EXPLORING THE VALUE OF ADVERSE LIFE EXPERIENCES OF SOCIAL SERVICE AND SUPPORT WORKERS

by

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ATTESTATION OF AUTHORSHIP

"I declare that this submission is my own work, to the best of my knowledge it contains no material previously published or written by another person, except where this has been defined and acknowledged, nor material which has been previously submitted to any institute of higher learning".

Fiona Mackinnon
23.11.2021

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The research undertaken was made possible by the open-hearted participation of the survey respondents who provided compelling observations of the relationship between adverse life experiences, post traumatic growth and helping professions.

Professionally I would like to acknowledge the comradery, sharing, and acceptance I have received from colleagues both in my current place of work and previous workplaces that contributed to my determination to complete this project.

Lastly, I would like to acknowledge and thank Bruno Anso for his steadfast encouragement and enduring support throughout the undertaking of this project.

Abstract

Social services provide support to benefit the community, collectively they are an intrinsic part of our culture. Numerous international studies have suggested that persons in helping professions such as health and social services have had more adverse experiences than the general population and that these experiences may have in part formed their vocational motivation. This is an area of little research in Aotearoa that I believed worthy of exploration given that I have worked in the sector for decades and had anecdotally identified a reoccurring theme amongst my colleagues and myself of adverse life experiences contributing to our vocational motivation.

The questions that guided this research inquiry were…

- To what extent are adverse life experiences perceived as an underlying motivator for the vocational choices of social service and support workers?
- To what extent are adverse life experiences perceived as contributing to advantageous attributes in social service and support workers?
- To what extent do social service and support workers perceive stigma and professional vulnerability exist as barriers to identifying adverse life experiences in the workplace?

The study was undertaken using a convergent parallel mixed method design. Mixed methods studies are often seen in health and social care research, as both quantitative and qualitative methods are thought to have complementary strengths when undertaken simultaneously, providing deeper insight into the experiences of research participants than either approach alone. Convergent design required both quantitative and qualitative elements to be analysed independently and then interpreted together, this layered approach further supported understanding the experiences of participants.

For the most part respondents commented in the first person when referring to adverse life experiences, suggesting a high incidence of adverse life experiences amongst respondents. Adverse life experiences were considered as influencing vocational choice by numerous respondents; however, it was clear barriers exist to identifying as having had adverse life experiences in the professional context due to fear of stigma and discrimination. Findings suggested there are issues relating to the collective understanding of what ‘recovery’ is that has implications for lived experience workers and those who identified as having had adverse life experiences.

I have recommended that further research is indicated as a means to advance understanding and acceptance of the relationship between adverse life experiences, post traumatic growth and helping professions in the cultural context of Aotearoa and our known societal issues.

The process of practitioner inquiry I believe has advanced my capacity to continue to evolve and develop and remain relevant to the sector and environments I work in. I envisage the enquiry process as having provided an enduring foundation to foster my growth and development on a continuum.

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1.1 Introduction

In this chapter I describe the development of the research project 'Exploring the Value of Adverse Life Experiences of Social Service and Support Workers' alongside my professional framework of practice. This first chapter provides background and context to the project, articulates my practice, and describes why this project is worthwhile.

There is little New Zealand based research regarding adverse life experiences in this professional context. Findings of numerous international studies have highlighted the risks and vulnerabilities attributable to adverse experiences. While recognising the significance of risks to wellbeing identified in existing research this project avoids replicating them. The tikanga value of manaaki underpins this projects approach in that it seeks to be mana enhancing and mana protecting as is reflective of my own practice. Mana enhancing practices are values based, with the end goal being one denominated as a value (Marsden, 2003, p. 39). This also reflects core values of social service provision including integrity, social justice, dignity, and the importance of human relationships.

1.2 Background

When laypersons and experts are asked to comment on how individuals become wise, the resounding answer is 'life experience' (Glück & Bluck, 2011; Jeste et al., 2010). It is thought adverse experiences can push us to reflect on why and how these experiences have occurred. Effectively this process, sometimes called post traumatic growth, can fuel insight, learning, personal growth, and behaviour change. This project is change seeking, with the intention of increasing understanding and acceptance of the extent of adverse life experiences and post traumatic growth amongst those who work in the social services sector.

My interest in the motivations of people to work in social services originates from both working in these services on and off for over 25 years and as a periodic service user myself. These experiences have prompted me to question what motivates myself and my colleagues: How did we get here? Why are we here? Why do we remain?

Apart from a passion for supporting others, why I keep coming back and why I remain is the comradery often present within the workforce. I have developed strong connections to many colleagues over the years. The shared experience of providing support in sometimes challenging circumstances I believe supports the potential for building connection and trust between workers.

Over the years colleagues who I share a connection with have exchanged parts of their stories with me. Often this has included mutual acknowledgement that similar experiences existed between many of us. For the most part these reoccurring themes reflected common social issues, with family violence being the dominant theme.

From 2019 to 2020 I worked on a project developing a services practice framework that included consideration of future development of lived experience roles (alternatively called ‘peer’ roles) within an organisation that did not have these roles at the time. Lived experience refers to a representation of the experiences of a given person, and the knowledge that they have gained from these experiences. Often a lived experience or peer worker has had similar experiences to persons who use the service they work for. These experiences may include recovery from homelessness, family violence, trauma, mental health issues and addictions. Additionally, such roles can include other lived experiences not considered within the context of a recovery orientation such as disability, hearing or sight impairment. The lived experience approach seeks to purposefully apply personal experience to a professional role to benefit those who use the service.

During this time my curiosity grew in consideration of knowledge, wisdom, and skills that workers may have developed through their own adverse life experiences. How could this be better understood and utilised? The stories colleagues had shared with me over the years now took on new relevance.

1.3 Social services Aotearoa

A wide range of social services support New Zealanders; these services are an integral part of our society that are ingrained in our culture. These services are often going unseen unless we require them, or we work in them. Services are focused on individuals, families, and communities, and are delivered by a range of government agencies, non-government organisations, communities, and businesses (MSD, 2014).

A social service is not defined by who is delivering it but what the service is for, service areas reflect the multi-faceted nature and depth of human support needs. Service areas include (but are not limited to) health, disability, income, employment, housing, food insecurity, care and protection and residential care.

The sector's workforce broadly reflects the layers of support that may be required to meet support requirements. Workers' titles vary, reflecting the kaupapa of their work and services they work for, these titles may include, social worker, youth worker, key worker, peer support worker, case manager, support worker, nurse and much more.

For the purposes of this research, I have applied the term social service and support worker in the broadest sense to ensure I am inclusive of all those in helping professions regardless of whether they are, for example, a registered social worker, support worker, key worker, peer support worker, youth worker or care worker. The social service and support sector is also considered in the broadest sense to capture all areas of social services inclusively.

Loosely speaking, support workers are often the persons who support the well-being of others in their day to day lives. These workers may hold a certificate level industry qualification but most likely not a degree level qualification related to the service area. There are many workers within the sector who are skilled and experienced who do not hold qualifications as this is not always a prerequisite. On the other hand, social workers and case managers are generally the persons who facilitate and coordinate access to services who most often have degree level qualifications related to the service area. Social workers are subject to mandatory registration and annual practicing certificate renewal with their registering body the Social Workers Registration Board New Zealand. This follows changes to the

Social Workers Registration Act that made registration of all social workers mandatory from February 2021.

In the early 1800s government officials from New South Wales, London, and British missionary societies with the aim of protecting Māori from the worst effects of European colonisation, decided to set up Christian missions in New Zealand (Derby, 2011). Missions represent the origins of social services in New Zealand. Good people, doing good work, however what was good for Māori was notoriously decided for them and done to them as Māori were considered by the colonisers as vulnerable and in need of protection. Today Māori continue to be overrepresented as service users and underrepresented within the sectors organisational structure and workforce.

1.4 Adversity?

The term adversity in the context of this project is referencing *The Childhood Exposure Study* often referred to as the Adverse Childhood Experiences or ACE study, conducted by the US Kaiser Permanente Health Service and the Centres for Disease Control and Prevention. Study participants were recruited between 1995-1997 and continued to be followed to study their long-term health and wellbeing outcomes. The study demonstrated an association between exposure to adverse and traumatic experiences in childhood and social and health problems throughout life. Adverse childhood experiences researched were divided into specific categories including direct abuse, neglect, family violence, witnessing abuse and neglect and having household members who have experienced, mental illness, substance abuse or incarceration. The ACE study could be perceived as having a deficit-based approach, one historically used in helping professions to consider vulnerability and risk in relationship to identifying and addressing social and health problems.

The original ACE study and numerous subsequent studies have focussed on childhood adverse experiences as these experiences have obvious significance to how a person develops. For the purposes of this project adverse life experiences across a person's lifespan are considered relevant to the research questions.

1.5 My practice

Currently I live and work in Tāmaki Makaurau. I have worked in the social services sector in a multitude of roles and geographic locations within Aotearoa, Australia, and the United Kingdom. The foundations of my practice are trauma informed, values and strengths based; pivotal to this is a respectful partnered approach to my practical work. Fundamentally, this approach applies the core belief that everyone has strengths, and that supporting mobilisation of these strengths is key to building hope and supporting change where change is sought. I believe that all persons can be experts of their own situations, which sits well in the context of this project.

I am at present a Specialist Youth Worker in a residential setting with a national charitable trust that seeks to improve the lives of rangatahi involved with care and protection and youth justice systems. The rangatahi within our care most often have complex needs relating to exposure to trauma and adversity. This role is very much 'on the floor' having found my previous teaching role unsustainable alongside completing this Master of Professional Practice.

In completing a Bachelor of Social Services undergraduate degree with the Otago Polytechnic Capable program in 2019, I articulated my framework of practice using the visual context of a human body, this represents a rational human approach to my practice. The presentation of vascular and nervous systems displays in a naturalistic manner the organic interconnectedness and interdependency of the key elements within the framework.

The context of head, heart, hands, and feet relate to the theoretical model of social pedagogy and its application in social care. This is reflective of a blend of academic knowledge, practical wisdom, and research skills (head), an understanding of emotions, ethics, values, and principles (heart), practical skills and activity (hands) the environments I am in, and where I feel I belong (feet) all utilised interconnectedly to support the people I work with to reach their full potential. There is a natural association between my framework and 'Te Whare, Tapa Whā' the holistic model of health and wellbeing created by Mason Durie (1985) in that balance within dimensions serves to illustrate balanced practice.

I am a humanist, valuing the agency of human beings, individually and collectively. I approach theory with a curious mind, most often finding the common-sense parallels that exist between theories, approaches, and practice wisdom. I prefer critical, evidence based rational thought and prize equality and social justice. Social pedagogy itself is a series of ethical and moral underpinnings and considerations about the inherent value of all human beings (Eichsteller & Holthoff, 2011). Social pedagogy resonates within my framework as the bringing together of key elements held for the role of working with people in a manner that embodies holistic practice.

The research questions align to my strengths and values-based practice approach in that I acknowledge the reality of risks and challenges while uplifting and mobilising capabilities. Practice evolution rather than change has naturally occurred throughout my journey with the Otago Polytechnic Capable program, previously in the undergraduate program and now in the domain of professional practice. To date this is reflected in increased practice confidence and understanding of what I require to sustain myself within the sector.

1.6 Conclusion

In conclusion this chapter introduced both myself as a social service practitioner and the sector I work in, alongside background and justification for the research project I sought to undertake.

Adverse experiences have been indicated in numerous research as negatively impacting on the health and wellbeing of those who have had these experiences. However, it is also known these experiences may hold potential for growth and learning unattainable through traditional channels. In undertaking this project, I seek to present balanced identification of strength and value rather than risk and vulnerability as it relates to adverse life experiences and the sectors workforce and their professional capabilities.

Undertaking any research relating to adverse experiences in Aotearoa I suggest may have a relationship to social issues known to be disproportionally higher in our population compared to other countries. In undertaking this project, I acknowledge the significance of these issues and the resonating negative impacts while exploring the potential for individual experiences of these issues to perpetuate a process of post traumatic growth.

Raising awareness is a recognised strategy for reducing stigma and discrimination. This study seeks to provoke dialogue and future research that may increase both awareness and understanding of the relationship between adverse experiences, post traumatic growth and vocational motivation in helping professions.

Chapter 2: Literature Review

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2.2 Gender dominance and lived experience of adversity in the sectors workforce
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2.1 Introduction

The previous chapter described my sector experience, professional practice and how I came to the realisation that adverse life experiences potentially influence vocational choice in helping professions. In this chapter I review literature with the intent of further developing my thinking in relationship to the field of enquiry and with consideration of what may require further investigation. The literature chosen for this chapter seeks to establish familiarity and understanding of existing research and key concepts that relate to exploration of the value of adverse life experiences of social service and support workers.

A term often used to describe frontline social service work is 'on the floor', which reflects the work of supporting others at ground level. In the spirit of this, the literature review does not rely on scholarly literature but includes industry relevant reports that support an understanding of the sector's environments. The review considers what a lived experience of adversity is, its impacts and implications and how these experiences may have a relationship to vocational choice. There is no one definition of lived experience or adverse experiences and each person's experience is unique; therefore, I draw on a range of definitions. Professions perceived as caring have been traditionally viewed as feminine led, which invites this literature review to consider societal issues relating to female gender in Aotearoa.

2.2 Gender dominance and adverse life experiences

The report *Women at Work* (Statistics New Zealand, 2015) informs us that social service roles from support worker to registered social worker are female dominated, these occupations are identified as lower paid than those dominated by men and subsequently opportunities for career development are limited. New Zealand is considered an open economy with a gender wage gap, low rates of unionisation, little collective bargaining, and high female employment rates. The New Zealand economy is said to be dominated by the service sector which refers to the sector that provides services, as opposed to goods and is inclusive of health and social services.

The Organisation for Economic Co-operation and Development (OECD) Gender Initiative examines barriers to gender equality in opportunity and well-being in both member and non-member countries. The Gender Portal supplies information on the monitoring and progress by governments in relation to gender equality. Data informs us that 70% of the long-term care workforce servicing aged, and disability care are personal care workers and 90% of these workers are women. Working in the sector is referenced as having a higher probability of worker poverty and exposure to risk factors that compromise personal safety. New Zealand is reported as ranking third highest in the OECD for gender dominance in the sector.

Social role theory (Eagly & Wood, 2012) provides us with a framework to consider gender role segregation. The theory suggests gender role segregation in its existence serves to perpetuate a cycle that feeds future generations to remain gender role segregated by influencing societal traits and values. Social role theory suggests that overrepresentation of women in helping roles reinforces societal stereotypes of women as inherently more oriented toward care of others, (Bakan, 1966). The previously mentioned report *Women at work:1991–2013* (Statistics New Zealand, 2015) findings included that two-thirds of occupational categories in New Zealand are dominated by one gender. Given the 22-year span of the data that supported this finding it suggests a societal issue that maybe considered in the context of social role theory.

The Childhood Exposure Study or ACE study by CDC-Kaiser Permanente between 1995- 1997 has provided a wealth of data and resources. Since the original study CDC-Kaiser Permanente has continued to research and report on the impacts and implications of adverse childhood experiences with over fifty published insight reports using the original and newly acquired data. The report *Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences* (ACE) Study (Felitti et al., 1998) presented key findings of the study for the first time. Findings suggested adverse childhood experiences are common and will often occur together. Subsequent studies further examine the cumulative and intergenerational effects of adverse childhood experiences, reflecting a dose–response relationship between adverse childhood experiences and wellbeing issues that tended to be co-occurring and resonating across generations of the same family.

The comparative research study, *Personal History of Psychosocial Trauma in the Early Life of Social Work and Business Students* (Black et al., 1993) compared social work students' history of psychosocial trauma to that of students of non-helping professions which was in this case business students. A key finding was that the social work students had a greater frequency of traumatic experience in early life, that was significantly greater than that of the business students. Existing research related to social service workers and adverse childhood experiences are largely concerning roles traditionally considered as higher responsibility and least likely to include the tasks of personal care or hands on support. Findings from existing research are for the most part confirming of one another in that those in helping professions generally have higher ACE scores. For example, the study, *Adverse Childhood Experiences Among Licensed Social Workers* (Steen et al., 2020), surveyed social workers in 13 American states to explore their exposure as children to adverse experiences. The reported high exposure rate of 23.6% was far greater than that of the general population.

Adverse childhood experiences in social workers have increasingly become the focus of research (Coombes & Anderson, 2000). Largely studies to date explore matters such as the effectivity of social workers who have had exposure to adverse experiences to maintain ethical behaviours, effective practice, and professional responsibility. Refreshingly the study, *The Effect of Adverse Childhood Experiences on Psychosocial Wellbeing* (Yundt, 2019) concluded 'this study demonstrated several positive relationships in regard to psychological outcomes after childhood maltreatment or adverse experiences' (p. 31). The studies exploration of post traumatic growth was suggestive of high ACE scores as indicators of an increased presence of the attributes of compassion and empathy in social workers.

In the book *The Practice of Psychotherapy*, (Jung, 1966), conceptualised the archetype of the 'wounded healer' in reference to helping professionals. Jung proposed that physicians who have suffered are best equipped to understand the suffering of others. Jung's archetype of wounded healer is frequently referenced in relationship to the Greek mythological half human, half creature character 'Chiron' that is thought to be the earliest representation of the phenomena of wounded healer. Abandoned by his father and rejected by his mother, Chiron was said to be emotionally wounded from the beginning, with maturity he is said to have become skilled in the art of healing. The concept of the wounded healer has been applied in numerous research to explain the phenomenon of why those with adverse childhood experiences often enter helping professions. (Barr, 2006; Newcomb et al., 2015; Reamer, 2014).

In summary, the literature reviewed in this section provided exploration of gender dominance and lived experience of adversity in the sectors workforce. There was opportunity within the review to consider the factors of gender dominance in the social services sector within Aotearoa, as statistical data was available. Literature was explored that supported increased understanding of the presence and potential of adverse childhood experiences within helping professions, this was confined to social work professionals as roles with less status appear less researched.

2.3 Family violence and adverse childhood experiences

According to the report *Safer Sooner*, (Ministry of Justice, 2016) New Zealand has the highest reported rate of intimate partner violence in the world. The report estimates over 80% of incidents are never reported to police, which indicates incidence of partner violence in New Zealand is much higher than we can quantify using available data. It is said where police have responded children are present at nearly two-thirds of incidents. The report reflects the ACE study (1995- 1997) in that the impacts on children of witnessing family violence is referenced as long lasting across generations, resulting in significant human, social and economic costs, one of these been imprisonment. In the report, *Where New Zealand Stands Internationally*, (Boomen, 2018) informs us New Zealand's prison population is unusually skewed in terms of sexual and violent offenders compared to thirty-one other jurisdictions in the Council of Europe (CoE), the United States, and Australia. The report confirms that 53% of offenders in New Zealand's prisons are there for interpersonal offending.

The process of colonising in Aotearoa was characterised by violence upon Māori and actions that left them dispossessed of land. Māori are traditionally spiritually bound to the land in a way that is understood as integral to their individual and collective wellbeing and identity. An introductory message from the issues paper, *Historical trauma and whānau violence, (*Pihama et al., 2019) was that understanding the impact of colonisation and historical trauma is critical to understanding the origins of family violence in Aotearoa. Māori are over-represented as victims and perpetrators of family violence including whānau violence related deaths (Family Violence Death Review Committee, 2014). It is widely referenced in reports exploring family violence in Aotearoa that in pre-European Māori society interpersonal violence was not tolerated and traditional knowledge is said to have provided clear guidance for behaviours within relationships. Historical trauma theory provides a conceptual model that illustrates how traumas such as colonisation play a significant role in the prevalence of disparity and inequity of health and wellbeing across generations in indigenous populations. This is discussed further in the following section 'Trauma, adverse experiences, lived experience and post traumatic growth'

The retrospective study, *The Association Between Adverse Childhood Experiences and Adolescent Pregnancy* (Hillis et al., 2004) was completed using data from the original ACE's study. The study found that woman who have had adverse childhood experiences were at increased risk of teen pregnancy and in turn their children are at increased risk of adverse childhood experiences and teen pregnancy. Social learning theory (Bandura, 1966, 1977) previously mentioned in this review in relationship to social role learning, may offer some theoretical context as the theory suggests a cycle exists where we learn behaviours by watching others, absorbing traits and values that support the behaviours and then in turn we may replicate the behaviours.

Adverse childhood experiences have been associated with risk of disrupted development in children, a recent study considered this in relation to school readiness. The objective of the study *Adversities of Childhood Experience and School Readiness* (MSD, 2019) was to analyse the issue of school readiness using data from the longitudinal study *Growing Up in New Zealand* (GUiNZ) which is New Zealand's largest, longest running, ongoing cohort study. Findings were reflective of those from the study mentioned in the previous paragraph, while providing context to the New Zealand environment. Adverse childhood experiences were reported as common in children of teen mothers, findings suggest that adverse experiences impact negatively on child development in a range of areas, influencing a child's ability to ultimately become school ready.

In summary, in exploring literature relating to family violence and adverse childhood experiences it is evident that they will likely have a strong relationship to one another in that adverse childhood experiences will be more likely where family violence incidents occur. Aotearoa has an evidenced high incidence of family violence; this suggests a natural correlation to high incidence of adverse childhood experiences within our populations.

2.4 Trauma, adverse experiences, protective factors, and post traumatic growth

Any discussion of trauma in New Zealand must be underpinned by the context of the Treaty of Waitangi, Te Ao Māori, and realisation Māori as indigenous people of this land, come from a place of individual and collective intergenerational trauma as a result of colonisation (Donaldson, Jury, & Poole, 2018). Historical trauma theory is a relatively new concept, whose origins I have found difficult to obtain for the purpose of attributing. Premise of this theory is that populations subjected historically to trauma such as that which is evidenced in the colonising process will likely have a higher prevalence of negative health and wellbeing issues that occur in a sustained manner over generations. Māori healing must be based on the restoration of the Māori cultural and healing paradigms that colonisation sought to destroy (Pihama et al., 2019).

Health and social policies themselves may be sources of historical and intergenerational trauma, and can continue to impact on individual and community health for marginalised groups (Bowen & Murshid, 2016). The governmental document *Whakamaua: Māori Health Action Plan 2020-2025* (Ministry of Health, 2020) sets out the government's current intentions for advancing Māori health and wellbeing by delivering on key objectives with the intention of reducing inequities of health and wellbeing that impact upon Māori. A high-level outcome sought by the action plan is the inclusion and protection of mātauranga Māori throughout health and care systems. Mātauranga Māori being the term that describes Māori knowledge and encompasses traditional concepts of health and wellbeing. The action plan supports the implementation of initiatives across governmental systems to include the contexts of mātauranga Māori. This reflects growing understanding that traumas such as homelessness and child uplift have happened within the jurisdictions of governmental systems and

have direct implications for the health and wellbeing of Māori individually, collectively, and cross generationally.

Trauma, adverse experiences and lived experience are often linked to describing experiences that are similar in nature. There is no one accepted definition to provide a central point for these terms, which may mean different things, depending on the environments and populations they are referencing. The behavioural health field's understanding of trauma (that is, psychological trauma) as a discrete symptomatology is evolving (Briere & Scott, 2015). Limiting the types of events that qualify as traumatic, The Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2013) definition requires 'actual or threatened death, serious injury, or sexual violence' and excludes 'stressful events not involving an immediate threat to life or physical injury such as psychosocial stressors. This reflects a discrepancy between diagnosis criteria and what may be understood in the practice sense, which has a closer relationship to the categories developed for the undertaking of the ACE study and understood within the context of the key trauma informed element of realising the prevalence of trauma.

The CDC-Kaiser Permanente's ACE studies adverse childhood experiences measuring tool (supplied in the appendices section) has been used widely in research concerning exposure to adverse experiences in childhood. The journal article, *Aces, Cultural Considerations and 'Common Sense' in Aotearoa New Zealand,* (Joy & Beddoe, 2019) informs us the ACE measuring tool is not known to be widely used in the New Zealand setting and describe it as low visibility, however the report tells us this does not mean that it is not in use here. The writers go on to consider the potential consequences of using the measure developed for international environments within the cultural context of Aotearoa. Suitability is questioned in that the tool fails to consider factors such as colonisation and prevalent societal issues that are known to increase traumatic experiences including poverty and racism. In conclusion the writers suggest that the use of internationally recognised adverse childhood experience measures in Aotearoa service settings may exacerbate existing inequalities.

In seeking to develop a mutually understood concept of trauma for those working with persons impacted by trauma other than that of the DSM-5 criteria included the concept introduced in 2017 by the European Federation of National Organisations Working with the Homeless (FEANTSA). The definition provides a reference point for defining the existence of trauma that is applicable to services other than those catering to homeless populations. In short, the FENTASA concept is as follows: type 1 is trauma that occurs at a particular time and place and is short-lived; type 2 is trauma that relates to events that are chronic such as those that begin in early childhood (ACEs) and occur within family or social environment and are often repetitive and involve direct or indirect harm or neglect by trusted adults; complex trauma is when both type 1 and type 2 are present together. Working within this conceptual definition in Aotearoa one can see an intertwined relationship between evidenced societal issues, adverse childhood experience exposure, type 2 and complex trauma.

Protective factors are defined as characteristics of the child, family, and wider environment that reduce the negative effect of adversity on child outcomes (Masten et al., 2012). Resilience is said to be the result of a combination of protective factors. The report, *Protective factors of children and families at highest risk of adverse childhood experience* (Walsh et al., 2019*)* is an analysis of children and families who are said to have 'beat the odds' using data from the longitudinal study Growing *Up in New Zealand,* (GUiNZ). We are informed that the largest protective factors associated with beating the odds were related to the mother-partner domain. In discussing limitations to the research balance

is provided by describing how observed correlations between mother-partner factors may be focused only on those adverse childhood experiences that are directly related to partner conflict. This suggests that where there is less interpersonal conflict in the home a child's ability to beat the odds is increased.

A study of the positive implications of protective factors in relationship to adult mental health (Bethell et al., 2019) found a dose-response link between positive childhood experiences and adult mental and relationship health among adults who had experienced ACEs, irrespective of how high their ACE's score. Please note, dose-response is a term used to describe cause and effect links in human behaviour. Findings suggest those with positive childhood experiences, regardless of how much adversity experienced will be less likely to incur negative consequence due to adverse experiences. This suggests that fostering protective factors such as positive experiences may negate some of the risk of negative outcomes from adverse childhood experiences.

The *'What's Your Resilience'* questionnaire was developed by early childhood service providers including paediatricians, psychologists, and health advocates of Southern Kennebec Healthy Start, Augusta, Maine, in 2006, and further updated in February 2013. Psychologists Mark Rains and Kate McClinn designed 14 questions exploring protective factors that have potential to support resilience to the impacts and implications of adverse experiences. The questionnaire was modelled on the ACE studies measuring tool questions. The questionnaire is often produced alongside the ACE score measure and in doing so may serve as a counterbalance to understanding how some persons are seemingly more able to weather challenging circumstances. The resilience questionnaire is supplied in the appendices section.

The concept of growth from adversity encompasses all dimensions of life, including vocational motivations across all sectors but possibly more so in sectors that serve others also impacted by adversity. Post traumatic growth is a theory of positive psychological change in the wake of struggling with highly challenging life circumstances (Tedeschi, & Calhoun, 2004).

The Post Traumatic Growth Inventory (PTGI) (Tedeschi & Calhoun 1996) was developed as an instrument for assessing positive outcomes reported by persons who have experienced traumatic events and serves to measure the extent to which those who have experienced traumatic events perceive personal benefits have occurred from learning to cope with trauma. The strengths-based tool recognises individual capacity for positive growth as a consequence of trauma, providing in its existence a counterbalance to deficit-based vulnerability and risk measures such as that of the original ACE studies measuring tool. The PTGI is supplied in the appendices section.

In summary, exploring literature relating to matters of trauma, adverse experiences, lived experience and post traumatic growth, I learnt these terms are often used to describe experiences that maybe similar in nature (or even interrelated) and that there is no one concept that universally defines these experiences. Largely these terms bear a relationship to one another in that they reference experiences thought to be adverse and potentially life altering by the person who has experienced them. The presence of protective factors was suggested as reducing negative impacts of how each person processes these experiences, contributing to improved overall outcomes and increased potential for post traumatic growth to occur.

2.5 Stigma attached to adverse life experiences

Adults who have experienced sexual abuse, intimate partner violence, violence by non-partners, serious crime, active hostilities during war, workplace physical violence and bullying are at risk of developing mental health issues (Baxter et al., 2006; Volpicelli et al. 1999). These experiences may add to the effects of ACEs or be associated with them (VicHealth, 2004). Mental illness and addiction are linked to adverse life experiences, and both are known to be linked to fear inducing stigma, discrimination, and marginalisation.

The study, '*The stigma of identifying as having a lived experience runs before me*' (Byrne et al. 2016) reported findings suggest a lack of understanding of recovery was a barrier to people accepting the value of lived experience and contributed to ongoing stigma and discrimination. What constitutes 'recovery' and what is the recovery model or approach can be a contentious issue theoretically and in practice. To me professionally and personally it seems apparent that perceptions of recovery often collide, creating discourse. Similarly, the term 'lived experience' has no one definition and each person's experiences are considered unique. The Oxford dictionary offers us the following meanings of recovery as 'a return to a normal state of health, mind, or strength' and 'the action or process of regaining possession or control of something stolen or lost'. It is little wonder than unless you are 'in recovery' or work within the recovery model or are from a recovery orientated organisation a lack of alignment in understanding of the term recovery may occur. The perception that persons who have attended a recovery program should be 'cured' having reached a final destination of wellness is common. However, recovery theory as it relates to mental health and addictions considers recovery as an ongoing path with no ultimate destination or finite cure.

Stigma is said to involve the deep discrediting of an individual due to perceived membership in a devalued group (Goffman, 1963; Link & Phelan, 2001). Adverse childhood experiences are said to heighten the risk of mental illness, this suggests that in identifying as having had adverse childhood experiences a person may risk associated stigma. Mental illness has been identified as the most stigmatised attribute a person can have in society. Research indicates that when an experience of mental health difficulty is known to others their opinions, ability and competence are devalued (Wahl, 2011), it is apparent stigma is alive and well in the minds of society at large, as well as within health professions (Nordt, Roosler, & Lauber, 2006)

The term 'medical model' is attributed to the report, *Politics of the Family and Other Essays* (Laing, 1969). Laing described the model as a process from which medical professional's work. Since its inception the medical model has been subject to numerous interpretations and criticisms. The medical model reflects a process that defines people by their condition or prognosis, and the attributable risks and limitations. The model is thought to fuel and reinforce negative stereotyping of mental health diagnosis by attributing risk to diagnose, therefore creating a dynamic that is suggested as potentially perpetuating fear and misunderstandings, both in the diagnosed person and the communities they come from. Limitations of the medical model are said to include difficulties understanding and describing what occurs in psychological therapy suggesting the model is informed by its ties with medicine and science and not in delivery or outcomes (Elkins, 2009). Participants in the study, *Lived Experience Practitioners, and the Medical Model: world's colliding*, (Byrne et al.,2016) described the medical model as a prevailing negative culture fuelling stigma and discrimination that exists amongst professionals and within systems.

In summary, exploring literature relating to stigma I found that the evidenced risk of negative outcomes including mental illness for those who have had adverse life experiences may include an increased risk of stigma and discrimination.

2.6 Conclusion

The process of literature review has supported the development of my own thinking in relationship to this enquiry by enabling discovery of research previously completed and identifying some of what is unknown in relation to my field of enquiry. This process confirmed the pertinence of this project's questioning and justification for the field of enquiry.

As suggested in the ACE study adverse childhood experiences are common, how common they are in Aotearoa and the relationship that potentially exists between adverse childhood experiences and our disproportionally high family violence statistics, I suggest requires further research. Further research in this area may support deeper understanding of the broader implications of adverse childhood experiences in the Aotearoa cultural context and the resonating implications of family violence that maybe present decades and generations after the experiences have occurred.

Literature reviewed in this chapter suggested that adverse life experiences may exist as an underlying motivator for vocational choice in helping professions. However, the potential for adverse experiences to contribute to professionally advantageous attributes was not widely considered; most often adverse life experiences are associated in existing research with risk and vulnerability. Additionally, literature reviewed supported deeper understanding of how persons in helping professions who have had adverse experiences, may consider themselves at increased risk of stigma and negative stereotyping if their experiences are made known.

Chapter 3: Methodology

3.1 Introduction

In the previous chapter I explored the theoretical and practical basis for 'Exploring the Value of Adverse Life Experiences of Social Service and Support Workers'. The concept of adverse life experiences has become better known in Aotearoa, in part due to the reporting of two significant longitudinal cohort studies, The *Childhood Exposure Study* (ACE) study (CDC-Kaiser Permanente ,1995-1997) and the *Growing Up in New Zealand* (GUiNZ) study (Auckland University 2009 – present). However, there are gaps of knowledge at the point where we consider the prevalence of adverse experiences in the context of known societal issues in Aotearoa. Additionally, gaps persist in understanding the relationship between adverse life experiences, vocational motivation, and post traumatic growth as it relates to those in helping professions.

This thesis tells the interconnected story of this research project alongside the evolution of my professional self throughout the process. The interconnectedness bares resemblance to the visual context of my framework of practice explained in the first chapter, in that this process is interdependent on the vital elements that feed it. Conceptually the knowledge and wisdom gained through the undertaking and completion of this project will serve to feed my professional development and here in the methodology chapter I illustrate how this will be undertaken.

In what follows I outline the underlying methodology and detailed method that have facilitated the undertaking of this development project. Research design will be justified, and choice described. I will convey the process's I have been required to undertake to obtain approval from both the Kaitohutohu office and ethics committee and the processes I have chosen to undertake to recruit participants, design the survey and enable analysis of the data gathered.

3.2 Research design = A convergent parallel mixed method design

When seeking clarity for design purposes Creswell (2003) informed me a convergent parallel design entails that the researcher concurrently conducts the quantitative and qualitative elements in the same phase of the research process, weighs the methods equally, analyses the two components independently, and interprets the results together . This provided me with a design focus that resonated with my project. Convergent parallel design fits my process of collecting both qualitative data and quantitative data separately but also simultaneously in one online survey. By choosing a convergent parallel mixed method design I was able to analyse research questioning by converging (or merging) quantitative and qualitative data.

Mixed methods research was defined by Johnson and Onwuegbuzie (2004) as "*the class of research where the researcher mixes or combines quantitative and qualitative research techniques, methods,*

approaches, concepts or language into a single study" (p. 17). My methodological choice was mixed methodology, referring to mixing, both qualitative and quantitative methodology within a single investigation. Mixed methods studies are commonly seen in health and social care research, as both methods are thought to have complementary strengths that support deeper insight than either approach undertaken alone.

Recent work in mixed methods research has called for more emphasis on qualitatively driven mixed methods (Morgan & Hoffman, 2021). My investigation was predominately qualitative with a quantitative element, this could be described as qualitatively driven. By mixing both qualitative and quantitative methods I sought to offset some of the limitations inherent in both these methods when conducted alone. Quantitative research is known for its weakness in providing deeper understanding of context or environment in which people behave. Qualitative research will offset this limitation by providing a fuller view of experience, behaviour and environment that is in turn balanced and enhanced by a quantitative element.

It is said qualitative inquiry is used to gain perspectives on things already known (Strauss & Corbin, 1990). These words relate well to the report I mentioned within my literature review, *Women at Work* 1991–2013 (Statistics New Zealand, 2015); here its mention serves to confirm what is already known regarding the social service's sector workforce in Aotearoa. Notably the report informs us it is a female dominated sector and that female-dominated occupations are identified as lower paid than those dominated by men. Furthermore, Denzin and Lincoln (2018), argue that there is a need to use qualitative inquiry to create social justice. Research participants come from a sector known for female dominance and lower pay and who may additionally have lived experience of adversity. I suggest by using a predominately qualitative approach with a quantitative element this project may better support hearing the participants' voice and understanding their individual experiences.

3.3 Survey Design

I designed an online survey to answer the research questions. The online survey questions are available to the reader within the appendices section at the end of this dissertation. The questions generated both qualitative and quantitative data. The online platform for the survey was provided by Otago Polytechnic Qualtrics web-based survey tool. Qualtrics enabled me to build, conduct and analyse the survey research while ensuring secure data collection and storage. The survey ran live online for a total of 67 days from 22.12.2020 to 27.02.2021.

The survey questions comprised of qualitative questioning designed to obtain insight and understanding of the personal experience and feelings of participants and how these relate to the research projects overarching questioning. The questions probed for connections between adverse life experiences and matters that related to the research questions such as career motivation and workplace stigma. This questioning provided textural data which was considered within a thematic process that was then supplemented by consideration of its relationship to quantitative data.

Closed ended ranking or preference type questions were designed to provide an additional layer of insight that further reinforced themes as they emerged through analysis. This approach supplied both numerical data and opportunity for comment therefore providing additional textural data to be considered in its relationship to the numerical data. This reflects a simple naturally occurring process of quantitative and qualitative data convergence.

Demographic type questioning was designed to provide what could be measured as numerical data. This supported understanding of the demographic composition of participants and their relationship to the social services environment.

3.4 Recruitment of Participants

I decided to use a Facebook advertising campaign to recruit survey participants. My objective was to draw persons from targeted groups to the Facebook research page. The page contained basic research information, an invitation to participate and a link to the survey on Otago Polytechnics Qualtrics platform. Facebook advertising tools supported customised refinement of the target audience. Customising options included selecting the audience based on location, demographics, personal interests, and work sector affiliations. I specifically targeted Facebook groups associated with Aotearoa social service and support worker networks. Targeting included unions, worker support groups, sector organisations and registering bodies. I ran the advertisement for two consecutive days on two occasions in February 2021.

Facebook advertising generates data using algorithms, this supported understanding nuances such as numbers and regional locations of those engaging with the page and how many progressed to clicking on the survey link.

Activity data for the 1st advertisement that ran for two days showed it reached 1,402 people, of these people 30 engaged with the post, 21 went on to click on the research link. Of the 1,402 persons reached 86% were women and 14% were men, they were aged between 18 to 65+, with 35 to 44 years of age making up the dominate age group represented at 30%. The location of participants data was satisfying in that it confirmed participants were from 16 locations nationally and not as Auckland centric as I was expecting.

Activity data for the 2nd advertisement showed it reached 2,429 people, of these people 57 engaged with the post, 41 went on to click on the research link. Of the 2,429 persons reached 90 % were women and 10 % were men, they were aged between 18 to 65+, with 35 to 44 years of age making up the dominate age group represented at 30%. As in the first advertisement the 2nd attracted participants from 16 locations nationally. The increase in engagement generated by the 2nd advertisement is accounted for by the fact it was live online Saturday and Sunday which are known to be high traffic days on Facebook.

Comparison of gender data relating to men who engaged with the Facebook page as a result of advertising (10- 14 %) and those who completed the survey (0%) indicates that men who engaged with the page did not go on to click on the survey link.

Facebook advertising was an effective tool that resulted in 62 people clicking on the survey link, therefore making up the largest portion of the 79 survey respondents. The data generated from the Facebook advertising for survey candidates is available within the appendices section.

3.5 Data Analysis

Within the overarching research design of convergent parallel mixed methods, I sought by analysis to integrate predominately qualitative data with the elements of supplementary quantitative data. This was conducted at the reporting level by firstly describing the qualitative and quantitative findings separately within a single survey finding report. I then go on within the reports discussions and conclusions section to merge these elements within my narratives. In the case of data derived from ranking questions with room for comment, convergence between qualitative and quantitative findings naturally occurs in the process.

I used thematic analysis for the qualitative data and descriptive statistics for the quantitative data. Thematic analysis considered themes within textural data supporting a non-linear natural process. Initially I needed to know the data, which involved spending time with the survey transcripts to become familiar with the content, repetitive reading and noting of emerging trends, relationships, differences, and reinforcements of what may already be known. Secondly initial codes were sought, again this required more repetitive reading further identifying and noting down ideas of emerging themes or sub themes. The process undertaken is aligned to both inductive and thematic analysis "discovering patterns, themes and categories in one's data" (Patton, 2014, p. 453). Deeper analysis sought confirmation of themes based on notes, reviewing of themes, and managing theme volume by seeking similarities and difference within the themes, at this point themes potentially merged, and sub themes were further identified. This required second level checking of patterns and ongoing review of the dataset (Braun & Clarke, 2006).

Descriptive statistical analysis was undertaken to present, summarise, and organise the quantitative data. This was done through simple summaries, graphics analysis and descriptive statistics. Otago Polytechnics Qualtrics platform provided web-based tools that supported the descriptive statistical analysis process and the customising of report graphics.

3.6 Ethics

Ethical issues may arise during the research process (Creswell, 2003). Ethics approval was sought via application to the Otago Polytechnic Research Ethics Committee which is in line with Otago Polytechnic guidelines on ethical practices in research. The project was reviewed, requiring a resubmission before final approval by the Otago Polytechnic Research Ethics Committee prior to commencement.

The application required detailed description of all matters relating to the proposed research including potential harm to participant or researcher. As this research related to adverse life experiences that may include traumatic life events, this section required consideration of these potentials and how to address them. I sought to reinforce ethical considerations from within an integrated approach that was considerate of all research ethics such as consent, dignity, rights, confidentiality, beneficence alongside ensuring participants were provided with links to resources and accessible services as appropriate to participants in trauma related research.

As mentioned, the process of obtaining ethics approval required resubmission as there were matters that required change and clarification. The original survey questioning underwent substantial changes before resubmission to the ethics committee. This reflected the committee's comments which noted that *"in the application there are some questions that could evoke strong emotional responses"*. The

comment propelled me to reflect on the appropriateness of the approach I had taken. The original survey design was largely quantitative, yes/no and multi choice questioning with an optional comment box to produce qualitative textural data. Survey questions were a blended adaption of three recognised adverse experience survey tools. These were CDC-Kaiser Permanente, ACE Study survey questionnaire, ACE Resilience questionnaire and the Post Traumatic Growth Inventory.

Reflecting on my responsibilities as a researcher and commitment to trauma informed practice, it seemed appropriate that I should seek to minimise the potential for questioning to trigger a strong emotional response by altering the approach taken. Original questioning that was largely personal experience centred was altered to an approach that invited generalised comments. For example, questioning was altered to start with 'What are your thoughts on', rather than questioning that sought personal experience by questions that started with 'Did you ever experience…'.

Within this new approach I sought to be both trauma sensitive and harm minimising. Personal experiences naturally emerged in an organic manner and participants were able to provide valuable insight into the matters and how they see them reflected in their workplaces.

The resubmitted application successfully gained ethics board approval and in doing so reflected my development during the approval process in that I had gained understanding of how tailoring questioning to minimise harm can enhance the depth of insight. Interestingly it seems that the direct approach of the original questioning would likely have resulted in findings that lacked the depth eventually achieved by the redesign taken. Additionally in redesigning the survey questioning the mixed methodology approach then altered from a predominately quantitative approach with a qualitative element to a predominately qualitative approach with a quantitative element.

Please note: The application to the ethics board was originally made using the title 'Exploring the Wider Existence of Historical Trauma in the Social Service Workforce' this was later redeveloped to the title 'Exploring the Value of Adverse Life Experiences of Social Service and Support Workers'

3.7 Māori consultation

Application for approval was made and given prior to conducting the research study through Otago Polytechnic's Kaitohutohu office. The application addressed the relevance of the research to Māori, the implications of collecting data related to Māori, and how the research may potentially benefit Māori. The consultation process supported me as researcher to receive effective feedback from Māori representation regarding the research proposal.

Studies conducted in Aotearoa have the potential to produce both benefits and harm for Māori. For this reason, consultation with Māori representatives is considered crucial in ensuring researchers adhere to the principles of the Treaty of Waitangi and understand their responsibilities to Māori. As tāngata whenua Māori have manaakitanga responsibility over all people in Aotearoa therefore it is fitting Māori representatives have opportunity to review research processes to confirm that research design, methods and analysis are respectfully appropriate.

Consultation with the Kaitohutohu office reinforced aspects of my approach. This included commitment to underpinning the practice of manaaki within the projects processes, in that the process of this research project sought to uphold and protect the mana of participants. I sought to do this by

creating a research project that may potentially be meaningful for participants while providing better understanding and appreciation of participants unique wisdoms, knowledge, and experiences.

Please note: The application to the Otago Polytechnic's Kaitohutohu office was originally made using the title 'Exploring the Wider Existence of Historical Trauma in the Social Service Workforce' this was later redeveloped to the title 'Exploring the Value of Adverse Life Experiences of Social Service and Support Workers'

3.8 Summary

In this chapter I have demonstrated this project's underlying methodological approach and the methods and process's that have supported both facilitation and undertaking of this work. Convergent parallel mixed method design was justified as the appropriate design choice for this project as a predominately qualitative approach with a quantitative element may best support understanding the experiences of participants. Additionally, description was supplied of the processes undertaken for Māori consultation, ethics board approval, data collection and data analysis.

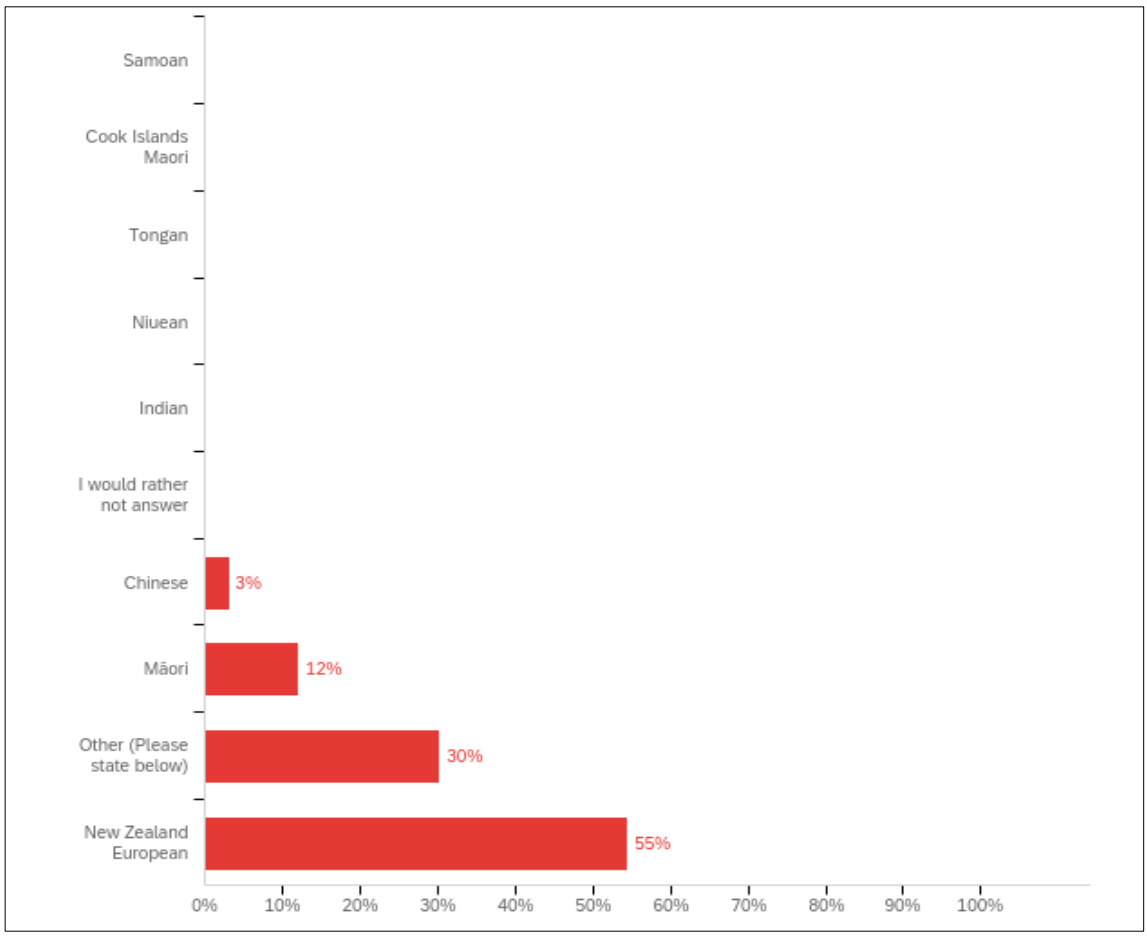
Chapter 4: Quantitative Findings

4.1 Introduction

In this chapter I analyse demographic data to better understand the relationship survey respondents have to the social services environment alongside their general make-up. In doing so I seek to gain greater insight into what makes up the sectors workforce. Furthermore, I consider the relationship findings may have to other research regarding the sectors make-up, further affirming relationship to the sector and its environment. In analysing the survey's quantitative ranking questions, I will be seeking a deeper layer of understanding as to how respondents felt about each option, based on popularity.

4.2 Participant Demographics

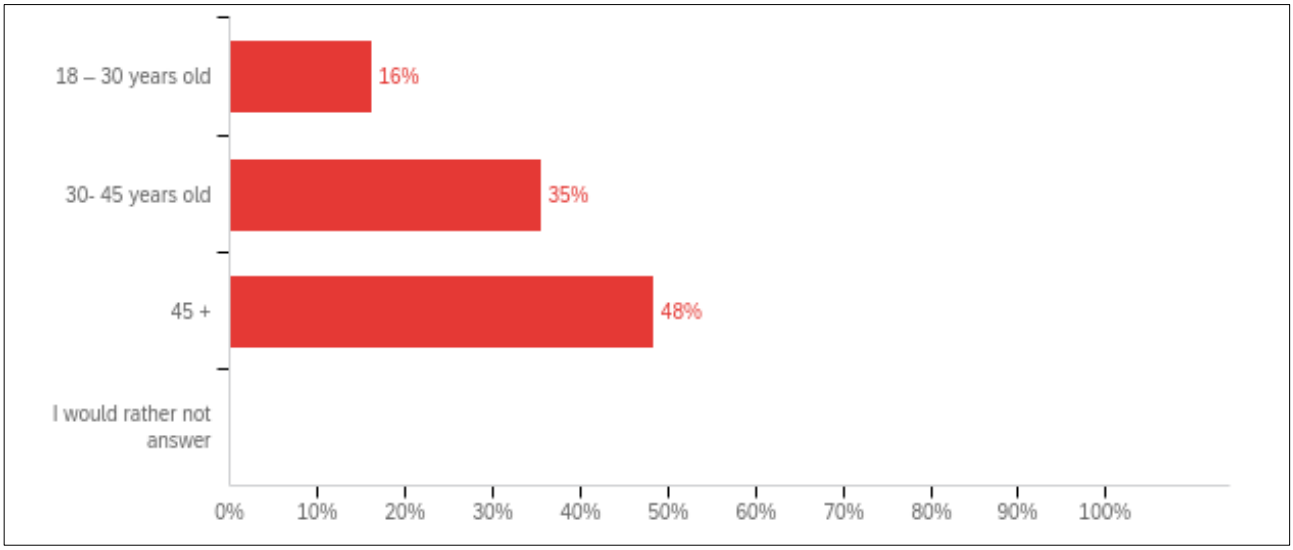
Figure 1: Ethnic groups of participants



Approximately 55% of the respondents identified as New Zealand European and 12% Māori. This is similar to the 2018 Census ethnicity data for the Auckland region (European 53.5% Māori 11.5%). This may reflect the largest portion of respondents originated Auckland.

Support workers, health care assistants and nurses from the Philippines are known to make up a large portion of the sector's workforce, the 2018 Census estimates Filipino workers make up 25.6% of the health and social service sectors workforce, this suggests a relationship may exist to the 30% of respondents who identified as other.

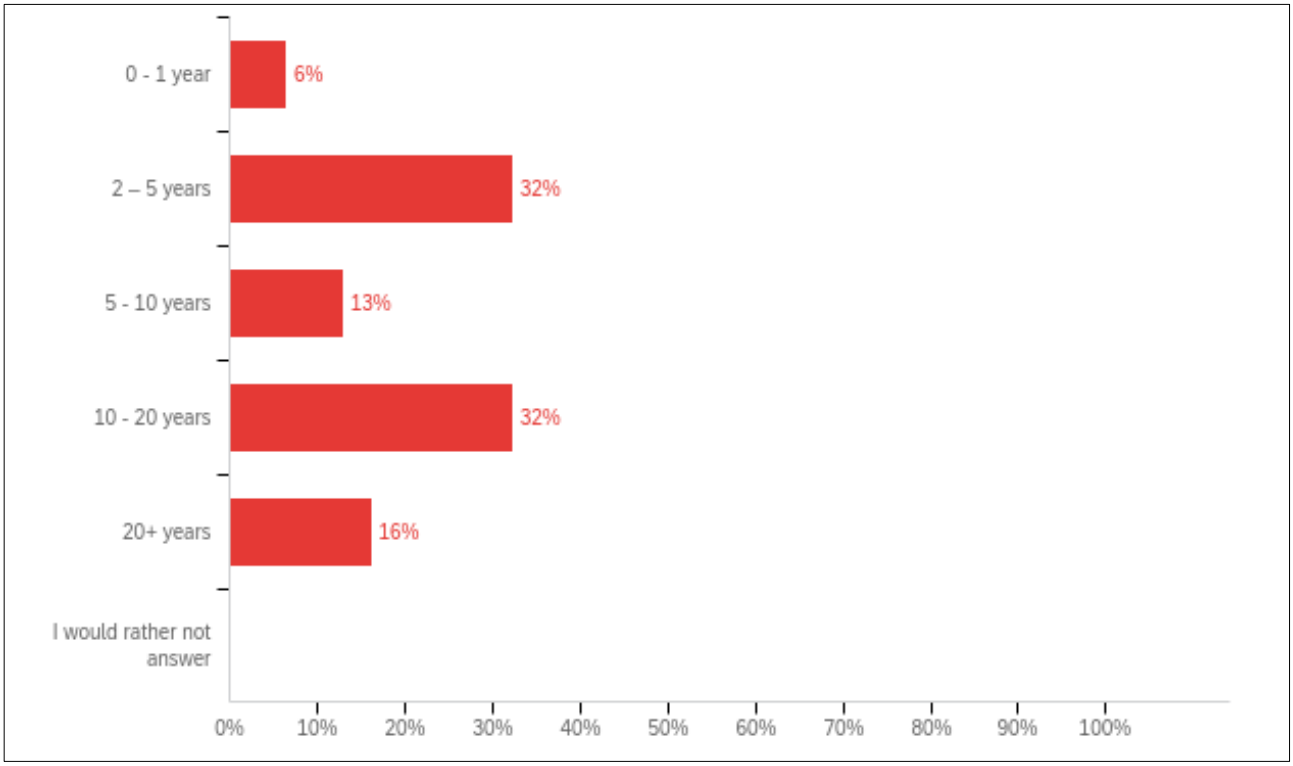
Figure 2: Age groups of participants



The age distribution of respondents in this study was 18 – 30 years 16 %, 30 – 45 years 35 %, 45+years 48%. The age grouping reflects the study, *Average age of employees in New Zealand 2018 by industry*, (Stats NZ 2019, as cited by Hinton 2019), that found the average age of community and social service sector employees to be 44 years.

Figures reported by New Zealand Nurses Organisation (2010) show that more than 40 % of registered nurses (RNs) and 72 % of enrolled nurses (ENs) and nurse assistants are aged 50 years or more. It is said to be likely these sectors will continue to be increasingly reliant on migrant workers to fill the gaps created by our ageing workforce.

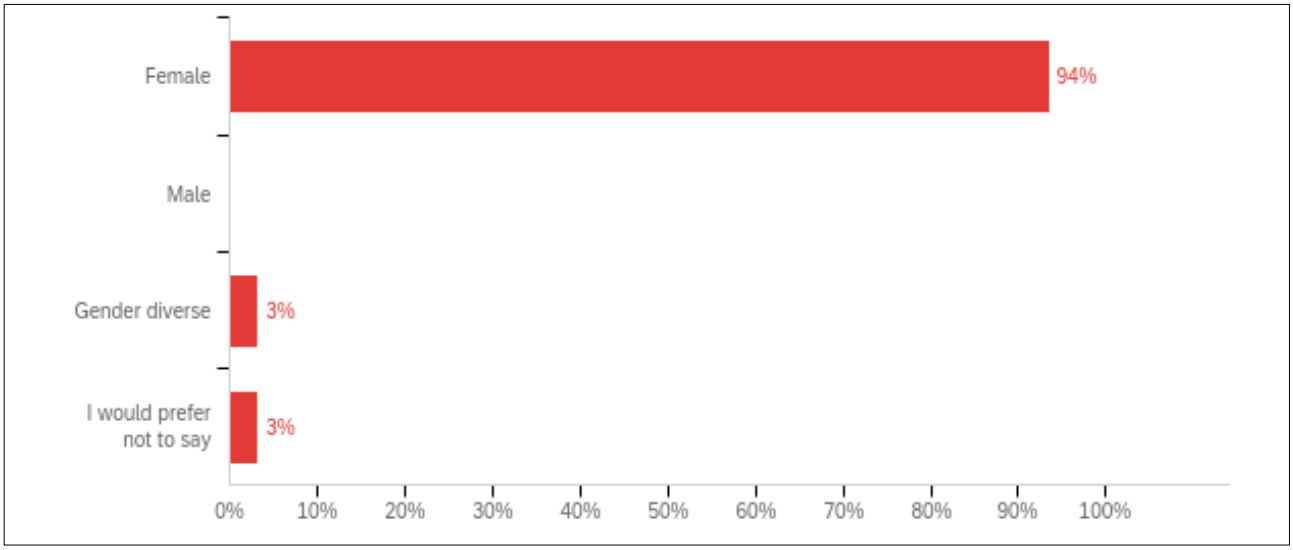
Figure 3: Length of time in the workforce



The findings indicate respondents' depth of relationship to the sector based on duration of service, 0 -1 year 6%, 2-5 years 32%, 5 -10 years 13%, 10 – 20 years 32%, 20+ years 16%. Seemingly there is a relationship between age distribution of respondents and length of service, in that workers aged 30 to 45+ years will naturally have had longer relationships with the sector.

The sector is known for high turnover rates amongst those in support roles, in my experience this may reflect workers changing their place of work rather that leaving the sector completely. Since 2015 there has been improvement in retention largely because of the action started in 2012 by Etu workers union on behalf of care worker Kristine Bartlett when a claim was lodged with the Employment Relations Authority maintaining that there was systemic undervaluation of care and support work because it was mainly carried out by women (E tū, 2019). The claim resulted in the government implementing a pay equity scheme said to have helped 55,000 care and support workers throughout New Zealand.

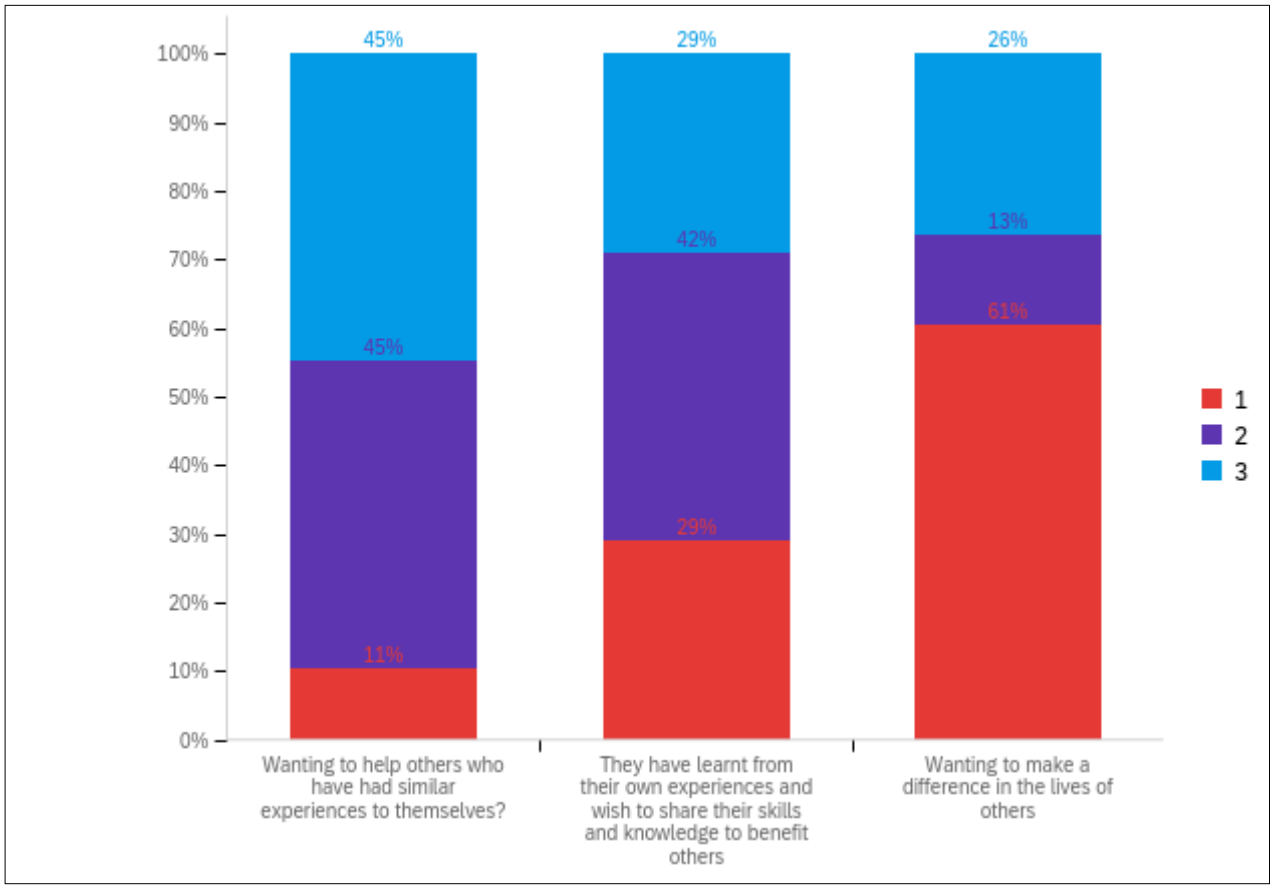
Figure 4: Gender identification



94% of respondents were female this is reflective of the report Women at work 1991–2013 (Statistics New Zealand, 2015) whose findings informed that support worker to social worker roles in New Zealand are female dominated. The report tells us that in 2013, 86.9 % of support workers and 79.7 % of social work professionals in New Zealand were all women. Female-dominated occupations in New Zealand are identified as lower paid than those dominated by men and that opportunities for career development are also restricted in low-paid female-dominated occupations.

4.3 Ranking questioning

Figure 5: Vocational motivators

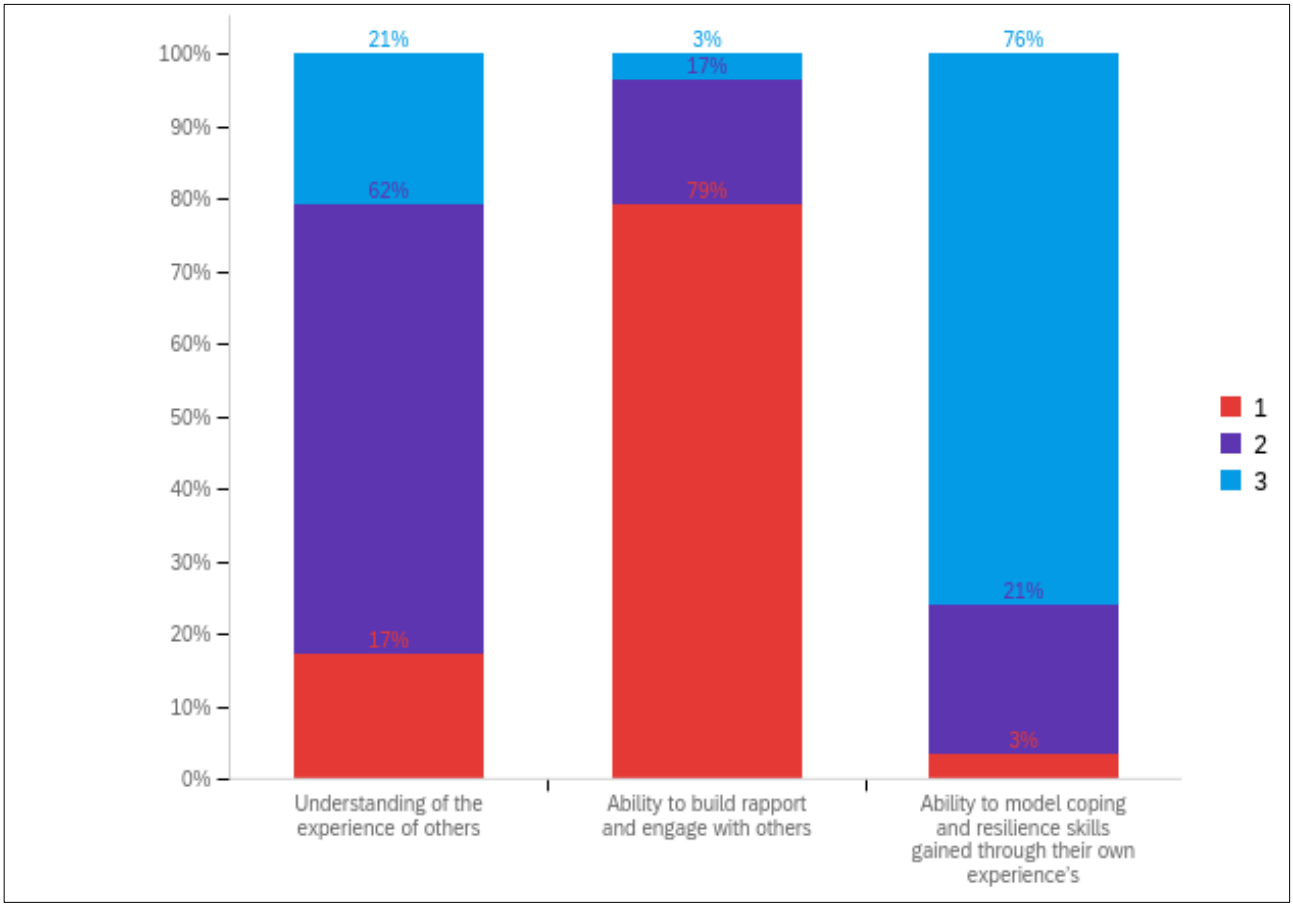


Reflecting the findings of existing research, respondents ranked 'Wanting to make a difference in the lives of others' as the most important factor in motivating people to seek employment in social services (61%). Reasons for choosing social work as a career can be an important influence on the quality and nature of the profession (Breen & Lindsay, 2002). Largely research on motivation of those who work in the sector is focussed on regulated roles such as social work however, understanding vocational motivation is thought to be important in terms of recruitment and retention within any profession and that in social services the consequences of mismatches between motivation and expectation about what professional practice involves are likely to have wider implications on a very human level.

Only 11% of respondents identify as being drawn to social service roles because they wanted to help others who have had similar experiences to themselves. Kwan and Reupert (2019) reported that experiences of social workers were often associated with their motivation to work with certain clients. The benefits of a worker's experiential knowledge I suggest may not require their having had similar experiences to those they are helping as knowledge of how to develop coping skills and maintain protective factors maybe referenceable across a variety of service settings.

29% of respondents identified as having learnt from their own experiences and wishing to share their skills and knowledge to benefit others. Tedeschi and Calhoun (1996) coined this phenomenon 'posttraumatic growth' whereby individuals may benefit from traumatic experiences. Numerous studies have suggested many who have experienced trauma endorse positive outcomes as result.

Figure 6: Worker attributes



Ability to build rapport and engage with others was ranked 1st by 79% of participants, this finding aligns with the sector's movement towards person centred and relationship-based approaches. A distinct attribute of strength-based practice is that it is mutual between the client and the practitioner (Duncan & Hubble, 1999).

The engagement process is sometimes identified using other terms such as cooperation, collaboration, participation or buy in (Tetley et al., 2011; Yachmenoff, 2005). Engagement and rapport building is said to create the foundations required for successful intervention as it promotes the building of trust that makes collaboration with service users possible.

Understanding of the experience of others was ranked 2nd by 62 % of participants. This finding relates well to social cognitive theory developed by Albert Bandura in the 1960s, the theory is widely applied in social work and is notable in recovery services. Social cognition includes amongst other factors the ability to understand and empathise with others.

Ability to model coping and resilience skills gained through their own experiences was ranked 3rd by 75 % of participants. Modelling behaviours are recognised widely in peer roles and additionally modelling behaviours reflects elements of social cognition theory. Modelling is said to create opportunities for learning new behaviours that can support change. In the context of the service relationship learning opportunities are said to exist in the actions of workers, by displaying behaviours such as keeping appointments, being punctual, honest, and reliable it is thought we may reinforce and elicit similar values from those we are working with.

4.4 Conclusion

These findings have supported my understanding of the general make up of survey respondents and their relationship to the sector environment. These findings are comparable to statistical data from *Women at work 1991–2013* (Statistics New Zealand, 2015) and the 2018 national census, this suggests survey respondents accurately reflect the sector and further suggests that the sectors make-up is stable in nature.

Person-centred interventions are multifaceted, consisting of opportunities for relationship building between worker and client (Brownie, & Nancarrow, 2013). Results from the ranking questions suggest respondents recognise the value of rapport building as a foundation to providing services, which would further suggest that respondents are likely to be working from within an approach that is both person centred, and relationship based.

Modelling coping and resilience skills gained through one's own experiences was ranked the lowest in questioning. Numerous studies (Andrews et al., 1979; Trotter, 1990, 1996, 2004) suggest workers reinforce behaviours regardless of whether they have an awareness of doing so. This suggests that modelling and reinforcing behaviours that support change may often occur naturally.

Chapter 5: Qualitative Thematic Findings

5.1 Introduction

Qualitative researchers are interested in understanding the meaning people have constructed, that is, how people make sense of their world and the experiences they have in the world. (Merriam, 2009,) The surveys questioning centred on understanding the experience of respondents in relationship to the research questioning. I have sought to remain true to the voice of respondents by allowing voice and not analysis to determine the discovering of themes from which three strong key themes emerged. The theme 'lived experience' of adversity emerged as an overarching theme requiring five interrelated subthemes to capture the depth and breadth of respondent's perspectives and insights.

5.2 Findings Theme: Adverse life experiences, wanting to make a difference and vocational choice

Wanting to make a difference in the lives of others and the concept of 'giving back' featured strongly within respondents' comments. The concept of persons who have experienced adversity looking to give back to society is not new; psychiatrist Carl Jung's archetype of the 'Wounded Physician'(Jung, 1951) described an individual who has struggled and has returned to help others.

"There seems to be a theme amongst the many people I have bumped into doing this work over the last 14 years that their own adverse experiences have led them to this work"

This respondent's comment resonates with both my own experience and comments made by colleagues over the years. It is widely appreciated that those who work in the sector start out wanting to make a difference in the lives of others. However, consideration of a connection between the adverse experiences of workers who are not in lived experience roles and their vocational motivation maybe less comfortably discussed or appreciated outside of conversations between trusted colleagues.

"*When you hurt badly, other priorities – money, career, recognition- drop in importance in terms of wanting to make a difference"*

In its rawness the respondents comment touches upon where some discomfort may lie when considering adverse experiences as a vocational motivator. The depth of sentiment seemingly conflicts with what some traditionally believe to be 'professional' and 'safe' potentially leading to consideration that traditional boundaries will be difficult to maintain. Partially as a means of managing risk seen as increased when employing lived experience workers wellness planning is often a contractual requirement, in contrast traditional role colleagues may not be required to do so. If we accept that statistically those in helping professions have had more adverse life experiences than the

general population and due to the nature of their work are likely to be further exposed to adverse experiences, this suggests it would be appropriate for all those in helping professions to complete wellness planning.

"In some instances, the experience of adverse events and trauma could be "cross referenced" it is very hard to understand what it feels like to have your rights and dignity stripped of you, unless you have experienced that yourself – and those human rights breaches are things that often drive people to enter social services."

"I believe that your own history especially that which has been challenging can motivate you to help others as you were helped yourself (or at times didn't receive the support you wish you had received during a difficult time). This personally has been a big motivator for me, and naturally being an empathetic person."

"The desire to give people the help they never got themselves."

"Negative experiences can inspire desire to see changes in the services you previously received, and having positive experiences can inspire desire to help in the same way you were helped"

Numerous respondents linked their personal experiences of using services as shaping their motivation to make a difference in the lives of others. This included experiences where the help they required was not provided and also positive experiences where service engagement was particularly worthwhile. Negative service experiences sometimes reflect the difficult issue of navigating across services where needs cannot be meet by one service alone. This can sometimes result in a misalignment of services, reducing the likelihood of positive outcomes. Workers with their own experience of navigating across services may have specific service user insights that potentially lessen the likelihood of negative service experiences associated with service fragmentation for those they provide support to.

5.3 Findings theme: Mutuality

Mutuality may be seen to exist as the potential for a positive, interactive relationship between people. Numerous studies of helping professionals have explored mutuality within relationships with service users. However, mutuality in this context is seen by many as subversive of traditional social service norms, which warn against the potential for creating dual relationships where loss of professional objectivity is thought to be at risk. This may suggest a disconnection between training, ethical standards, and how we practice.

"When you have hurt, you want to ease hurt"

"People in recovery from adverse events often find altruism another step in their journey"

The notion of healing oneself by helping is obviously not without controversy. That helping others may assist workers to process, make sense and further heal from their own experiences challenges tradition and is fraught with consideration of vulnerability and risk existing for the helper and the helped. However, the transition from lived experience of adversity to helping professions is a well-documented phenomena and has been suggested as an entirely expected pathway.

"Sometimes it helps people make sense of what they have been through themselves (either personally or experienced with whanau/friends). There can be a feeling of powerlessness that may be partially regained by supporting and helping others."

"A career in the helping profession allows the growth of the professional helper alongside the growth of the person or people in need"

"To be able to tell your "own your story" is important to move forward and I believe is needed to be able to support others. This requires ongoing reflection about why you are making certain decisions, how you are working with someone etc. there is a fine line walking alongside someone and disclosing appropriately – disclosing too much and it is becoming about you rather than the person you're supporting"

"I want to give back to my community who helped me when I needed it, and I am now in a position where I am physically able to"

"A feeling of giving back to others, also a passion to support and assist others"

"I am a people helper and want to give back to community. I find I am happy in this space"

The concept of 'giving back' was often touched on by respondents; this was sometimes referenced as giving back for help they themselves had received - inferring they were giving back to social services, society, or people in general. This suggests a relationship exists between a worker's history and their current professional life.

5.4 Findings Theme: Workers with history of adverse experiences

Respondents referring to their own history of adverse experiences or commenting on those of other workers had a strong presence throughout the survey questioning. For the most part (other than 2 responses) these comments did not suggest the respondent was in a lived experience role, where their experiences are part of their recognised skill set, this suggests for the most part comments were from workers who hold traditional roles.

One respondent spoke of a visit by Bruce Perry an American professor of psychiatry and behavioural sciences, widely referenced in New Zealand young person's services in relation to trauma informed care. Bruce Perry's comment mentioned by the respondent reflects findings from numerous studies that suggest persons in helping professions have a higher incidence of adverse childhood experiences than the general population.

"Bruce Perry came to NZ and held a workshop with professionals a few (10) years back to talk about trauma and the effects on the developing brain. He reckoned over 80% of the audience had trauma backgrounds which was why they were in the field although over 50% of those hadn't considered their own trauma experiences"

It is apparent there is no one universally accepted definition of trauma. Generally speaking, trauma may result from adverse experiences or incidents that have shaped us, applying this simple definition, we may have all experienced some degree of trauma in the process of living. Bruce Perry's statement suggests unrecognised trauma widely exists and that trauma is particularly evident in persons in

helping professions. This bears a relationship to the SAMHSA concept of trauma (Substance Abuse and Mental Health Services Administration, 2014) and its key elements that include realising the prevalence of trauma and, recognising how trauma affects all individuals involved.

Social service organisations often seek to incorporate a trauma sensitive approach, reflecting recognition that traumatic experiences may have implications for service user presentation, engagement, and outcomes. Extending the sentiment of a trauma sensitive approach to further consider the implications of pre-employment traumatic experiences within those in helping roles is unlikely unless the worker is in a lived experience role. However, workers are commonly provided with external supervision and employee assistance programmes (EAP) this supports reflective practice and the addressing of issues that potentially impact on wellbeing and professional capacity. These supports may also assist workers to explore and identify their histories and its relationship to their practice.

5.4.1 Sub theme: Lived experience of adversity may assist workers to carry out their role

Numerous respondents commented on skills and knowledge they attributed to their own adverse experiences. This included the ability to purposefully model positive behaviours and coping skills and enhanced self-awareness, personal resilience, open-mindedness, and empathy. The quality of support provided is understood to be closely connected to the attributes of those delivering the service rather than the service directives themselves, not what is delivered but how it is delivered and by whom. Findings suggest that respondents feel their acquired attributes positively supported their professional capabilities.

“It is my experience that people who undertake study in this field or enter the field to work, who have had adverse life experiences, bring with them an understanding that is not possible to achieve through academic studies alone”

“It feeds into what we know works in many cultures where lived knowledge is seen as incredibly important and passed on from one generation to the next. We need to see the "lived experience workforce" as a "cultural workforce" where the culture of "lived knowledge" informs the work at a much higher level.”

“During training you find out that things you've been doing your whole life are useful professional skills, this is very reassuring and validating”

This comment resonates with my own experience, in that service trainings I have attended have generated similar feelings of validation and reassurance. The notion of lived experience informing practice is suggested from research as a potentially natural occurring phenomenon. However, lived experience is less understood or accepted compared to traditional practice norms this suggests that this phenomena as less valued and an area requiring more research.

Positive coping mechanisms and coping skills are said to be vital for navigating life’s challenges. The following comments suggest coping mechanisms present in workers who have had adverse experiences may exist as both desirable and undesirable and that self-knowledge and purposeful application are important in the practice sense.

“If the person has appropriate coping skills yes, their favourite go-to skills may not cover the whole gamut of what’s available for someone else, and everyone has their own preference. For example, I journaled my way out of depression, but expecting someone who doesn’t feel creative or want to write, isn’t going to work for them. To a degree it’s beneficial, but a helper needs to be able to offer more than just what works for them”

“It also leads to development of not-so-great coping skills. HAH! “

“Double edged sword – as some of those coping strategies while good at the time can become unhelpful in different situations and with different people Self-knowledge and awareness is very important.”

The development of positive coping mechanisms, skills and strategies are not available in a one size fits all manner and most people need to go on their own discovery journey to understand what resonates for them. Reflective supervision potentially supports a journey of self-discovery, acknowledging the implications of one’s past experiences and how they may resonate in the present tense both professionally and personally.

5.4.2 Sub theme: Engagement, rapport, and modelling

The potential for a practitioners lived experience enhancing service engagement, rapport building and connection to those one supports professionally was commented on robustly by numerous participants.

“You cannot get anywhere without a connection with people and building rapport. Trust is so important – a person will not open up or be honest without this. This is also crucial for client centred plans, and goals led by the person you’re supporting. It too is important to model calm behaviour and not let your own trauma take over otherwise it becomes more about you then the person you are supporting.”

“You already have an understanding / knowledge of various experiences what people are going through, it’s the engagement and establishing rapport with whanau / family. It’s the HOW you gain their trust and establish a beginning. (Foundation work, understanding culture diversity, how do you approach this, never use assumption).”

*“Well, if you can't grasp someone's experience then you'll be unlikely to be able to build rapport or role model resilience strategies. Caring begins with empathy, you can't just bash in and tell people you know their problems and if they do *this* it will be magically fixed.”*

"I know what's best for you because either I've never experienced what you've been through and therefore, I'm in a superior position or I've been there done that and recovered" attitude doesn't fly with people. Non-judgement is key to rapport, engagement, and trust. Humility helps to level the power imbalance. I've heard those working in helping roles use language like "underclass" and "living miserable lives" when referring to the people they are supporting. And yet these workers believe they are helping and making a difference. Also, an ability to work on our practice through supervision and self-reflection is key to a good robust workforce.”

There is a call for a return to social work interventions based on effective engagement (Ruch et al., 2010). Successful engagement I suggest is more likely where trust is present, amongst other things this will likely be best supported by core engagement strategies such as listening and seeking to understand. A service user may not be motivated to engage with a support person if there is no trust or rapport between them, it would seem relationship and connection is indeed key.

5.4.3 Sub theme: Notes of caution and concern

Persons in helping roles who openly identify as having had lived experience or adverse life experiences is a relatively new and emerging concept in westernised practice, that is increasingly seen within the mental health and addictions field but also in other areas such as domestic violence and health management.

The following comments regarding workers with lived experience were strongly worded suggesting the matter is of very high concern to these respondents.

"NO, it shouldn't happen as the work could trigger the employee"

"I would think some life experiences would mean some jobs aren't suitable, the employer in any area would need to see that the potential employee is not at risk of causing harm to clients either way"

"I've seen a lot in my 20 years, and they are not able to step outside their own emotional trauma and be objective"

Persons with a particular diagnosis or traumatic history have been traditionally aligned to perceptions of vulnerability and risk. It seems the context of lived experience applied professionally remains a hard concept for some to accept without applying a lens of vulnerability and risk. Potentially I suggest there is there is self-feeding relationship between stigma and perceptions of increased risk attached to persons with a particular diagnosis or histories. The lack of credibility of lived experience workers in the eyes of professionals has contributed to common experiences of professional isolation, marginalisation, and tokenism particularly within traditional services (Byrne et al., 2016).

"I see folks in these jobs that are not fully recovered.... helping others can help them heal.... but sometimes it can have a detrimental effect on the clients they are trying to help"

Defining the terms 'recovered' and 'recovery' is difficult, as professionals, organisations, service users and people in general will understand these terms in a variety of ways. An individual in recovery may consider it to be an ongoing journey, or a way of life, that is without a finite destination, the outcome of fully recovered may not be the purpose or intent of recovery in this context. The notion that some may hold that people working in the sector should be 'fully recovered' may give rise to unrealistic expectations and potentially lead to workers feeling the need to continually prove their wellness alongside accepting additional scrutiny and oversight than their traditionally aligned colleagues.

5.4.4 Sub theme: Stigma

Research has indicated that when an experience of mental health is known, people may encounter rejection personally and in their social work roles and that their opinions, abilities, and competence are devalued (Wahl, 2011). Respondents' comments largely relate to the potential for disclosures by persons in traditional roles to result in stigmatisation, in the context of a lived experience role some

degree of disclosure would have already taken place, however the potential for stigma and discrimination may also exist.

"The stigma and prejudice around disclosure is significant. A lot of fear-based responses about disclosure as it could (and has) hampered career progression, could put people into situations where they are viewed as "affected" and cannot escape the lived experience "tattoo" even when they want to."

"I personally believe there is a degree of fear to disclose due to being concerned it may stop career progression, or used against you in some way for example being told you're not coping etc. This is unfortunate as if you are in a place where you can disclose it can be very powerful and again owning your story – and can be a real strength to your practice. Despite this I believe a lot of people are drawn to working in social services and often have a story of their own which involves facing some sort of adversity and challenges and therefore should be normalised."

"I can understand the cautiousness, since there is a real lack of understanding, especially with certain mental health challenges that are far more stigmatised like schizophrenia, bipolar, etc."

"Workers might be scared that the employer might doubt the worker's cognitive state of mind. Or use it against the worker in a negative way to cause harm to the worker's healthcare career."

"I have seen employees make disclosures that have later been weaponised to distract from the organisation's structural issues. I do not feel safe to disclose some aspects to my employer."

These comments relate to the survey question *'Research indicates that workers who have had adverse life experiences maybe cautious regarding disclosing these experiences to their employers due to potential stigma'*. Responses were confirming that disclosure is indeed an issue of high significance for many workers. The respondents' concerns suggest risk of stigmatisation creates a sizeable barrier to disclosure and that workers would benefit from a culture of understanding and acceptance in regard to disclosure of adverse life experiences.

"As a peer support worker sharing my story is my bread and butter. This is not a regurgitation of my story but a purposeful sharing when appropriate. I am therefore very fortunate that my employer specifically employed me for my lived experience. I think it may be a factor for others who disclose as discrimination and stigma is still alive and well."

"I have never had any problem with disclosing past/historic adverse life experiences to an employer. However nervous of disclosure of any current adverse life experiences."

The previous comments identified elements of the lived experience role that are distinctive from traditional roles, in that one's 'story' is accepted in context to their professional role. Nervousness regarding disclosure of current adverse experiences may suggest an environment that holds to the notion that people working in the sector should be 'fully recovered'. In such cases stigma, discrimination and marginalisation may exist for those not considered by others to be fully recovered which as mentioned previously can give rise to unrealistic expectations not experienced by those in traditional roles.

5.5 Conclusion

There have been numerous studies internationally measuring trauma and adverse experiences in social workers and other recognised professional roles. Research on the subject pertaining to those in roles that are unregulated (meaning not requiring registration within a governing body) such as support worker have been less studied. This potentially equates to less understood and accepted. Further research may increase understanding and lessen the presence of stigma associated with adverse life experiences.

Aotearoa is a unique environment that includes a distinct trauma history including that of colonisation that is widely referenced as negatively impacting upon indigenous persons across generations. Additionally, we are a nation with disproportionate representation in negative social statistics compared to other westernised countries, that also disproportionally impacts upon our indigenous population. Any exploration of stigma and adverse life experiences in Aotearoa I suggest needs to explore the implications of the environment as holding potential for systemic stigma in that multiple systems reinforce stigma within already marginalised populations.

Chapter 6: Discussion and conclusions

6.1 Chapter overview

The questions that guided this research inquiry were:

- To what extent are adverse life experiences perceived as an underlying motivator for the vocational choices of social service and support workers?
- To what extent are adverse life experiences perceived as contributing to advantageous attributes in social service and support workers?
- To what extent do social service and support workers perceive stigma and professional vulnerability exist as barriers to identifying adverse life experiences in the workplace?

This project has been confirming of overseas research that has suggested that those in helping professions may have had more adverse experiences than the general population and that these experiences have in many cases contributed to vocational motivation. Additionally, the research project has provided a unique opportunity to better understand the representation of adverse experiences in those in helping professions in Aotearoa based on observations and insights from persons in helping professions.

The following chapter presents discussions, conclusions, and recommendations I have come to as a result of having undertaken this research project. I will also address limitations to the research I have considered.

6.2 Extent of lived experience of adversity

This research project targeted social service and support workers inclusively of all roles in the sector this suggests respondents were representative of both traditional and lived experience roles. Participants were not questioned directly as to whether they identified as having had adverse life experiences, however, for the most part comments were in the first person when referring to adverse life experiences, this may further suggest a high incidence of lived experience of adversity. It is unknown if this is greater than that of the general population. American research that confirmed a high incidence of adverse life experience in social service workers used the ACE measure and was able to compare results to that of the general population using findings reported from the CDC-Kaiser Permanente Adverse Childhood Experiences (ACE) Study conducted from 1995 to 1997.

Given the high proportions of personal experience of mental distress and awareness of mental distress in others, most New Zealanders will be affected by mental distress at some point in their lives (Wilson, & Nicolson, 2020)). Aotearoa is recognised globally for significantly high negative social statistics, relating to the areas of domestic violence, child abuse, sexual offending, and youth suicide

these are all identified in the ACE measure as major contributors to adverse childhood experiences. This may indicate New Zealanders collectively have had more adverse childhood experiences exposure than populations less dominated by these issues.

In 2020 UNICEF reported that New Zealand has one of the worst records of child abuse in the developed world and links abuse to negative outcomes in later life for New Zealanders who have either experienced or witnessed abuse, these negative outcomes include mental and physical health issues, addiction, suicide, incarceration, and lowered quality of life. The issue of high incarceration rates as mentioned in the UNICEF report are reflected in the Department of Corrections comparison report (2018) that informs us New Zealand's prison population is unusually skewed in terms of sexual and violent offenders compared to 31 jurisdictions in the CoE (Council of Europe), having the highest percentage of sentenced prisoners convicted of violent and sexual offences and one of the highest imprisonment rates in the developed world. It has been suggested that domestic violence is the most common form of violent crime in New Zealand (Ministry of Justice, 2016).

There is now evidence that children are directly impacted by being exposed to domestic violence and are emotionally damaged even if they are not physically harmed (Swarbrick, 2011). New Zealand Police (2010) reported that 70% of child abuse cases were family related and that in most family violence cases attended, children were present. This reinforces the potential that participants in this project who identify as having had lived experience of adversity may have witnessed violence or been subject to violence.

In summary it is evident that exposure to adverse life experiences in Aotearoa will mirror our evidenced societal issues. These issues are recognised as globally significant in that they are disproportionate to population in comparison to other westernised countries. I surmise that our disproportionately high negative social statistics relating to domestic violence, child abuse and sexual offending will naturally equate to disproportionately high incidence of exposure to adverse experiences in our population in general.

6.3 Seeking meaning and wounded healers

Numerous participants of this research survey embraced the concept of giving back, persons who have had adverse experiences looking to give back to society is not new. The German philosopher Friedrich Nietzsche (1844–1900) is often attributed with the quote '*What cannot kill me will make me stronger'* that clearly infers personal growth through suffering. On further research I learnt this quote is an interpretation of text from his final work Ecce Homo: *How One Becomes What One Is*, where the words '*that which does not kill him makes him stronger'* are to be found (The-complete-works-of-Friedrich-Nietzsche-VOL-XVII,1911, Pg,13). Nietzsche explores how unbearable it may be to suffer without meaning and wrote of how humans will naturally search for meaning in relation to their own suffering.

Swiss psychiatrist Carl Jung reflected the sentiment of giving back and seeking meaning in his archetype of the 'wounded healer' which was described as an individual who has struggled and has now returned to help those still hurting (Benziman et al., 2012). Jung is said to have likely been a wounded healer himself as he had written and spoken of visions and probably had his own mental health challenges (Dunne, 2000). The concept of wounded healer is not Jung's creation but is thought to date back to ancient times. It is claimed the Athenian philosopher Plato said the most skilful

physicians are those who have suffered. This sentiment is further reflected in the ancient Greek mythological creature Chiron whose deep wounds enhanced his ability to heal the wounds of others.

In summary adversity and suffering have been said to be an inevitable consequence of living and that maybe traumatic scarring is a reasonable expectation of living. People consciously reflect in order to understand events in their lives and as a consequence hopefully add and enhance meaning (Heyler, 2015). In processing adverse life experiences it seems we may naturally seek to attach meaning and purpose to our suffering through reflection, which in turn may support our potential for growth.

Jung had wrote of wounded healers as having learnt from their wounding experiences, enabling them to help others who are also suffering , his sentiments can be seen to relate to the process of reflection and why some people grow as a result of adverse experiences and others do not. It is noteworthy that reflective practice and reflective supervision is widely supported within the sector as enhancing professional development and safe practice.

6.4 Stigma

The issue of stigma and discrimination for those identifying as having had adverse lived experiences has been addressed in numerous studies (Benbow et al., 2014; Byrne et al., 2019; Krupchanka et al., 2018). Goffman (1963) defined stigma as 'an attribute that is deeply discrediting'. Participants comments clearly suggested that for the most part those who have had adverse life experiences may feel compelled to hide their history due to fear of stigma, discrimination, and professional consequences, additionally responses indicated workers who are in lived experience roles were reluctant to discuss current issues for fear of been seen as not adequately recovered. The ingrained nature of stigma as it relates to mental health in particular is highlighted in a review of studies on stigma by American Psychiatric Association (2021) which shows that while the public accept the nature of a mental health disorder and the need for treatment, many have a negative view of those with mental illness.

Jones (2012) in his book '*Chavs: The Demonization of the Working Class'* suggested stigmatisation may be a direct consequence of applying labels to people and that any label creates potential that a person will be perceived and treated differently from others. Jones described the stigmatisation of working-class communities in the UK via the commonly used label 'chav' suggesting that the label served to perpetuate social inequalities and that a self-feeding cycle existed between labelling, stigma, and discrimination. If we apply Jones' thinking to the use of 'lived experience' as a label, it maybe suggested as potentially perpetuating stigma and limiting opportunity.

Until recent times persons with adverse life experiences may have been openly discouraged from entering helping professions. This is in keeping with the belief that certain conditions and experiences were indicative of a predisposition to future adverse events, therefore helping professions were seen as a risk laden unsuitable career path. Work-related stress is a universal risk in helping professions, however the presence of stigma and perceptions of vulnerability will likely contribute to assumptions that persons who have had adverse life experiences are less likely to cope with work related stress than those without.

American Psychiatric Association (2021) reported that people often avoid or delay seeking treatment for stress and mental illness due to concerns about being treated differently or fears of losing their jobs. Given that the lived experience movement is considered a human rights movement (World

Health Organisation, 2010) and that empowerment and participation by people with lived experience is considered essential to progress this human rights agenda, it seems that fear of stigma and discrimination continue to act as barriers to progressing our understanding and acceptance of those whose life experiences may differ from our own.

Fear of stigma and discrimination were highlighted as a significant area of concern for numerous respondents. This key finding suggests a collision between what some respondents experience, and the values of social justice, human rights and inclusiveness organisations will be seeking to uphold. I suggest it is not only desirable but imperative that matters of stigma, discrimination and inclusiveness are addressed and managed by service environments in a manner that reflects committed change to ensure the rights of all workers to be free of the fear of stigma and discrimination in the workplace are upheld, including those who have had adverse experiences and those that may have ongoing life challenges due to the impacts of these experiences.

6.5 Attributes that enhance service engagement

Respondents for the most part felt benefits existed for service users as a result of having workers who have had adverse life experiences themselves; benefits expressed included an enhanced ability to engage and connect with service users. Where the worker is not in a lived experience role it is unlikely service users are aware of the workers adverse life experiences. This suggests that benefits to engagement may not require identification of a worker's experience, instead benefits may exist in attributes that support effective engagement that workers have developed as a consequence of learning from their experiences. Effective engagement is understood to be largely due to the attributes of workers rather than solely from service directives, not what is delivered, but how it is delivered and by whom.

Where workers value their role, the service users and their service experience, there is obviously increased likelihood of successful outcomes for those using the service. The term ‘hard to reach populations’ relates to those who experience persistent barriers to obtaining services. Often this is in part due to a service user's previous service use experiences which may include traumatic abuses of their rights within governmental systems including child protection, institutionalisation, and justice systems. In these cases, the attributes of workers are what makes engagement possible as before support can be provided trust needs to be developed to create the foundations required for successful engagement.

Clearly workers with enhanced engagement skills will be particularly effective at meeting the needs of those from hard-to-reach populations. In part this will be possible through their ability to connect, this can be considered in the context of an interconnectedness that may encompass a naturally occurring sense of whānau such as spoken of in relation to the homeless community and recovery networks. The mana of others you do not see with your eyes, possibly the story of others that has increased their ability to understand your experiences is also felt – maybe you don't need the story to feel the connectedness.

In summary the old recovery sayings, ‘the opposite of addiction is not sobriety it is connection’ and ‘no man is an island’ reflect what is known regarding the link between loss of connection and loss of well-being, humans are born from and into connection and it seems we don't just prefer connection we likely need it to sustain us. I surmise that a worker’s personal attributes and not their academic

knowledge or sector experience may increase the likelihood of effective engagement, this in turn increases likelihood of improved service outcomes.

6.6 Limitations of the research

There are numerous studies internationally measuring adverse childhood experiences in social workers and other professional roles. However the lack of studies in the area of lived experience of adversity in general in Aotearoa and particularly of the social service workforce meant I needed to refer to international research which lacked the context of our unique environment with its significant social issues that include globally disproportionate representation in negative statistics relating to suicide, child abuse and partner violence and how these statistics may influence any exploration of adverse life experiences in Aotearoa.

Sandelowski (2000) acknowledged the researcher is neither impartial nor a bystander. Sandelowski's statement is reflective of my position as I have both a history that is deeply invested in the sector and my own adverse life experiences story. The consideration of limitations to the research project due to the potential for bias required continual reflection on my own impressions and opinions (and often challenging them) while analysing the data and forming conclusions.

6.7 Recommendations

Arising from this research project there were issues relating to understanding the life histories of the sectors workforce that potentially limits valuing and utilising their unique capabilities. Social services are delivered by humans for humans and the overarching requirement for successful engagement I suggest is the workers ability to firstly establish rapport and connection. The ability to engage effectively it seems requires more than service directives and education to exist. I recommend further research to advance understanding of personal attributes that enhance engagement including those attained through a process of learning and growth as a consequence of adverse life experience.

Numerous respondents suggested that identifying adverse life experiences in the professional environment increased their risk of experiencing stigma and this risk acted as a barrier to doing so. Fears included professional repercussions in that their work may be devalued or questioned in future. Stigma and discrimination (actual experiences and fear of) are evidenced as contributing to professional isolation and self-stigma and are representative of health and well-being risks. *The Health and Safety at Work Act* (2015) directs employers to take steps to protect and prevent harm, this includes psychological harm. *The Human Rights Amendment Act* (2001) prohibits workplace discrimination against people on the grounds of psychological disability or impairment, which could be argued to include those who have ongoing challenges due to adverse experiences exposure. In the workplace these acts of parliament serve in-part to direct organisational policy, I suggest governmental directives and organisational policy may be inadequate on their own in addressing the issues related to stigma and discrimination highlighted by those who participated in this research project.

'*Like Minds, Like Mine'* is a long running public awareness programme operated by The Health Promotion Agency (HPA) in partnership with the Mental Health Foundation it aims to increase social inclusion and end discrimination towards people with experience of mental illness or distress. Periodically this program has run high profile media campaigns aimed at promoting inclusion and ending discrimination, serving to get the issues noticed and supporting the potential for societal behaviour change. Currently the program supplies information resources via their website, undertakes

research and funds periodic awareness campaigns. I suggest that to achieve sustained behaviour change in relation to inclusion and freedom from discrimination as it impacts on those with adverse experience histories requires sustained high-profile campaigning as befits the addressing of an ingrained societal issue.

Aotearoa's disproportionately high negative social statistics will naturally equate to disproportionately high incidence of exposure to adverse experiences in our population and maybe further evidenced within those in helping professions. Wellness planning can be a contractual requirement for those in lived experience roles but is often not required for those in traditional roles. In considering the potential interconnectedness between negative social statistics, adverse experiences, and vocational motivation in helping professions we need consider the known risks of helping professions which include burnout, compassion fatigue, secondary trauma, and vicarious trauma. I suggest wellness planning supports growth and maintenance of individual protective factors and is pertinent for all those in helping roles and should not isolated to those in lived experience roles.

Increased acceptance of the existence of adverse life experiences creates opportunity to further consider the scope of support available to workers. Current economic issues of high rents and housing shortages increase potential for lower paid workers to experience unequal access to social determinants of health and well-being. This maybe particularly so for those in social service support roles where conditions may include low pay, casual contracts, and limited opportunity for advancement. Potentially this combination increases incidence of workers experiencing food insecurity, overcrowding and debt. These stressors are known to contribute to an increased incidence of negative wellbeing issues. Increasing the scope of support offered to workers may include referral pathways to practical welfare support alongside the existing provisions of EAP and supervision.

6.8 Purpose and achievement

This research project has shone a light on the interwoven relationship between adverse life experiences, post traumatic growth and vocational motivation for those in helping professions in Aotearoa. In shining a light, I suggest the time has come to integrate wisdoms attained through a growth process as a result of adverse experiences inclusively (rather than separately) within capability and competency frameworks. In doing so we may better reflect values of inclusiveness and diversity acceptance.

A primary achievement of this project is reflected in the strength of the survey findings as they related to stigma and discrimination (actual) and fear of stigma and discrimination within the sector. These findings reflect a human rights issue, in that respondents did not feel they have freedom from stigma and discrimination realised within their places of work. Where stigma and discrimination are perceived to exist in relation to workers with adverse life experiences, I suggest there is increased likelihood of stigma and discrimination in relation to other human differences. This finding optimistically offers opportunity for the sector to apply a wider all-encompassing lens when considering the issues of stigma, discrimination, negative stereotyping, and bias.

Identification by philosophers, theorists, and researchers of the phenomenon of people seeking meaning from their adverse experiences by helping others and of the special skills and knowledge they may hold has a history that goes back to ancient times. This study is offered as a seed planting project in that it may grow understanding and awareness of the evidenced phenomenon as it exists in Aotearoa

6.9 Conclusions

Concernedly respondents repeatedly reflected on matters relating to stigma and discrimination. One memorable comment described a willingness to identify historical adversity in the context of the requirement attached to their lived experience role but an unwillingness to identify current adverse experiences for fear of professional repercussions. Workplace attitudinal barriers are seen in literature as contributing to both lived experience workers and those in traditional roles experiencing *'A culture where stigma is the norm and discrimination or abuses are tolerated'* (National Mental Health Consumer and Carer Forum, 2010, p. 21) This sentiment was reflected across the survey responses.

Adverse life experiences were indicated as an underlying motivator for vocational choice by many respondents, however within the responses it was clear that there exists professional discomfort around workers identifying this due to fear of stigma and discrimination. The extent respondents perceived stigma and professional vulnerability existing as a barrier to identifying adverse life experiences was pervasive throughout the comments received. This reflects poorly on the sector as stigma and discrimination are evidenced as harmful and life limiting.

Numerous respondents sought to make a difference in the lives of others who have had experiences like their own, wanting others not to suffer as much as they had and wanting to share skills and knowledge that they have learnt from their own experiences to benefit others. This demonstrates that adverse life experiences motivated vocational choice for many respondents. It appears adverse life experiences are a contributor to not only what drives service user needs but also the sector's workforce. Reflection organisationally and individually on the relevance our histories have to the work that we do would support deeper understanding of the makeup and potential of the workforce. Again ...why are we here?... how did we get here?

Potentially the human systems we work within unconsciously support negative stereotyping of those who have had adverse life experiences by inadvertently portraying these experiences as something that happens to some and not others. This separation of human experience may support silence and shame within the workforce and further feed fear stigma, discrimination, and professional isolation. The value of organisations moving towards an alliance to the principles of trauma informed care is said to support balance that may address these issues as it increases acceptance that trauma exists in general as part of the wider experience of living. Enactment of the core principles of trauma informed care are said to provide mutual benefit for services users, workers, and service systems. These principles include safety, trust, collaboration and empowerment alongside avoidance of repeating unhealthy dynamics within the helping relationship.

There is an abundance of research indicating childhood abuse, neglect, family dysfunction and domestic violence are prevalent in Aotearoa. It is said the reasons some people may not only survive but possibly thrive because of adverse experiences may be the presence of protective factors, identified as including healthy relationships, gender equality, social connection, cultural identity, diversity acceptance and feeling safe to reach out for help. Supporting the advancement of protective factors present in workers in social service environments would potentially serve to enhance service effectivity and the safety and wellbeing of both those who serve and those who receive services.

Adverse life experiences were widely identified by respondents as contributing to advantageous attributes. Numerous respondents' felt they had gained enhanced understanding and insight into the experience of service users and an increased ability to establish the rapport needed to support effective

engagement. It is said workers with lived experience may contribute to breaking through system hierarchies that can act as barriers to engagement while providing insight into how to make use of a service user's unique strengths. This demonstrates attributes that potentially advance and increase leverage, traction and effectivity of service activities.

Chapter 7: Critical reflective commentary

7.1 Introduction

In this chapter I reflect on the learning that has occurred for myself through the process of this practitioner inquiry project. I consider the impact on my practice during the enquiry process and moving forward I consider future implications to my practice as a consequence of having undertaken this process.

7.2 The impact of the learning process on my practice

In chapter one I described having undertaken a learning journey facilitated within the Otago Polytechnic Capable program, previously in the undergraduate program and now in the domain of postgraduate studies. I described what I termed as having undergone a 'practice evolution' rather than transformational change, in that the process of learning has been organic in nature and naturally occurring throughout. I perceived the online learning environment provided by the Capable program as learner centred, as such the program recognised my capacities and grew my capabilities through a process that facilitated the naturally occurring organic development I have suggested.

The process of practitioner inquiry I envisage as having created an enduring foundation that will furnish the grounding required for growth and development on a continuum. This is reflective of an ecosystem approach to my development, in that in undertaking this process I have nurtured my future in a tangible way by growing my capacity to continue to evolve and develop and remain relevant to the sector and the environments I work in.

7.3 Nevertheless, here I am

I can't understand the 24-hour clock, I don't know left from right, I have never been able to ride a bike, I cannot do basic calculations and my handwriting could be kindly described as 'naive'. We are all unique and likely have things that we perform less well than others. However, for me there is a noticeable discrepancy between how I perform some tasks and my intellectual capabilities. This can be a barrier in education environments that are unable to cater to diverse learners, such as that which was available to me in 1960s and 70s. There were other factors that can share blame as to why I left school at fourteen years of age after not having been in regular attendance for many years, however the education system of the day played a significant part. Nevertheless, here I am decades later completing a Master of Professional Practice.

In completing a Bachelor of Social Services undergraduate degree in 2019, I did not articulate myself as neuro diverse, though in the chapter of my early life influences I described events that had negatively influenced my ability to achieve and progress through life. On a practice level I know that early life experiences have the potential to impact upon development as neurobiological, and

psychological studies have repeatedly shown that adverse experiences in childhood can have implications on a person's ability to learn.

During this inquiry project I have had reason to reflect on why in recent years I have openly identified as dyslexic when dyslexia is an element of wider difference and not an identification that accurately describes me. Concluding in the discussions chapter of this thesis I wrote 'concernedly respondents repeatedly reflected on matters relating to stigma and discrimination'. This learning process has been far more personal than I had envisaged when considering undertaking this project, in that findings resonated with my own experiences and in doing so prompted deeper reflection on my own self identifiers and consideration of how they may be reflected within the issues of stigma and discrimination and how this may bare a relationship to my practice values. What I unearthed was that I have persistently 'sanitised' what I present both professionally and personally and that the two are inextricably intertwined when you work in a helping profession, in that one's practice values reflect core beliefs representative of the 'whole person' which is made up of both a professional and an individual.

Undertaking this project has provided me with opportunity to explore the origins and development of my practice and personal values on a far deeper level than I believe would have been possible using any other process. When young my differences resulted in unequal access to education and life opportunities. Though this maybe (in part) the origin of my social justice values, the ability to apply these values purposefully to my own practice have been developed through a reflective process, undertaking this project has advanced this process by providing opportunity for deeper reflection and exploration of my practice over a sustained period.

7.4 Stigma… it's a problem

Self-stigma can be equated to perceived stigma, the recognition that society holds prejudices and may discriminate against a person because of their differences. A general process of self-stigmatising can be described as the awareness that negative stereotypes exist, agreement that these stereotypes apply to oneself, and application of stigma to self. This can be understood in the context of this critical reflection as referring to societal views and negative stereotyping of those with learning differences and adverse life experience.

I have on reflection failed to apply my values to myself, in that I have compartmentalised professional sanitised self and personal self as separate entities when in fact they are fundamentally intertwined. I have not represented in my presentation of self that which I value including social justice and equality and in doing so though I may have felt a little 'safer' at the time without realising I reinforced negative stereotyping I held about myself and contributed to harming both my professional and personal self-esteem and self-efficacy. Holy shite, I have been part of the stigma problem!

There is a classic description of a person who is unable to read, who pretends to read, this in turn may also deny the person opportunities to learn to read. I read well; however, I don't process it well. There is no reason to explain or reveal this or the numerous 'quirks' that make up my neurodiverse landscape and to do so without caution may open me to the potential for others to see me as flawed and question my capabilities. The same applies to differences in life histories, mine been one of adversity that has helped shape who I am and what I value, but to share this is as I have learnt is fraught with potential for discrimination based on persistent negative stereotyping of persons who have had adverse

experiences as ‘damaged’. It seems I have accepted stereotypes that may pertain to myself, and I have indeed applied them to myself.

A common stereotype is that learning differences and adverse life experiences affect low performers. It has been said that when high performers talk about their challenges, it can help to address misconceptions and negative stereotypes. This is all very nice however it doesn’t adequately represent the fear and risk that ‘outing’ oneself may hold and the potential this may preclude a rollercoaster of both professional and personal empowering moments alongside feelings of losing control as one cannot control the prejudices of others and any discriminatory actions, they may take based on their prejudices. In the professional setting, such actions are often difficult to substantiate and address, which can lead to people not only feeling victimised but also managing the implications to themselves professionally and personally of subversive discriminatory actions.

Currently my perspective is I do not feel obligated to highlight my differences to champion the cause of battling negative stereotyping and associated stigma and discrimination. None the less sometimes when I feel comfortable doing so and it is appropriate to the situation, I may share some of my story in a purposeful manner. This may include using self-identifiers such as neurodiverse and lived experience and terms that reference recovery orientated practice such as self-empowerment and self-advocacy. However, I will not label myself a neuro diverse lived experience practitioner. This is in keeping with my framework of practice in that I understand and value that difference is indeed normal and adverse experiences are common and we are all unique in our composition, capabilities, and experiences.

In revisiting this section, I am compelled to mention that in the time I have undertaken this practitioner inquiry I have had a significant experience of workplace discrimination based on my points of difference and personal history. Undertaking the thematic analysis process the textural data frequently threw up the word’s stigma, prejudice, and discrimination. While the irony was exquisite, the process provided me with a degree of mutuality in that hearing the voices of respondents I had opportunity to better understand and reflect on my own experience.

This section’s purpose has been to display an area of significant growth that has occurred through this learning process, in that by addressing my own self stigmatising behaviours I have increased my self-efficacy and potentially in doing so I may influence others to address negative stereotypes.

7.5 Fake it till you make it (or how hustling can backfire)

‘Fake it till you make it’ describes where a person may imitate confidence to achieve a result. ‘Hustling’ is a term often used in a negative context aligning to illegal activities. In Tāmaki Makaurau hustling is often associated with coin seeking on the street. Both these terms apply to me in that due to my points of difference such as leaving school at 14, neuro diversity and adverse life experiences I have needed to adapt my presentation so as to afford myself opportunity and shield against stigma. As I am from generations of hustlers I learnt this adaption from the behaviours modelled in my formative environment. During the process of this learning enquiry, I have had reason to consider ‘hustling’ and ‘faking it’ as it has resulted in miscommunication. On reflection the implication is that it is now time to refine my ‘hustle’.

Within the context of faking, it until you make it, I have often chosen not to say I do not understand something as there is a lot I don’t understand. This is in part due to the fact that some knowledge that

maybe universally accepted as understood is not understood by me due to not having had some mainstream early life experiences or alternately because of how I digest information. Here enters the 'hustler' who will go forth, research and find what I need to enable me to understand and undertake what I need professionally and academically to be part of both these worlds. Noteworthy the act of 'faking it' when used in this context and without dishonest intent can be seen as providing a shield of protection against stigma and judgement based on the negative stereotyping of others.

I wanted to progress from an undergraduate degree to post graduate studies and the Capable programs learner centred structure was a place I felt had allowed me to grow and flourish, so continuing on to a Master of Professional Practice with Capable was a natural fit. However, and importantly, I did not understand what I was undertaking in a Master of Professional Practice as I assumed it to be the same as a traditional master's program; I failed to clarify. Also, I did not comprehend the magnitude of the work required, if I had I may not have undertaken this project , however in having done so I am significantly enriched and uplifted as a practitioner and as a person. A Master of Professional Practice is not something you can hustle through, I instead I have had to 'hold the tiger by the tail' and learn quite literally by giving blood along the way on a journey that challenged my values, resilience, and sustainability to the core of my being by having to access and utilise the capabilities required to undertake this learning journey that I did not even know existed within myself…. phew!

What follows is a comical example of the implications of 'faking it': In sending my work in to be commented upon by facilitators, there were comments made about signposts. I did not know what a signpost was, and I did not want to ask, in hindsight I felt I risked appearing ignorant. Instead I concluded without researching that sign posting probably reflected my progress through the learning process. Therefore, I assumed signposts potentially indicated that I may not have met required expectations at this point of the process. I was later sent an attachment regarding signposts which I did not open as I was concerned that I would read of my shortcomings in the learning process. I had worked to my full capacity so felt if I was 'signposted' as not meeting requirements at this point I should consider stopping (this obviously also reflects self-stigmatising behaviours) Bravely and with some ceremony I eventually opened the attachment and learnt what signposts are, providing me with a game changing lightbulb moment that should not be underestimated. From there on in I managed to work on the clarity and flow the thesis document was lacking and required, additionally I was supplied with opportunity to further reflect on my relationship to self-stigma.

7.6 Navel gazing and coexistence

During the learning process I had discomfort around how personal the process was, especially around the ad nauseum use of the word 'I' which I kept avoiding and having pointed out to me as appropriate. I trace this back to not seeking full understanding of what a Master of Professional Practice was, therefore, I did not realise that my topic of choice would be completely impossible to separate from self. I wrongly assumed this piece of work was to be objective not subjective. Herein lies discomfort, ensuing self-talk included 'this is way too revealing = way too personal' questioning if this was a 'vanity project' and in being so was surely not professional, and additionally there was genuine fear that I may risk exposure to stigma and discrimination given my decision to be true to self in writing this thesis.

This journey has been one of surprises, which is to be expected considering I did not allow myself to be fully informed prior to commencing! Significantly as a result of undertaking this learning process and the opportunities for deep reflection that have presented along the way, the entities of my personal

and professional self now coexist with greater unity. This I envisage strengthens professional and personal protective factors and is supportive of my resilience and sustainability in a sector known for its risks and challenges.

7.7 Outputs, impacts and where to from here

Outputs from this research project are reflected in three parts. The thesis document presents the entirety of the research project I have undertaken and the findings and conclusions I have come to. A second document I have titled 'Whakakotahi' to reflect the documents intention to integrate and uphold the wisdoms that practitioners may have acquired through a process of posttraumatic growth as result of having had adverse experiences. The third part is the articulation of my 'where to from here' vision that shares the themes of potential, evolution and change that in sentiment are woven into this document.

The potential in this research lies as previously said in theoretically planting seeds that ignite dialogue and future research that may in turn support change. The third output supports the potential for change to be realised, it is my 'where to from here' intention to present the research I have undertaken to the sector I work in through a series of presentations in the form of journal reports and in person presentations. Whakakotahi supports these presentations in that it serves to display the concept of organisational change that supports integration of lived experience knowledge within the context of a capability framework.

Evolutionary theory denotes a process by which different organism develop from earlier forms, in a Darwinesque move the third output intends to give life to key findings deserving of their own focus such as those relating to stigma and discrimination and the relationship between negative social statistics, adverse life experiences and those in helping professions. Reflecting the theme of change the third output understands that to achieve change or influence behaviours sustained actions are required. I suggest the third output as the most tangible action to support realising the potential of this research project to initiate sector dialogue, research, and change.

'Whakakotahi' is conceptual in that it is a presentation of an idea of how an integrated capabilities and competencies framework with an accompanying self-appraisal tool may look and function. Whakakotahi is designed specifically for social service agencies that address social need rather than health and wellbeing as this is the area of social services, I primarily work in. The document embraces the theme of 'potential' a sentiment that is reflective of where I foresee the impacts of this research project as a whole will rest. The impact of 'potential' is that it may ignite dialogue and further research while also encouraging acceptance that adverse experiences are common in Aotearoa, and persons who have had adverse experiences are evidenced as well represented in helping professions.

In designing Whakakotahi I revisited work I had completed for my employer organisation in 2019 This exercise of reflecting on work I had created previously had an interesting parallel to the two case studies I had also completed in 2019 to support a Bachelor of Social Services undergraduate degree with the Capable program. The two case studies one from my early practice years and a recent case study were used to show how my practice had developed over time. Revisiting my 2019 work served to similarly display how I had progressed in my practice through the Master of Professional Practice learning process. The lens I am now able to apply (due to my development) to my previous work allowed reflection on what changes I had undergone. Reflecting on the previous work, I would not write the same today, my language would be less officious, more inclusive and accessible . I no longer

feel compelled to use language that infers hierarchy or when writing documents, although of course I did not see myself as compelled to do so in 2019. This interestingly has a relationship to having addressed my own self stigmatising behaviours through the learning process, in that the tone of the document on reflection may have been an extension of the shield I often unintentionally assumed to deflect the risk of exposure to stigma

How this research may impact on the sector as a whole is a rather grand thing to contemplate. I am a realist and the impacts I envisage are therefore real and not visionary. As mentioned, In the discussions chapter the primary achievement of this project I believe is reflected in the strength of the survey findings related to stigma and discrimination (actual) and fear of stigma and discrimination within the sector. I suggested the impact of these findings could be optimistically seen as signifying opportunity for the sector to reflect on issues of diversity inclusion, stigma and discrimination with a lens that considers the authenticity of how articulated values are best represented in practice. Reflection would support the potential for change and include consideration of the need to implement improvements sensitive to the experiences of those who use social services and those who work in them.

Potential of this research project may also be optimistically measured in justification for future research that seeks to further increase understanding of the impacts and implications of negative social statistics, adverse life experiences, post traumatic growth and the interconnected relationship these may have to vocational motivation in Aotearoa.

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Whakakotahi

Social services Aotearoa

Integrated capabilities and competencies framework and self-appraisal tool

CONTENTS

WHAKAKOTAHI

Integrated capabilities & competencies framework and self-appraisal tool

The title Whakakotahi has been chosen to reflect the documents intention to encourage inclusive practices that have potential to increase acceptance of the evidenced relationship between adverse life experiences, post traumatic growth and vocational motivation in the social services sector. Whakakotahi seeks to do so by recognising certain attributes attained through the process of posttraumatic growth as professionally relevant and existing within the wider scope of human potential present within the sectors workforce.

The social services sector is increasingly accepting of lived experience practice models however it has been suggested that without careful application these models maybe potentially career limiting and reinforcing of stigma. Lived experience can be understood to be inclusive of persons who have had adverse life experiences. Lived experience practitioners have long been negatively referenced as having greater vulnerability to boundary crossing actions and practice induced vicarious trauma and in some instances have been subject to oversight that traditional practitioners are not.

Whakakotahi accepts risks exist universally for all persons in helping professions and that selfcare and professional oversight requirements can be understood equally and inclusively of both those in traditional roles and those in lived experience roles. The outcome sought through this approach is to decrease stigma and increase inclusion therefore elevating potential for workplace wellbeing, alongside safe and ethical practice.

Woven purposely throughout the framework and shown in italics are sample capabilities and competencies practitioners may have developed as a result of having undergone a process of post traumatic growth as a consequence of having experienced adversity . The framework bears an obvious relationship to other tools developed and used for the sector, including those which I have both used and developed myself. Whakakotahi notably moves to include lived experience knowledge within one inclusive framework rather than separately. This can be understood as a stigma reducing action that accepts the existence of pre-professional adverse life experiences and post traumatic growth.

The Whakakotahi self-appraisal tool reflects the Whakakotahi framework and also has direct connection to the foundations of my practice. Pivotal to this is a respectful partnered approach that implies the core belief that everyone has strengths, and that supporting mobilisation of these strengths is key to building hope and supporting change .

WHAKAKOTAHI

Capabilities and competencies framework

What are competencies and capabilities? Capability in the context of this framework is the capacity to apply specific skills and knowledge to undertake a range of tasks and also the potential for development. Competence can be seen here as an advanced version of capability and reflects advanced skill and knowledge.

What is an inclusive framework? The term inclusive is used to demonstrate the framework's strengths-based approach to workforce development. The framework purposefully includes capabilities and competencies that may have been developed through a process of post traumatic growth as a result of adverse life experiences. Whakakotahi models acceptance that adverse life experiences are common and a natural reflection of Aotearoa's disproportionally high negative social statistics. Further to this Whakakotahi models understanding that adverse life experiences potentially provide unique opportunities for growth and development unattainable through traditional pathways and that this knowledge when applied purposefully in the practice sense has positive implications for those who use and work in our services.

The purpose of the framework is to support the identification of knowledge and skills staff require in the context of their roles. In addition, this framework supports identification of knowledge and capacity for development. The framework is not to be seen as an exhaustive listing but as a tool that supports reflection and recognition of both capability, competency.

The intention in doing so is to enhance our effectivity by improving how we recognise the attributes and potential of our workforce and in addition may also:

- Indicate capacity for development
- Enhance workforce recruitment and retention
- Recognise, develop, and utilise unique skill sets that new applicants and current staff possess, including those acquired as a result of post traumatic growth and not attained through educational achievement or sector experience

The framework may be used by individual workers to:

- Support a reflective process
- Understand the capabilities required to work at their current level and the capabilities required to work at a different level
- Self-identify current capabilities
- Self-identify gaps in skills, knowledge and behaviours and target opportunities for development
- Guide career planning discussions

The framework can be used by senior practitioners, team leaders & managers to:

- Align workforce capability to organisational needs
- Identify workforce capabilities and competencies
- Assist with a range of human resource functions including role design, recruitment, selection, and workforce development
- Support increased service effectivity through targeted workforce development
- Assist in staff review by supplying a tool for referencing development and advancement opportunities
- Assist in the identification of unique and specialist skill sets in new candidates and existing workforce

WHAKAKOTAHI

The three-dimensional capabilities and competencies framework approach explained

Tahi is the first dimension, which encompasses the minimum skill threshold for all staff. Staff whose skills are captured solely within this dimension will not supervise the work of others; they work under the direction of others and apply their skills within the guidelines established in their job description. Staff may individually have their capabilities and competencies realised across all 3 dimensions however all staff universally are represented in the minimum skill threshold of Tahi.

Rua is the second dimension, which reflects an increased level of integrated academic knowledge and sector experience; and is inclusive of the minimum skill threshold described in Tahi. Staff aligned to the dimension of Rua may or may not support and advise the work of others.

Toru is the third dimension which recognises advanced, specialist skills and knowledge, while also encompassing unique capabilities that are able to be purposely applied in practice. Toru is inclusive of the minimum skill threshold described in Tahi and some of what is described in Rua and additionally applies to staff who may lead, supervise, guide, support, educate, and resource the work of others.

Knowledge & skills	Tahi	Rua	Toru
Engagement	Understands key principles integral to effective engagement and can apply them in practice Has knowledge of approaches and strategies that enhance engagement and can apply them in practice Understands barriers to effective engagement that may exist and has strategies to approach them Seeks appropriate support and advice to enhance service engagement and address barriers	Integrated academic knowledge and sector experience that reflects increased understanding of effective engagement Models' engagement skills using a range of evidenced approaches that reduce barriers and enhance potential for effective engagement Provides support and advice to others to support effective engagement and address barriers *Purposefully applies lived experience knowledge to increase engagement potential*	Broad range of advanced and integrated skills, academic knowledge and sector experience that reflects deeper understanding of effective engagement Provides resources and learning opportunities to others that potentially increase engagement effectivity and address barriers to effective engagement
Diversity &inclusion	Knowledge of how to work inclusively of culture, ethnicity, disability, economic status, age, sexuality, gender identity, faith, and belief. Seeks appropriate support and advice when needed to meet the needs of diverse persons Displays behaviours that promote social equity and are supportive of a workplace that is inclusive and respectful of difference	Demonstrates integration of advanced knowledge, skills & experience of working inclusively with culture, ethnicity, disability, economic status, age, sexuality, gender identity, faith, and belief Models, promotes, and reinforces workplace inclusive behaviours Provides support and advice to others to meet the needs of diverse persons	Broad range of advanced skills, knowledge & experience relating to inclusivity, culture, ethnicity, disability, economic status, age, sexuality, gender identity, faith, and belief. Promotes and reinforces diversity acceptance and an inclusive workplace by facilitating initiatives and educational opportunities to the workplace *Can purposefully apply own unique experiences to increase workplace understanding and awareness of inclusion and diversity acceptance*
Working in partnership with tāngata whenua	Understands and undertakes a Māori-centred approach to engagement with Māori Knowledge of approaches to protect and enhance the mana of tāngata whai ora and whānau Māori	Demonstrates integration of academic knowledge, skills & sector experience of effective engagement undertaking a Māori-centred approach	Broad range of advanced and integrated skills, academic knowledge and sector experience that reflects deeper understanding of effective engagement undertaking a Māori-centred approach

	Knowledge of Māori health and wellbeing models and Māori wellbeing perspectives Seeks appropriate support and advice when needed to ensure effective engagement undertaking a Māori-centred approach	Has deeper understanding of responses to supporting Māori health and wellbeing that include Māori wellbeing models and Māori wellbeing perspectives Is familiar with local Māori groups and organisations and their roles in the community *Identifies as tangata whaiora with advanced recovery orientated wisdoms that can be purposely modelled and applied to practice*	Provides resources and educational opportunities and access to support that advances the workforces ability to engage effectively with Māori using a Māori-centred approach Engages with local and national Māori groups in their roles as guardians of Māori cultural knowledge *Able to share advanced lived experience wisdoms to support, advise, mentor and advocate for improving the service experience for Māori both individually and collectively*
Evidenced based practice	Knowledge of what constitutes evidence-based practice Has core understanding of the underpinning theories and models of the service and how these are applied in practice Seeks appropriate advice when needed to ensure an evidence-based approach is implemented	Models integrated knowledge, experience and skills relating to the underpinning theories & models of the service Has wider understanding of models, theories, concepts, approaches used in the social services sector Provides support and advice to others to increase understanding and application of evidenced based approaches that underpin the service	Provides educational opportunities & resources to reinforce and grow the workforces understanding of the theories and models that underpin the service *Advanced knowledge and practice wisdom of evidenced based approaches both as a service user and as a practitioner*
Policy and procedure	Awareness of policies and procedures, including where they are digitally stored for referencing in practice Understands how to implement workplace policies & procedures in practice Seeks appropriate support and advice when needed to ensure adherence to	Models' knowledge of and adherence to policies and procedures and maybe able to advise and support others to do so Maybe able to participate if asked in review and development of policy & procedures	Able to contribute to clear and workable policies and procedures that align with the service Provides educational opportunities for staff to maintain knowledge of current policies and procedures *Provides input and advise on policy from a lived experience perspective (i.e., adverse experiences and trauma informed perspectives and*

	organisational policy and procedure		*how these may be considered and reflected within organisational policy and procedure)*
Selfcare	Understands the context of undertaking and managing own self-care as integral to maintaining safe practice and practice effectivity Has planned for own wellbeing needs Asks for wellbeing advise and support when needed Attends external supervision monthly	Models in own practice, proficiency at planning, undertaking, and managing self-care Can assist others to access support to plan and address their own selfcare	Provides learning opportunities, resources, and access to services that support the wider workforce to meet their self-care and wellbeing needs Can respond directly to staff requiring wellbeing support *Utilising own recovery orientated, lived experience knowledge is able to advise the workplace regarding the development & implementation of selfcare strategies*

WHAKAKOTAHI

The self-appraisal tool

Self-appraisal is component of Whakakotahi that reflects our collective commitment to a cycle of improved practice effectivity and professional development.

The review is undertaken annually by staff and the results shared with their line manager. This process is intended as a reflective balanced assessment of one's own performance that supports staff to autonomously recognise their strengths while also establishing specific self-development goals for the forthcoming year.

Guide to completing the self-assessment template:

- Self-assessment is undertaken using the Whakakotahi, capabilities and competencies framework as a tool.
- Reflect on your individual capabilities and competencies across all 3 dimensions
- Consider the areas you identify as reflecting your strengths and where you have capacity for development.
- Reflect upon your job description and the key tasks of your role, consider your task related strengths and where you believe you can develop further
- Reflect and review the previous year's self-appraisal statements and development goals. What goals did you achieve and what requires reconsideration?
- Reflect on training and development you have undertaken in the previous year, what was useful? what wasn't? what training would you like to undertake in future?
- Arrange a time with your manager to discuss the results of your self-appraisal and plan your development goals for the forthcoming year.

Staff person's name:	Team:	Position title:	Date completed:
How would you rate your level of satisfaction in your role out of 10?	Length of time in role:	Where do you want to be in the next 1-2 years (career wise)?	Where do you want to be in the next 2-5 years (career wise)?

Capability and competency framework self-assessment *(enter number of capabilities & competencies within each dimension)*

Tahi	Rua	Toru	Strengths:	Challenges:	Where I have capacity and desire to develop:

Capabilities and competencies statement:

Job description self-assessment *(enter number of key tasks in JD and number of tasks you feel confident in)*

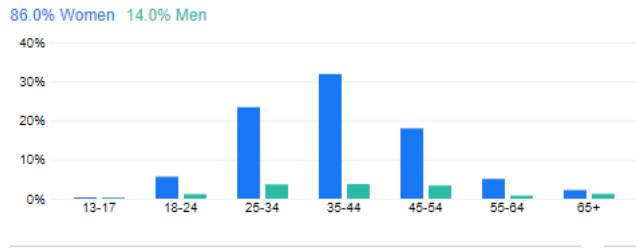
Number of key tasks in JD:	Number of key tasks I fulfil with confidence:	Number of key tasks I do not fulfil with confidence:	Task capabilities I seek to develop:

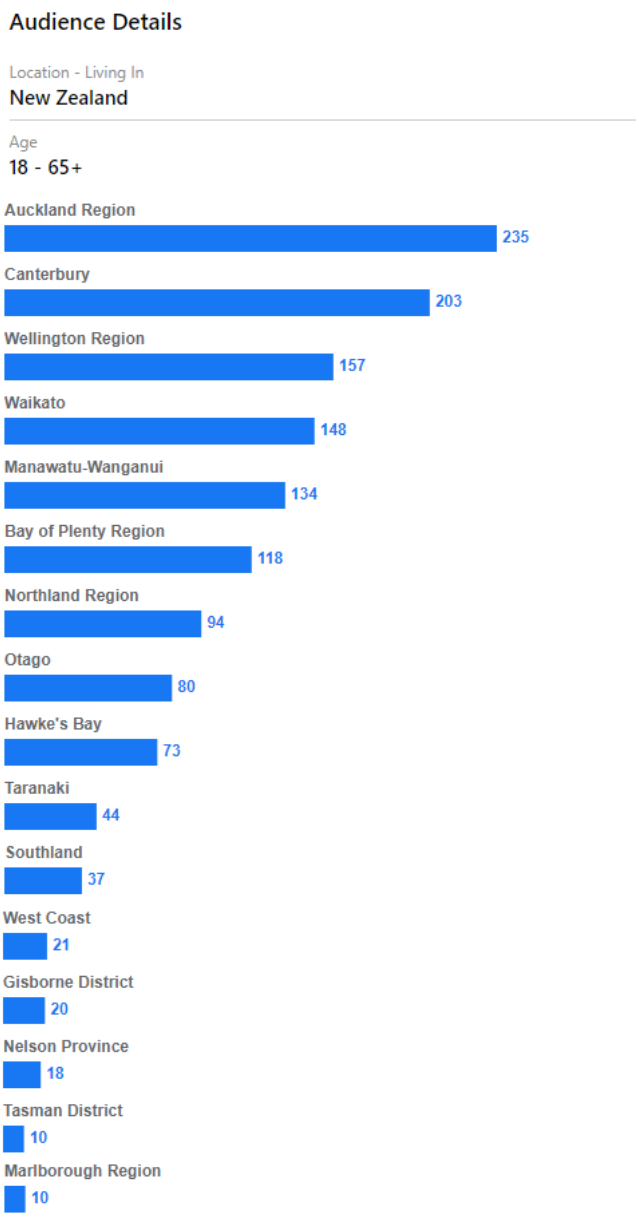
Statement of JD strengths and development:

Training & development you have undertaken both internal and external over the past 12 months (remark if incomplete)
Training & development you seek to undertake both internal and external over the next 12 months (where necessary include costs & study or training time required)
Additional comments:

1st Facebook advertising research survey participant recruitment campaign

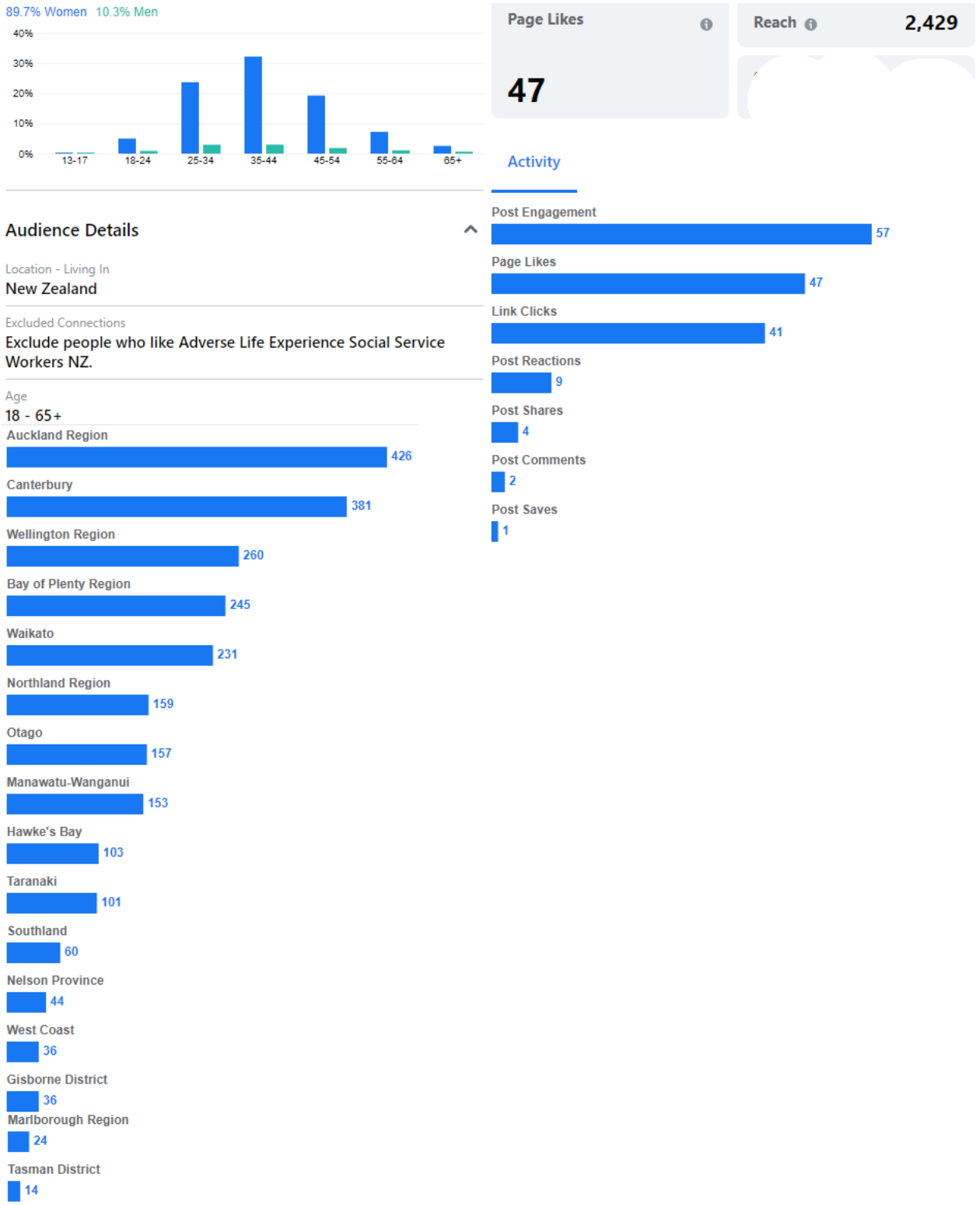
Activity data for the 1st advertisement that ran for two days showed it reached 1,402 people, of these people 30 engaged with the post, 21 went on to click on the research link. Of the 1,402 persons reached 86% were women and 14% were men, they were aged between 18 to 65+, with 35 to 44 years of age making up the dominate age group represented at 30%. The location of participants data was satisfying in that it confirmed participants were from 16 locations nationally and not as Auckland centric as I was expecting.





2nd Facebook advertising research survey participant recruitment campaign

Activity data for the 2nd advertisement showed it reached 2,429 people, of these people 57 engaged with the post, 41 went on to click on the research link. Of the 2,429 persons reached 90 % were women and 10 % were men, they were aged between 18 to 65+, with 35 to 44 years of age making up the dominate age group represented at 30%. As in the first advertisement the 2nd attracted participants from 16 locations nationally. The increase in engagement generated by the 2nd advertisement is accounted for by the fact it was live online Saturday and Sunday which are known to be high traffic days on Facebook.



Otago Polytechnic, Qualtrics research survey

PRF1.This survey should take approximately 30 minutes to complete

The project is undertaken by Otago Polytechnic student Fiona Mackinnon as a body of work towards a Master of Professional Practice Participation in this survey is voluntary. You may refuse to take part in the research or exit the survey at any time. You are free to decline to answer any question you do not wish to answer for any reason. Please note once you have clicked the surveys submit button you will be unable to withdraw or ask that information be removed due to the anonymity of the submitted data. The next two pages contain information and about the purpose of this research as well as de-identification and data storage, you will be asked to consent before proceeding and must do so in order to continue.

PRF2. Purpose of the research:

To identify to what extent adverse life experiences are perceived by social service and support workers as motivators for choosing a career in social services and support roles?

To identify to what extent adverse life experiences are perceived by social service and support workers as contributing to advantageous attributes in social service and support workers

To identify to what extent social service and support workers perceive stigma and professional vulnerability exist as a barrier to identifying adverse life experiences to their employers

The data gathered may potentially increase positive perception of the intrinsic value of personal growth from adverse life experiences in the workforce and lessen traditional assumptions and potential bias that persons who have adverse experiences are in deficit (i.e., vulnerable).

PRF3.De-identification and data storage:

All data gathered from the research survey will undergo a de- identification process, no personal identifiers will exist. All responses will remain anonymous. No one will be able to identify you or your answers, and no one will know whether you participated in the study. Data will be kept for seven years; at which time it will be destroyed.

Electronic Participant Consent: Please select choice below. Clicking the “Agree” button indicates the following

You have read the above information
You voluntarily agree to participate
You are over 18 years of age

- Agree
- Disagree

Q1. Please rank in order of importance which of the following factors you believe most motivates people to seek employment in social service and support sectors

- Wanting to make a difference in the lives of others
- They have learnt from their own experiences and wish to share their skills and knowledge to benefit others
- Wanting to help others who have had similar experiences to themselves?

Q1.5. Something else? Please state:

Q2. Why do you believe these factors motivate people to seek helping roles in social service and support sectors?

Q3. Research indicates that adverse life experiences can motivate people to seek helping roles in social services and support sectors. What are your thoughts on this?

Q4. Please rank in order of most favourable the following personal attributes for those employed in helping roles in the social service and support sectors.

- Ability to build rapport and engage with others
- Understanding of the experience of others
- Ability to model coping and resilience skills gained through their own experience's

Q4.5. Something else? Please state:

Q 5. Why do you believe these attributes are favourable in people employed in helping roles in the social service and support sectors?

Q 6. Research indicates that adverse life experiences can help some people to develop positive coping skills and knowledge that may be beneficial in 'helping' professions. What are your thoughts on this?

Q 7. Research indicates that workers who have had adverse life experiences may be cautious regarding disclosing these experiences to their employers due to potential stigma. What are your thoughts on this?

Q 8. Which ethnic group do you belong to?

Q 8.5. If other, please state below

Q 9. What is your age?

Q10. How long have you worked in the social service /support sector?

Q11.What gender do you identify with?

As a research participant, you may potentially experience discomfort when reflecting on experiences. If you do, you may wish to access the following resources.

- 24/7 Mental Health chat and txt 1737
- Lifeline – 0800 543 354 (0800 LIFELINE) or free text 435
- Depression Helpline – 0800 111 757 or free text 4202
- Peer Talk 0800 234 432 between 5pm and Midnight
- Māori Helpline – Kaupapa Māori support services: phone 0800 787 798, text 8681
- Pasifika Helpline – Pacific support services: phone 0800 787 799, text 868
- HELP 0800 623 1700 (sexual abuse)
- Safe to talk 0800 044 334 (sexual abuse)
- Online resources: https://www.bigwhitewall.com A safe online 24/7 community for members to take control, get support and feel better. Peer to peer community and professional community resources

Whāia te pae tawhiti kia tata. Whāia to pae kiā maua.
Persue the distant horizons so that they may become your reality.

Office of the Kaitohutohu Māori Research Consultation Feedback
Date: 17 August 2020
Researcher name: Fiona MacKinnon
Department: Capable NZ MPP
Project title: Exploring the Wider Existence of Historical Trauma in the Social Service Workforce.

TAIAO: Achieving environmental sustainability through Iwi & Hapū relationships with the whenua & moana	
Mātauraka Māori: Exploring Indigenous knowledge	
Hauora: Improving health & wellbeing	The researcher is seeking insight into vocational choice of social service workers and its relationship to adverse childhood experiences and post traumatic growth through an online survey. The research participants have experience in working in social services which support people that have experienced trauma, and the participants are experienced in using will interviews with using trauma screening tools, trauma awareness, experienced and able to address their own triggers and vulnerability to trauma, including awareness of resources available for responding to trauma. The Participant Information Sheet and Consent Form was not completed, but the writer is confident that the applicant will be well guided in this area by her Capable facilitator and mentor. It was pleasing to read how the applicant had incorporated and taken into account a kaupapa Māori approach to healing in this space, including hollistic Māori models of health and support services. You may wish to incorporate some te reo Māori / Māori concepts into your survey. We wish you all the best with you research Fiona.
To Live as Māori: Kaitiakitaka to ensure Māori culture and language flourish	

Unlocking the innovation potential of Māori knowledge, resources and people.

Name: Kelli Te Maihāroa

17 February 2022

Fiona MacKinnon
c/- Capable New Zealand
Otago Polytechnic
Private Bag 1910
Dunedin 9054

Dear Fiona

Ethics approval for project
Reference Number: 873
Application Title: *Exploring the Wider Existence of Historical Trauma in the Social Service Workforce*

Thank you for your application for ethics approval for this research project.

This letter is to advise that the Otago Polytechnic Research Ethics Committee review panel has approved your application, following the amendments made in response to feedback.

We wish you well with your work and remind you that at the conclusion of your research to send a brief report with findings and/or conclusions to the Ethics Committee.

All correspondence regarding this application should include the project title and reference number assigned to it.

This protocol covers the following researchers: Fiona MacKinnon.
Project approval is valid for three (3) years from date of letter.

Regards

Liz Ditzel

Dr. Liz Ditzel
Chair, Otago Polytechnic Research Ethics Committee

Master of Professional Practice: Course 2: Advanced Practitioner Inquiry
Review Panel Feedback

Learner Name	**Fiona**
Learner ID	**MacKinnon**
Facilitator	**Glenys Forsyth**
Academic Mentor	**Emilie Crossley**
Review Panel	
Review Date:	**7/9/2020**
Panel Members:	**1. Sam Mann**
	2. Jo Thompson
	3. Jeremy Taylor
Review Panel Recommendation (circle as appropriate)	
Accept (no change required)	**Revise and resubmit**
Comments for resubmit:	
Date for Resubmit:	
Additional notes to consider in Course 3 *Recommendations should be reviewed in conjunction with additional comments	
There are some helpful suggestions for you to consider in Course 3.	
Results Table: Advanced Practitioner Enquiry	
Pass	
Name (please print): Dr Jo Kirkwood	**Designation: Postgraduate Programme Lead**
Signature: *J Kirkwood*	**Date: 7.9.20**

Sourced from: https://cls.unc.edu/wp-content/uploads/sites/3019/2016/08/From-ACESTOOHIGH-ACES-and-Resilience-questions.pdf

What's Your ACE Score? And What's Your Resilience Score?

There are 10 types of childhood trauma measured in the ACE Study. Five are personal — physical abuse, verbal abuse, sexual abuse, physical neglect, and emotional neglect. Five are related to other family members: a parent who's an alcoholic, a mother who's a victim of domestic violence, a family member in jail, a family member diagnosed with a mental illness, and the disappearance of a parent through divorce, death, or abandonment. Each type of trauma counts as one. So, a person who's been physically abused, with one alcoholic parent, and a mother who was beaten up has an ACE score of three.

There are, of course, many other types of childhood trauma — watching a sibling being abused, losing a caregiver (grandmother, mother, grandfather, etc.), homelessness, surviving and recovering from a severe accident, witnessing a father being abused by a mother, witnessing a grandmother abusing a father, etc. The ACE Study included only those 10 childhood traumas because those were mentioned as most common by a group of about 300 Kaiser members; those traumas were also well studied individually in the research literature.

The most important thing to remember is that the ACE score is meant as a guideline: If you experienced other types of toxic stress over months or years, then those would likely increase your risk of health consequences.

Prior to your 18th birthday:

1. Did a parent or other adult in the household often or very often… Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?
   No___If Yes, enter 1 __
2. Did a parent or other adult in the household often or very often… Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?
   No___If Yes, enter 1 __
3. Did an adult or person at least 5 years older than you ever… Touch or fondle you or have you touch their body in a sexual way? or attempt or actually have oral, anal, or vaginal intercourse with you?
   No___If Yes, enter 1 __
4. Did you often or very often feel that … No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?
   No___If Yes, enter 1 __
5. Did you often or very often feel that … You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   No___If Yes, enter 1 __
6. Were your parents ever separated or divorced?
   No___If Yes, enter 1 __
7. Was your mother or stepmother:
   Often or very often pushed, grabbed, slapped, or had something thrown at her? or sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   No___If Yes, enter 1 __
8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?
   No___If Yes, enter 1 __

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
   No___If Yes, enter 1 __
10. Did a household member go to prison?
    No___If Yes, enter 1 __

Now add up your "Yes" answers: _____ This is your ACE Score

The study's researchers came up with an ACE score to explain a person's risk for chronic disease. Think of it as a cholesterol score for childhood toxic stress. You get one point for each type of trauma.

The higher your ACE score, the higher your risk of health and social problems. (Of course, other types of traumas exist that could contribute to an ACE score, so it is conceivable that people could have ACE scores higher than 10; however, the ACE Study measured only 10 types.)

As your ACE score increases, so does the risk of disease, social and emotional problems. With an ACE score of 4 or more, things start getting serious. The likelihood of chronic pulmonary lung disease increases 390 percent; hepatitis, 240 percent; depression 460 percent; suicide, 1,220 percent.

What's Your Resilience Score?

This questionnaire was developed by the early childhood service providers, paediatricians, psychologists, and health advocates of Southern Kennebec Healthy Start, Augusta, Maine, in 2006, and updated in February 2013. Two psychologists in the group, Mark Rains and Kate McClinn, came up with the 14 statements with editing suggestions by the other members of the group. The scoring system was modelled after the ACE Study questions. The content of the questions was based on a number of research studies from the literature over the past 40 years including that of Emmy Werner and others. Its purpose is limited to parenting education. It was not developed for research.

RESILIENCE Questionnaire

Please circle the most accurate answer under each statement:

1. **I believe that my mother loved me when I was little.**
   Definitely true Probably true Not sure Probably Not True Definitely Not True

2. **I believe that my father loved me when I was little.**
   Definitely true Probably true Not sure Probably Not True Definitely Not True

3. **When I was little, other people helped my mother and father take care of me and they seemed to love me.**
   Definitely true Probably true Not sure Probably Not True Definitely Not True

4. **I've heard that when I was an infant someone in my family enjoyed playing with me, and I enjoyed it, too.**
   Definitely true Probably true Not sure Probably Not True Definitely Not True

5. **When I was a child, there were relatives in my family who made me feel better if I was sad or worried.**
   Definitely true Probably true Not sure Probably Not True Definitely Not True

6. **When I was a child, neighbours or my friends' parents seemed to like me.**
   Definitely true Probably true Not sure Probably Not True Definitely Not True

7. **When I was a child, teachers, coaches, youth leaders or ministers were there to help me.**
   Definitely true Probably true Not sure Probably Not True Definitely Not True

8. **Someone in my family cared about how I was doing in school.**

Definitely true Probably true Not sure Probably Not True Definitely Not True

9. **My family, neighbours and friends talked often about making our lives better.**
   Definitely true Probably true Not sure Probably Not True Definitely Not True

10. **We had rules in our house and were expected to keep them.**
    Definitely true Probably true Not sure Probably Not True Definitely Not True

11. **When I felt really bad, I could almost always find someone I trusted to talk to.**
    Definitely true Probably true Not sure Probably Not True Definitely Not True

12. **As a youth, people noticed that I was capable and could get things done.**
    Definitely true Probably true Not sure Probably Not True Definitely Not True

13. **I was independent and a go-getter.**
    Definitely true Probably true Not sure Probably Not True Definitely Not True

14. **I believed that life is what you make it.**
    Definitely true Probably true Not sure Probably Not True Definitely Not True

How many of these 14 protective factors did I have as a child and youth? (How many of the 14 were circled "Definitely True" or "Probably True"?) _____ Of those circled, how many are still true for me? _____

Source: https://www.careinnovations.org/wp-content/uploads/Post-Traumatic-Growth-Inventory.pdf

Post Traumatic Growth Inventory

Client Name: _____ Today's Date:_____

Indicate for each of the statements below the degree to which this change occurred in your life as a result of the crisis/disaster, using the following scale.

0 = I did not experience this change as a result of my crisis.
1 = I experienced this change to a very small degree as a result of my crisis.
2 = I experienced this change to a small degree as a result of my crisis.
3 = I experienced this change to a moderate degree as a result of my crisis.
4 = I experienced this change to a great degree as a result of my crisis.
5 = I experienced this change to a very great degree as a result of my crisis.

Possible Areas of Growth and Change	0	1	2	3	4	5
1. I changed my priorities about what is important in life.						
2. I have a greater appreciation for the value of my own life.						
3. I developed new interests.						
4. I have a greater feeling of self-reliance.						
5. I have a better understanding of spiritual matters.						
6. I more clearly see that I can count on people in times of trouble.						
7. I established a new path for my life.						
8. I have a greater sense of closeness with others.						
9. I am more willing to express my emotions.						
10. I know better that I can handle difficulties.						
11. I am able to do better things with my life.						
12. I am better able to accept the way things work out.						
13. I can better appreciate each day.						
14. New opportunities are available which wouldn't have been otherwise.						
15. I have more compassion for others.						
16. I put more effort into my relationships.						
17. I am more likely to try to change things which need changing.						
18. I have a stronger religious faith.						
19. I discovered that I'm stronger than I thought I was.						
20. I learned a great deal about how wonderful people are.						
21. I better accept needing others.						

Post Traumatic Growth Inventory Scoring

The Post Traumatic Growth Inventory (PTGI) is scored by adding all the responses. Individual factors are scored by adding responses to items on each factor. Factors are indicated by the Roman numerals after each item below. Items to which factors belong are not listed on the form administered to clients.

PTGI Factors

Factor I: Relating to Others
Factor II: New Possibilities
Factor III: Personal Strength
Factor IV: Spiritual Change
Factor V: Appreciation of Life

1. I changed my priorities about what is important in life. (V)
2. I have a greater appreciation for the value of my own life. (V)
3. I developed new interests. (II)
4. I have a greater feeling of self-reliance. (Ill)
5. I have a better understanding of spiritual matters. (IV)
6. I more clearly see that I can count on people in times of trouble. (I)
7. I established a new path for my life. (II)
8. I have a greater sense of closeness with others. (I)
9. I am more willing to express my emotions. (I)
10. I know better that I can handle difficulties. (III)
11. I am able to do better things with my life. (II)
12. I am better able to accept the way things work out. (Ill)
13. I can better appreciate each day. (V)
14. New opportunities are available which wouldn't have been otherwise. (II)
15. I have more compassion for others. (I)
16. I put more effort into my relationships. (I)
17. I am more likely to try to change things which need changing. (II)
18. I have a stronger religious faith. *(N)*
19. I discovered that I'm stronger than I thought I was. (III)
20. I learned a great deal about how wonderful people are. (I)
21. I better accept needing others. (I)