioners themselves are looking for (Eketone, 2012). If there is an increasing pressure and expectation by agencies, colleagues and clients for these younger Māori workers to work using Kaupapa Māori-informed processes, the need then for appropriate cultural supervision that enables Māori social workers to work confidently and safely will continue to grow (Eketone, 2012).

Once the term cultural supervision was recognised as professional supervision, Kaupapa Māori supervision became a natural outcome of specialised professional supervision (Elkington, 2014). Kaupapa Māori supervision is named according to the value system on which it is based, building on the notion that values, protocols and practices of Māori culture are being adhered to (Walsh-Tapiata & Webber, 2004, as cited in Elkington, 2014). Bi-cultural supervision might refer to the supervision that allows for both cultures to be developed according to competency within each culture to work together (Elkington, 2014). Probably the closest at the moment to bi-cultural supervision is a bi-lingual framework that does not compromise through translation from Māori to English, the Māori concepts of a Kaupapa Māori supervision framework (Elkington, 2014).

The examination of the current supervision situation in various professions has been telling as the investigation of power relations operating here, identifies following key solution areas for constructing ways forward as summarised (Elkington, 2014):

- High visibility of mono-cultural values in models of supervision from western origin
- High mono-cultural awareness and acknowledgement of their contribution to ineffective social service delivery as evidenced by high statistics of Māori service use
- Revival and creation of more Kaupapa Māori supervision models within safe and protected environments
- Appropriate Kaupapa Māori research methodology, particularly of bi-cultural initiatives in Kaupapa Māori, to enable appropriate interpretation and analysis for appropriate development

Some of the tasks identified by Māori for non-Māori to work on and develop, at such time that only non-Māori can decide, included a need for high visibility and self-awareness of mono-cultural values and their contribution to ineffective social service delivery particularly when faced by the high statistics of Māori service use (Elkington, 2014). Some of the tasks identified by Māori for Māori, are the revival and creation of more Kaupapa Māori supervision models within safe and protected environments (Elkington, 2014). Some frameworks might need to use an appropriate Kaupapa Māori research methodology, particularly of bi-cultural initiatives in Kaupapa Māori, to enable appropriate interpretation and analysis for appropriate development (Elkington, 2014).

Retention of Social Workers

The provision of professional supervision can contribute to the retention of social workers in the workforce, both at an agency level and also more generally to retain individual social workers within the profession (Chiller & Crisp, 2012). Presumably, this suggestion by research can also apply to trauma workers in general and Historic Claims staff specifically but more specific research is needed in this area. A lack of resources or the need to respond to ever-present crises at an agency level can readily result in supervision not being prioritised by either social workers or agency management (Davys & Beddoe, 2010, as cited in Chiller & Crisp, 2012). While there will be times when rescheduling or deferring supervision is necessary and appropriate, agencies that value and prioritise regular professional supervision have a greater ability to retain social worker employees (Chiller & Crisp, 2012). The guidance and support of an effective supervisor can contribute to staff retention, even for very experienced practitioners (Vredenburgh, Carlozzi, & Stein, 1999, as cited in Chiller & Crisp, 2012). Individuals are assisted to recognise and respond to the emotional impact of the work (Guy et al., 2008), effective supervisors can also contribute to retention through encouraging their supervisees to undertake a variety of work (Stalker et al., 2007), as well as have regular leave and holidays (Guy et al., 2008) and develop other strategies for dealing with stresses of the job. There have been several recommendations aimed at encouraging retention and foremost among these has been the call to recognise the importance of regular and supportive supervision (Chiller & Crisp, 2012; Stalker et al., 2007).

Areas to improve in professional supervision

While appreciative of the positive impact of supervision, participants still acknowledged that supervision at times was far from ideal, especially the type characterised as unsupportive, bureaucratic, and done in order to tick the box so to speak (Chiller & Crisp, 2012). A total lack of supervision at some stage in their career was also a common experience for the participants in the study as it would often get pushed aside in busy workplaces (Chiller & Crisp, 2012). One participant in the study described how a lack of supervision early in her career had created a considerable amount of stress (Chiller & Crisp, 2012). In another study there was disagreement over functions of supervision including the provision of critical feedback and whether supervision was a performance appraisal tool (Ducat & Kumar, 2015). Barriers in terms of professional supervision including time and clinical load were reported, dual relationships when a practitioner was asked to supervise a colleague who was a friend, increase in documentation, and lack of choice of supervisor (Ducat & Kumar, 2015). Recommendations for improvement within this health setting included the need for more time, resources, consistency, structure, and feedback in regard to the supervision process

(Ducat & Kumar, 2015). Overall, there was general consensus on the benefits of professional supervision, yet the literature also highlighted areas for improvement including improving training to support supervision and the use of innovative technologies (Ducat & Kumar, 2015).

Chapter 5: Discussion and Implications

In 1995, Pearlman & Saakvitne, (as cited in Way et al., 2004, p. 33) stated the following:

> "Unaddressed vicarious traumatization, manifest in cynicism and despair, results in a loss to society of that hope and the positive actions it fuels. This loss can be experienced by our clients, as we at times join them in their despair; by our friends and families, as we no longer interject optimism, joy, and love into our shared pursuits; and in the larger systems in which we were once active as change agents, and which we may now leave, or withdraw from emotionally in a state of disillusionment and resignation."

This quote introduces the concept of the widespread effect vicarious traumatization can have on the people directly effected as well as their social circles, their clients, and larger systems they are located within. Before discussing the implications of the research findings, this quote highlights what could theoretically take place if vicarious trauma is left unaddressed – namely for the Historic Claims staff and their clients and systems they are located within.

Tactics to manage vicarious trauma

Ellen Fink-Samnick of EFS Supervision Strategies, a company that provides professional speaking, training, and consultation to empower the interprofessional workforce, was interviewed and asked what some strategies are to manage vicarious trauma in the workplace (Thew, 2020). She stated that in the first instance healthcare professionals have to give themselves permission to stop, to do things like debrief and they need to be able to accept support from each other which does not imply that they are weak (Thew, 2020). Another suggestion was to limit social media to engage in more energy-fulfilling activities where COVID or other trauma related issues are not talked about (Thew, 2020). Another example is to help shift the narrative to something positive at work for example one emergency department had a 'bring a picture of your pet' day (Thew, 2020). Finally, another strategy is to eat well, hydrate and prioritize sleep hygiene (Thew, 2020).

Awareness

Some research suggests that the foremost measure to guard against vicarious trauma is awareness of the concept so that practitioners can translate the signs they may be experiencing any form of vicarious trauma (Macfarlane, 2020). Education on both vicarious

trauma itself and its manifestations is the first and most important measure to guard against its occurrence (Macfarlane, 2020). In order to have an awareness of emerging symptoms of vicarious trauma, practitioners need to have established solid self-awareness and familiarity with their internal environment; this will allow them to notice changes in thoughts and feelings as early as possible (Macfarlane, 2020). This research also suggests that organisations hold responsibility for creating a culture among their staff where vicarious trauma is part of the daily language and opportunities are created to assess for it and address it when it occurs (Macfarlane, 2020).

It is an important first step and is becoming popular for employers to educate their staff on vicarious trauma and self-care (Macfarlane, 2020). Organisations can cement this first step by providing formal training for all staff on mindfulness practice and other forms of self-care, and then embedding this learning through mandatory, protected time for self-care breaks built into each shift (Macfarlane, 2020). Historic Claims staff should be trained on what vicarious trauma is to raise awareness and learn signs and symptoms of it. As the research has suggested, raising awareness would be key to guard against vicarious trauma (Macfarlane, 2020). This would be the first step in a strategy to mitigate or prevent vicarious trauma. Part of trainings could also include strategies for better self-care, ways to debrief, the use of social media and activities around social wellness and team building (Thew, 2020; Macfarlane, 2020).

Preventative practice

Supervision is a preventative practice identified in almost all the literature as it has long been a significant part of social work practice (Joubert, Hocking & Hampson, 2013; Ashley-Binge & Cousins, 2020). The provision of supervision was the only factor mentioned as both a personal responsibility and a preventative measure that organisations can adopt, notably as a mediator for vicarious trauma (Ashley-Binge & Cousins, 2020). The need for reflective spaces and places for developing and maintaining integrated approaches to practice has been highlighted to mediate vicarious trauma (Hingley-Jones & Ruch, 2016; Ashley-Binge & Cousins, 2020). For supervision to be part of a vicarious trauma prevention strategy, its quality and usefulness to the worker are key, rather than simply its provision (Ashley-Binge & Cousins, 2020). Pearlman and Saakvitne (1995, as cited in Way et al., 2004) suggest that it is crucial to the wellbeing of clients and clinicians to recognize and resolve vicarious traumatization. Based on research and the suggested findings, Historic Claims would benefit from providing quality professional supervision to its staff to prevent vicarious trauma and ensure the best outcomes for the claimants they serve.

There is no universal approach to preventing burnout among social workers (Dollard et al., 2001; Chiller & Crisp, 2012) and presumably no similar approach to prevent burnout among trauma workers including Historic Claims staff. Yet guidelines for qualified psychologists working with refugees in the UK posit that one of the four key issues when working with forcibly displaced populations is the need for supervision, described as a space to share traumatic stories heard from clients and an aid in the prevention of secondary trauma (BPS, 2018, as cited in Roberts, 2020). Following on from this, it may be hypothesised that supervision could be an important factor in the prevention of compassion fatigue, the lack of which may leave workers at a heightened vulnerability to experiencing high levels of burnout and secondary trauma (Roberts, 2020). Due to the hypothesised impact of supervision in the prevention of compassion fatigue, such as burnout and secondary trauma, it is important to understand how these factors interact (Roberts, 2020). Feelings of compassion fatigue is referred to as professional quality of life - the quality one feels in relation to their work as a helper where compassion satisfaction is defined as the pleasure you derive from being able to do you work well (Stamm, 2010, as cited in Roberts, 2020). Social work supervision programs, focusing on improving intervention skills, have been identified as playing a significant role in reducing burnout (Joubert, Hocking & Hampson, 2013).

Furthermore, in a research synthesis, some evidence was identified suggesting that supervision may act as a protective factor against vicarious trauma (Baird & Kracen, 2006; Roberts, 2020). For example, Apostolidou and Schweitzer (2017, as cited in Roberts, 2020) interviewed nine participants working with refugees who identified the importance of supervision as a source of personal and professional empowerment, promoting self-care and protecting practitioners from burnout. Thornberry et al. (2014, as cited in Roberts, 2020) report on the implementation of a supervision model within a palliative care team in a quantitative study, which resulted in increased self-awareness, job satisfaction, improvements in team dynamics and decreased compassion fatigue. This research combined highlights the importance of supervision as a means to offset compassion fatigue and vicarious trauma (Roberts, 2020). Those with high supervision satisfaction reported significantly less secondary trauma and a positive association was found between time spend in supervision and secondary trauma (Roberts, 2020). This is a key finding that has significant implications when applied to Historic Claims staff in terms of mitigating or decreasing any vicarious trauma. Quality professional supervision can be provided for historic claims staff as a preventative practice to offset any compassion fatigue such as burnout and secondary trauma or vicarious trauma staff may experience from their work with claimants.

Preventing burnout

Professionals must learn to distinguish between normal tiredness or tension and the early signs of burnout through an on-going self-assessment process to prevent burnout (Grosch & Olsen, 1995, as cited in Canfield, 2005). Early signs of burnout include sensitivity to and awareness of feelings of dread about going to work, excessive boredom, feelings of flatness or tiredness, and pessimism about the future (Canfield, 2005). Distinguishing between tiredness from other stress and burnout can be difficult (Canfield, 2005). Grosch and Olsen (1995, as cited in Canfield, 2005) state that symptoms of burnout can simply mean that a holiday or change in work-related routines is long overdue. However, they add that if symptoms persist following such interventions, burnout should be diagnosed. Knowledge of the definition and early signs of burnout should be shared with Historic Claims staff so that they can practice self-awareness in identifying early signs. If there is a Ministry policy for staff to take annual leave in order to remain under a certain threshold, this should also assist in preventing burnout by having staff take a vacation, holiday or time off work. A change in work-related routines can also take place if the organisation is open to flexible working arrangements as well as the nature of the workload to be discussed with Team Leaders.

Phases for trauma workers

Research suggests that trauma workers go through several phases as they attempt to constructively manage the aftermath of engagement with traumatic material (Harris, 1995, as cited in Canfield, 2005). The first phase involves attempting to manage the psychological responses immediately following exposure and confronting feelings of secondary traumatic stress (Canfield, 2005). The period of safety is the definition of the second phase during which an individual may or may not experience stress symptoms over an extended period of time (Canfield, 2005). The secondary traumatic stress reaction phase is the third phase where the trauma worker does the mental labour of assimilating the experience into his/her cognitive model of the world (Canfield, 2005). As this is the subsequent phase in which the trauma worker either moves forward toward emotional mobility by successfully integrating the secondary traumatic stress experience, or moves toward emotional immobility if unsuccessful, this third phase is of paramount importance (Canfield, 2005). If integration is successful, in the final phase practitioners effectively assimilate and accommodate the effects of their trauma work (Canfield, 2005). However, if integration is unsuccessful, practitioners develop secondary traumatic stress disorder, which involves their resignation to a victim role (Canfield, 2005). Consequently, survivorship is no longer actively pursued as attempts at integration stop (Harris, 1995, as cited in Canfield, 2005). It may look as if attempts at integration are continuing when this occurs, but these are largely oriented toward

reducing the effects of the victimization rather than toward assimilating and accommodating the material (Canfield, 2005).

If Historic Claims staff can be trained about the phase's trauma workers go through according to this research, their knowledge and awareness will increase accordingly. Specialist training can be provided to Historic Claims support and assessment staff alike for when they encounter, hear and empathize with the traumatic events they hear repeatedly. Experts in the field can help Historic Claims staff to navigate how to recognize and confront feelings of secondary traumatic stress and how to manage the psychological responses immediately following exposure as outlined in the first phase. Knowledge and awareness of stress symptoms will help staff recognize whether they are experiencing them or not in phase two. In the important phase three, experts can help train and guide staff to do the mental labour of assimilating the experience into their cognitive model of the world to move toward emotional mobility by successfully integrating the traumatic experience (Canfield, 2005). This model of phases for this training by experts in the field will aim to help Historic Claims staff effectively assimilate and accommodate the effects of their trauma work with successful integration so they do not develop a secondary traumatic stress disorder or vicarious trauma (Canfield, 2005). The sharing of this knowledge and guidance can be carried out in group training of the staff and/or in one-on-one sessions when staff have their professional supervision.

Organisational support and research needed

Social workers report that the impact of working in a potentially stressful environment requires both the individual practitioners and managers to be aware of the need to provide support to reduce the impact of vicarious trauma (Joubert, Hocking & Hampson, 2013). Staff experiencing vicarious trauma can hinder their colleagues by not being available for consultation or supervision, or by lowering morale by displaying cynicism (Weaks, 1999; Ireland & Huxley, 2018). This cynicism can lead to retraumatizing clients by focussing on their own needs over the needs of the clients, disrupting boundaries such as forgotten appointments, client abandonment, abuse or the client, or professional mistreatment (Weaks, 1999, as cited in Ireland & Huxley, 2018). This will have a negative impact on the professionalism of the organisation and such organisations in this position can then face burnout and shortened careers of their staff, leading to high staff turnover and the need for finding and training replacements (Weaks, 1999, as cited in Ireland & Huxley, 2018). Newer staff members should also be monitored more closely as they are more likely to experience symptoms of vicarious trauma (Neuman and Gamble, 1995, as cited in Ireland & Huxley, 2018; Way et al., 2004). It may be that those who are new to the field require more specialized training on the potential risks of doing trauma work and self-care and such

education should emphasize that vicarious trauma is a normal response to working with traumatized people and is not a result of deficiencies in clinicians (Pearlman & Saakvitne, 1995, as cited in Way et al., 2004). Social workers and other helping professionals are often warned about the effects of burnout in their training, but there is a responsibility for employers to educate and anticipate how the nature of the work will affect their employees over time (Pack 2014).

In order to create an environment that is more likely to reduce or mitigate the effects of vicarious trauma, this area of research can aid with the development or refinement of specific policies for staff (Ireland & Huxley, 2018). Vicarious trauma affects the staff member, the client and the organisation as a whole as the effect is widespread (Ireland & Huxley, 2018). Both the staff member and the organisation have the responsibility to take the necessary steps to reduce the likelihood of developing vicarious trauma or reducing already presenting symptomatology (Ireland & Huxley, 2018). It is imperative that there is a deeper understanding of vicarious trauma due to the severe symptom's individuals can present with (Ireland & Huxley, 2018). Research on vicarious trauma can help to inform staff about ways to detect, prevent and reduce symptoms and it can provide guidance to formulate appropriate policies (Ireland & Huxley, 2018). If vicarious trauma goes undetected, it can have detrimental effects on staff, their relationships with others, the organisation and negatively impact their clients (Weaks, 1999 as cited in Ireland & Huxley, 2018). Beyond self-care and work life balance, organisational response are required to safeguard social workers and trauma workers alike (Ashley-Binge & Cousins, 2020). "All the exercise, yoga and red wine in the world will not ameliorate a culture of bullying, poor quality supervision or unrealistic caseloads" (Ashley-Binge & Cousins, 2020, p. 204).

Cultural context needed for Māori and Pacific models of trauma

The Meihana model builds on the work of other Māori health models and is specifically designed to support health practitioners to gain a fuller understanding of the presenting complaint and the context of the patient and whānau (Pitama et al., 2014). The purpose of the framework is to encourage health practitioners to broaden their range of assessment to provide quality health care and reduce health disparities between Māori and non-Māori (Pitama et al., 2014). This model allows diverse Māori realities within a colonised society to be recognised and responded to as the inclusion of fluid, variable elements that explore societal and cultural influences encourages health practitioners to identify which components are relevant to individual patients and whānau and prioritise such components (Pitama et al., 2014). This not only provides opportunities to explore the presenting complaint but also extends health practitioners to consider wider influences of hauora that may lead to positive health outcomes (Pitama et al., 2014). There is consistent evidence of biomedical, social,

political and cultural factors that contribute to health inequalities of indigenous communities internationally (Pihama et al., 2014). The Meihana model takes into account this research and provides a clinical assessment framework to assist health practitioners working with Māori patients and whānau to contribute to improved Māori health outcomes (Pihama et al., 2014).

In Te Ao Māori, everything has a genealogy or whakapapa as whakapapa is the foundation of mātauranga Māori (Māori knowledge) and Māori society in that it organises all living things and the spiritual realm within the context of the creation story (Salmond, 2017, as cited in McGregor, 2020). It is essential that Māori health is examined within Te Ao Māori because the connection between the past and present is fundamental to a Māori reality and therefore historical contexts are equally as important as contemporary issues when understanding Māori wellbeing (Durie, 2001; McGregor, 2020). The examination of the colonisation of Aotearoa is fundamental to Māori wellbeing given the importance of whakapapa in Te Ao Māori (McGregor, 2020). The significant events of the colonisation of Aotearoa include the land wars, death by infectious diseases, land confiscation and dispossession, and cultural oppression and assimilation – ethnocide (Durie, 2001; McGregor, 2020).

Critical to social work practice is cultural competence as it has been defined as the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services, thereby producing better outcomes (National Association of Social Workers, 2015, as cited in Godinet, Vakalahi & Mokuau, 2019). How cultural competence is conceptualized and realized continues to be a discourse within the profession as varying thoughts and perspectives are considered as relevant to the practice of cultural relevance in promoting social justice and well-being of minorities and the oppressed (Godinet, Vakalahi & Mokuau, 2019). Cultural competence has been criticized by those who argue that the focus on group culture may deter attention from the individual client's unique context, identity and rights (Godinet, Vakalahi & Mokuau, 2019). While this may be a valid viewpoint, supporters of cultural competence argue that focusing on the individual only ignores institutional racism and oppression that plague systems in which clients are served (Fisher-Borne, Montana Cain, & Martin, 2015, as cited in Godinet, Vakalahi, & Mokuau, 2019).

Professional Supervision

Given the increasing prevalence of traumas and the potential impacts, clinicians will need to be appropriately equipped and supported to deal with the associated challenges (Coleman, Chouliara & Currie, 2018). To train, support and supervise clinicians appropriately for this

type of work is crucial and will safeguard patient safety, engagement with psychological therapy, and satisfaction with services (Coleman, Chouliara & Currie, 2018). In terms of research in the field of trauma focussed work, there has been a widely held belief that the work is inherently damaging (Coleman, Chouliara & Currie, 2018; McCann & Pearlman, 1990; Schauben & Frazier, 1995). Based on findings, the provision of supervisee led supervision, rather than a case/line management model, is likely to offer a more supportive environment for clinicians by facilitating a more open exploration of client work and impacts (Coleman, Chouliara & Currie, 2018). The consistency of positive findings in the supervision literature seems to support the fundamental value of professional supervision, yet also highlights the complexity of this area and multiple definitional, process and outcome variables that are not clear (Ducat & Kumar, 2015). Rigorous, high-quality research on the effectiveness of supervision practices and contexts is required, particularly within the allied health professions (Ducat & Kumar, 2015). This call for more specific research in this area is the same for Historic Claims staff in particular as well.

Findings highlight the need to supply a robust professional, well trained, supervised body of clinicians to meet the potentially increasing needs of traumatised individuals worldwide (Coleman, Chouliara & Currie, 2018). This would extend to trauma workers alike including Historic Claims staff. By highlighting the value of specialist training, sensitive recruitment policies, appropriate supervision, and good practice guidelines for self-care, it is hoped that the welfare of the workforce is safeguarded as well as the wellbeing of the vulnerable client group as well (Coleman, Chouliara & Currie, 2018). This is likely therefore to aid the retention of staff and facilitate better satisfaction and engagement with services (Coleman, Couliara & Currie, 2018). Training can also develop active coping strategies such as problem solving, cognitive restructuring, seeking social support and expressing emotions, and this may help staff to avoid depersonalizing clients and may contribute to a stronger sense of accomplishment (Stalker et al., 2006). By implementing a strategy focussed on providing appropriate and effective professional supervision, staff retention and satisfaction will be the result as research has shown, with better quality services for the vulnerable populations Historic Claims staff serve. Trauma work can be rewarding, and growth based if the challenges of this work are well managed on a personal and organisational level with training, practice and supervision (Coleman, Chouliara & Currie, 2018).

Limitations of a narrative literature review

Narrative overviews, also known as unsystematic narrative reviews, were once quite common but are slowly falling into disfavour in some journals due to a lack of systematic methods that should be employed to construct them (Green et al., 2016). The methods used in creating the paper have rarely been divulged to the reader and usually the number of

sources employed to find the literature are incomplete, possibly creating an insignificant knowledge base from which to draw a conclusion (Green et al., 2016). Selection of information from primary articles is usually subjective, lacks explicit criteria for inclusion and leads to a biased review in this rather unsystematic approach (Green et al., 2016). All these potential pitfalls are avoidable if the author is aware of them and takes the appropriate steps to avoid them (Green et al., 2016). To address these limitations in this research, the research methods have been detailed for the reader, as well as the reflection and reflexivity of the researcher to address bias, and a wider range of sources have been utilized to find the literature to draw a more complete knowledge base.

Future Research

Future research is needed in this space of vicarious trauma and professional supervision for trauma workers in New Zealand. There are only a handful of studies in New Zealand in this narrative literature review – seven to be more precise. A number of these research pieces explored cultural supervision and Māori models of trauma and health as well as the historical context in New Zealand for Māori. A key piece of research was on Historic Claims in New Zealand with another key piece of research looking at a culture of professional supervision for social workers in New Zealand. There was also a handful of research on vicarious trauma and Pacific Island models of trauma in Australia, Canada and the USA. However, it should be emphasized that future research is needed to address the gaps in the literature addressing vicarious trauma and the role of professional supervision for trauma workers in New Zealand. It would also be of a significant contribution to further research Māori and Pacific models of trauma and how that translates to work on the frontline for trauma workers. Future research is also needed for Historic Claims staff although this may be difficult to carry out due to the sensitive nature of the topic and issues at hand in New Zealand. The susceptibility of social workers to higher rates of burnout, secondary traumatic stress and vicarious trauma is demonstrated by much research, however, less is known about how to protect these workers from undergoing psychological trauma that potentially affects client care (Singer et al., 2020) and more research is needed in this area for social workers and trauma workers alike.

Closing Remarks

‘Solo i tua ni ao taulia’ – the clouds that are spent are retreating:

Alagāupu/Samoan proverb.

This Samoan proverb is used when a family has just come through an extremely tragic event, but now the clouds are clearing.

“People can and will recover from trauma and we must honour and support their determination and resilience to do so” – Te Pou o te Whakaaro Nui, 2018, p.4.

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