HOW DO COMMUNITY MENTAL HEALTH WORKERS MAINTAIN WELLNESS WHILE RESPONDING TO THE FENTANYL OVERDOSE CRISIS?

by

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A DISSERTATION SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF

DOCTOR OF PHILOSOPHY

in

THE FACULTY OF GRADUATE AND POSTDOCTORAL STUDIES

(Counselling Psychology)

THE UNIVERSITY OF BRITISH COLUMBIA

(Vancouver)

March 2022

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How do Community Mental Health Workers Maintain Wellness while Responding to the Fentanyl Overdose Crisis?

submitted by Matthew McDaniel in partial fulfillment of the requirements for

the degree of Doctor of Philosophy

in Counselling Psychology

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Abstract

Community mental health workers (CMHWs) are a subset of mental health workers who integrate themselves into the communities that they serve. As a result of their work setting and community focus, they often function as under-recognized front-line first responders during public health and addictions crises. The current and ongoing fentanyl overdose crisis has increased the strain put on these workers. Despite the increased challenges involved, some CMHWs report that they are successfully maintaining their personal wellness. This study aimed to understand what is helping and what is hindering these workers in maintaining their wellness.

Sixteen CMHWs working with clients that have experienced fentanyl related overdose participated in an open-ended semi-structured interview based on the enhanced critical incident technique (ECIT). The ECIT is a well-established qualitative research method, and it was used to obtain a description of what helped, hindered, or would have helped participants' wellness. The results obtained are in the form of five categories and thirteen subcategories of helping, hindering, and wish list helping factors.

The contributions of this study included enhancing empirical literature with regards to the support of workers doing challenging helping work, providing practical suggestions to practitioners in supporting similar workers, providing suggestions for supportive organizational policy, and making suggestions for further worker sustainability focused research. In addition, this study makes clear the urgent need for systemic advocacy regarding these similar workers and their clients. Finally, this research assists workers by providing examples of the shared struggles, supports, and connections that may be used in fostering career sustainability.

Lay Summary

Community mental health workers (CMHW) seek to offer support within client communities, and, as a result, are in first contact with people experiencing critical overdoses and similar health crises. Previous research has found that, despite being a high stress occupation, some CMHWs report being successful in maintaining their personal wellness. To the author's knowledge, an academic study has never directly asked these workers what is helping them maintain their wellness. Using open-ended interview questions, 16 CMHWs working with people directly affected by the fentanyl overdose crisis were asked what is helping and hindering their personal wellness along with what potentially could help their wellness. The participants identified several factors related to the meaning of the work, individual strategies, social supports, work-life boundaries, and structural supports that influence their wellness. These finding are expected to help similar workers, practitioners, organizations, policy makers, researchers, and advocates in supporting people doing similar work.

Preface

This dissertation is the original and unpublished work of the author Matthew McDaniel. Data collection and data analysis were conducted independently with the approval of the University of British Columbia Behavioural Research Ethics Board (BREB), under certificate number: H18-02663.

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Acknowledgements

First and foremost, I want to thank the participants in this study. The work you are doing is incredibly challenging, significant, and inspiring. Your dedication to providing care to people that much of society sees as less than is incredible, as is your tenacity in accomplishing this job. Thank you so much for sharing your experiences with me. You are important, and I feel honoured to have been entrusted with your stories.

I feel immense gratitude for the people in my life that encouraged me, inspired me, pushed me, and supported me throughout this degree. Without my family, friends, and fellow PhD students I would have never considered this path for my life. Your incredible support and inspiration made this accomplishment possible. I am shocked and humbled to be here and I owe it to you folks.

Thank you to the faculty and staff at UBC. My supervisor, Dr. Bill Borgen, provided unwavering belief and encouragement. My committee members, Dr. Marla Buchanan and Dr. George Belliveau, inspired me to be much more open and curious than I thought possible. The patience, expertise, and vision of the faculty at UBC in general facilitated the growth in confidence as a researcher and academic that I needed to complete this dissertation. Finally, Karen Yan knows where all the levers and buttons at UBC are, and I would have been lost there without her. Thank you each for the patience, care, and wisdom you have offered throughout this degree. It's incredible and I am so grateful to have worked with you.

Chapter One: Introduction

> Pretending that nothing's wrong doesn't help. Thinking that I was powerful enough to deal with it on my own and realizing that nobody is. This stuff can only really be dealt with a community to help you. You can't do it on your own. (Participant 12)

Community mental health workers (CMHWs) are a subset of mental health workers who integrate themselves into the communities that they serve. They frequently work in homeless shelters, low-barrier housing units, community drop-in centres, community-based health clinics, outreach teams, and safe-injection sites. The clients they work with face severe addictions, marginalization, and mental health related challenges. As a result of their work setting and community focus, CMHWs often act as under-recognized front-line first responders during public health and addictions crises, needing to administer anti-overdose drugs and perform CPR to keep their clients alive while waiting for emergency services. The fentanyl overdose crisis has resulted in the death of over 1400 British Columbia residents in 2017, 1500 in 2018, 984 in 2019, and 1700 in 2020, and more than 1800 in 2021, putting strain on the CMHWs who are working to save their lives (British Columbia Coroners Service, 2021; Lupik, 2017b; Nagy & Jones, 2021). This crisis continues today, with the BC coroners service reporting 6.5 overdose related deaths per day in October of 2121. This is a symptom of a much larger problem. We do not understand the broader societal effects of poorly managed addiction crises, resulting in a lack of life saving holistic care for substance users and inadequate mental health supports for the workers that attempt to support them. As a result, CMHWs have been found to experience high rates of burnout, secondary traumatic stress, and post-traumatic stress (Dreison et al., 2018; J.

Johnson et al., 2018; McDaniel & Haney, n.d.; Salyers, Rollins, Kelly, Lysaker, & Williams, 2013; Waegemakers Schiff & Lane, 2019). Consequently, CMHWs have been identified as a population in need of increased research and support.

This study responds to this call for research and support by exploring what CMHWs who self-identify as doing well describe as helping and hindering their wellness. Previous research has found that some CMHWs report success in maintaining their work related wellness long-term (Dreison et al., 2018; Luther et al., 2017; Morse, Salyers, Rollins, Monroe-DeVita, & Pfahler, 2012; Salyers et al., 2015). To the author's knowledge, an academic study has yet to ask this population of workers to put in their own words what is contributing to their wellness. The discovery of what is helping and what is hindering these workers in their pursuit of wellness has the potential to increase the effectiveness of the supports provided to workers in difficult environments, while adding to our overall understanding of human stress and coping processes. With these goals in mind, this study asked a crucial, yet unanswered question: *How do CMHWs maintain wellness while responding to the fentanyl poisoning crisis?*

The investigation of this question is theoretically grounded in Lazarus and Folkman's (1984) transactional model of stress and coping. The transactional model of stress and coping describes the interaction among environmental stressors, the way in which people appraise those stressors, the strategies they use to cope, and the degree of distress felt in response. Stress is defined as a relationship between the environment and the person, in which the person appraises a situation as taxing, exceeding their resources, or endangering their well-being (Lazarus, 1993). Each person's unique resources and skills influence this assessment of stress. The way in which a person appraises and responds, or copes, is neither inherently good nor bad, but may be more or less effective in any given situation. Depending on the effectiveness of a person's coping

strategy, they may experience varying levels of distress in response to a perceived stressor (Lazarus & Folkman, 1984). Although firmly established, modern research on the transactional model of stress and coping has been criticized for oversimplifying the process. Open-ended and exploratory research has been suggested as necessary to meet these critiques (Cooper & Quick, 2017; Folkman & Moskowitz, 2004; Lazarus, 2000).

The effects of long-term distress in mental health worker populations are known as burnout. Originally used by members of the illicit drug scene to describe the negative effects of chronic drug abuse, the term "burnout" was borrowed by drug and alcohol counsellors in the 1970s to describe the results of their own occupational stress (Maslach, Leiter, & Schaufeli, 2009). Burnout is more than a simple stress response, but rather the result of repeated, long-term difficult relational transactions (Maslach et al., 2009; Maslach, Schaufeli, & Leiter, 2001). Quantitative research has established three dimensions involved with burnout: the manifestation of the feeling of being depleted of one's emotional resources (*emotional exhaustion*), cynicism and detachment towards interpersonal relationships (*depersonalization*), and a lack of feelings of achievement and productivity (*personal achievement*) (Maslach et al., 2009). In addition to these primary features, burnout has been associated with increased depression, anxiety, sleep problems, impaired memory, neck and back pain, alcohol consumption, flu-like symptoms, and gastroenteritis (Awa, Plaumann, & Walter, 2010; J. Johnson et al., 2018). Burnout has been further connected with poor client outcomes, an increase in adverse work-related events, and negative client safety indicators (Dreison et al., 2018; J. Johnson et al., 2018). On an organizational level, burnout has been associated with reduced commitment and negative attitudes toward the employing organization, absenteeism, high turnover, job dissatisfaction, low staff group morale, sick leave, and reduced adherence to evidence-based practices (Morse et al.,

2012). Contemporary research on the lived experience of burnout is limited, but has found that workers facing burnout report feeling their self-image as a competent professional threatened, a lack of trust in themselves, shame, confusion, and judgment from others (Ekstedt & Fagerberg, 2005; Y.-S. Lee & Tae, 2012; Severinsson, 2003; C. M. Young, Smythe, & Couper, 2015). They report having made choices in their lives with the expectation of creating a meaningful career, only to find their choices within the helping profession are limited and their will to continue is fading (Judd et al., 2017; Pines, 2017).

Prevalence rates on some burnout dimensions within all health care fields are estimated as being between 21 and 67% (J. Johnson et al., 2018; Morse et al., 2012)**.** Studies comparing burnout levels between general health care workers and community based workers have found community workers to consistently experience more burnout than other groups (Lasalvia et al., 2009; Lloyd & King, 2004; Webster & Hackett, 1999). These high prevalence rates, combined with the devastating effects of burnout and the identification of CMHWs as under-researched and under-supported, puts them in high need of research attention.

In addition to burnout, those working with traumatized populations have been known to experience secondary traumatic stress (STS). STS is "the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other—the stress resulting from helping or wanting to help a traumatized or suffering person" (Figley, 1995 p. 7). Workers suffering from STS experience symptoms that match the symptoms of post-traumatic stress disorder (PTSD), including experiencing tension and preoccupation with traumatized clients, re-experiencing client's traumatic events, avoiding and numbing reminders of the events that clients experienced, and being in a constant state of persistent arousal regarding clients. It has been suggested that STS can cause changes in a worker's view of the world,

spirituality, self-capacities and abilities, psychological needs and beliefs, and feelings about safety, trust, esteem, intimacy, and control (Saakvitne, Pearlman, & Abrahamson, 1996). It has been suggested that burnout and STS typically occur concurrently, and burnout may be required in order to develop STS (R. E. Adams, Boscarino, & Figley, 2006; Cieslak et al., 2014). Quantitative research regarding STS has been criticized regarding rigour, construct inconsistencies, and reliance on small correlations (Kapoulitsas & Corcoran, 2015; Sabin-Farrell & Turpin, 2003). Calls for increased STS research have been made, with qualitative exploration having been recognised as providing the clearest evidence thus far.

While the concept of psychological wellness may be considered widespread now, its discussion is relatively recent in the psychological literature (Roscoe, 2009). Early research on wellness proposed six interdependent dimensions of wellness: social, emotional, physical, intellectual, spiritual, and occupational (Hettler, 1980). Subsequent research has focused on refining and expanding the various dimensions that contribute to wellness (Miller & Foster, 2010; Roscoe, 2009). In general, wellness is conceptualized as a subjective, holistic and interconnected experience, best thought of on a dynamic continuum rather than as a static on/off condition (Bart et al., 2018; Miller & Foster, 2010; Roscoe, 2009). From this perspective maintaining wellness involves daily pursuit and maintenance of various wellness dimensions within personal, interpersonal, and environmental contexts, rather than success or failure in attaining a concrete and permanent state of wellness. Critiques of the wellness construct point out that wellness does not have a clear, unified definition within the literature (Bart et al., 2018). Despite this lack definitional coherence, most research on wellness involves the validation and use of various quantitative dimensional measures. These measures are largely created to match the definition and conceptualization of wellness that they correspond with, however, in most

cases these conceptualizations were created out of theory without prerequisite exploratory research (Harari, Waehler, & Rogers, 2005; Roscoe, 2009). This makes clarity in research a challenge and suggests the need for more qualitative research. The current study responds to this need by asking participants to discuss their subjective self-definition of wellness.

The concept of subjective well-being (SWB) shares much of its origin with the concept of wellness. As with wellness, early modern research into well-being grew out of the desire to re-focus psychology away from its pre-occupation with negative states post-World War II (Diener, Suh, Lucas, & Smith, 1999). Debate about the definition of SWB has taken place throughout its academic history, with researchers largely split on conceptualizing it in hedonic (balance of pleasant versus unpleasant experiences) or Eudaimonic (making progress towards one's potential, living a meaningful life) terms (Maddux, 2017). With this debate in mind, early researchers identified three components of SWB: life satisfaction, positive experiences, and negative experiences (Diener, 1984). Modern researchers largely maintain these components, expanding them to include a sense of control, sense of purpose, the development of one's potential, and positive relationships (Huppert, 2009; Ruggeri K, Garcia-Garzon E, Maguire Á, Matz S, & Huppert F, 2020). Debate has also taken place about if subjective well-being may be best measured with single or multidimensional instruments, with most measures being criticized for a lack of theoretical basis for their creation (Huppert, 2009). In response to early criticisms of this kind, Ryff (1989) proposed 6 literature based and theory derived dimensions of well-being (self-acceptance, positive relations with others, autonomy, positive relations with others, environmental mastery, purpose in life, personal growth) and operationalized into a measure (The Psychological Well-Being Scale or PWB). Since its inception the PWB has been utilized and validated with a wide variety of diverse groups, and undergone confirmatory factor analysis

(Ryff & Keyes, 1995). As the current study is exploratory in nature, no definition of wellness or well-being was provided to the participants. As detailed above, they were asked if they believed that they are successfully maintaining their wellness and what wellness means to them. Areas in which their responses converge and diverge with Riff's (1989a, 1989b) six domains are evaluated in the discussion section.

Exposure to traumatic stress does not always result in PTSD or STS. At times, it has also been found to result in growth. The term post-traumatic growth refers to the psychological exploration of positive changes that individuals may potentially experience as a result of struggle with major loss or trauma (Calhoun & Tedeschi, 2001). The potential changes that may take place afterwards may be transformative, with alterations to cognition, emotions, and behaviour being possible (Tedeschi & Calhoun, 1996). This change is seen as occurring as a result of the struggle with the aftermath of crisis, and has the potential to create positive growth (Tedeschi, Shakespeare-Finch, Taku, & Calhoun, 2018). PTG does not necessarily indicate a decrease in distress and increase in well-being; a person may experience PTSD and PTG simultaneously (Tedeschi & Calhoun, 2004). Rather, PTG indicates growth in several areas that is instigated by distress. Literature reviews have found rates of self-perceived growth after a traumatic event to be as high as 58% to 83% (Jayawickreme & Blackie, 2016). Qualitative inquiry has been primarily utilized to discover how PTG manifests and the qualitative exploratory nature of the current study provides an opportunity to contribute to the literature on growth in the face of adversity.

The population in the current study attempt to serve clients that are typically marginalized and oppressed. Therefore, through their acts of advocacy, service, and care, CMHWs are social-justice focused workers and social justice themes should be considered in

doing research with them. Social justice proponents within counselling psychology advocate for equal opportunity for all individuals to reach their potential across life domains, free from barriers in society (M. Adams, Bell, & Griffin, 2007). The right to quality education, appropriate health care services, and equal employment opportunities regardless of individual characteristics or group membership is also highlighted, as is the fact that clients and participants do not exist independent of society, culture, and context (Crethar & Ratts, 2008; Lewis, Ratts, Manivong, Paladino, & Toporek, 2011). Recent calls have been made to include more social justice focused research in counselling psychology (Kennedy & Arthur, 2014; Palmer & Parish, 2008; Sinacore & Ginsberg, 2015a). This study answers these calls by considering social justice themes throughout.

The enhanced critical incident technique (ECIT) was selected as the method for this study. The ECIT was chosen in response to the call for more open-ended and exploratory stress and coping research; the need for increased qualitative research on burnout, STS, PTG, and wellness; the gap in knowledge about what workers themselves identify as supporting their wellness; and calls for social justice focused research. The ECIT is an exploratory and inductive method, suitable for use in under-researched areas (Butterfield, Borgen, Amundson, & Maglio, 2005; Butterfield, Borgen, Maglio, & Amundson, 2009; Woolsey, 1986b). Lining up with the subjective and transactional nature of the stress interaction, ECIT involves the coding and analysis of interview data based on the identification of critical events that the participant has interpreted as helping or hindering, making it an ideal stress investigation tool (Butterfield et al., 2009; Flanagan, 1954). The ECIT technique has been used with a wide variety of similar populations facing comparable occupational challenges, including, but not limited to: social workers (Mills & Vine, 1990; Savaya, Gardner, & Stange, 2011), nurses (Hosie, Agar, Lobb,

Davidson, & Phillips, 2014; Schluter, Seaton, & Chaboyer, 2008), paramedics (Mulholland, Barnett, & Woodroffe, 2015), doctors (Humphery & Nazareth, 2001), and police officers (Conn & Butterfield, 2013). Finally, with a focus on participant perspectives and practical use of the data, the method chosen for the current study blends well a social justice focused approach (Burns, Morley, Bradshaw, & Domene, 2008; Butterfield et al., 2005, 2009)

CMHWs are filling a vital role in keeping vulnerable substance users alive, well, and connected to community. As the fentanyl poisoning crisis and similar social inequality rooted challenges continue, this study provides valuable exploratory information to practitioners, policy makers, and researchers seeking to support and advocate for more equitable and inclusive social support systems. The experiences of the participants in this study may be used as areas of exploration, strengthening, and normalization for counsellors supporting similar workers, while also informing supportive workplace policy and suggesting several specific areas of important future worker sustainability related research.

Chapter Two: Literature Review

This chapter reviews literature related to stress and coping broadly and as it applies to community mental health workers. The following areas will be reviewed and discussed: (a) stress and coping theory and application, (b) burnout, (c) secondary traumatic stress, (d) post-traumatic stress, (e) post-traumatic growth, (f) psychological wellness, (g) community mental health workers, (h) a short history of Vancouver's downtown east side, and (i) a social justice perspective on these areas.

Stress and Coping Theory

The concept of stress is pervasive in modern society. Earliest references to the concept of stress have been dated back to ancient Roman engineering, through their consideration of the effects of physical force upon an object in building arched bridges and coliseums (Robinson, 2018). Contemporary understandings of stress focus on it as a psychological phenomenon stemming from difficult experiences, capturing the negative effects in varying degrees of daily hassles, work or health concerns, and significant traumatic experiences (Robinson, 2018). Observations that external and internal forces, physical or otherwise, may also affect human health have been noted across history, but records of systematic exploration of these observations is unknown until the 19th century (Hinkle, 1987; Robinson, 2018). This review will detail the history of contemporary stress theory, describe the current transactional theory, define its application to occupational context, and detail critiques of the theory.

History

19th century. Three prominent stress researchers during the 19th century significantly contributed to our modern conceptualizations of stress. The first is the American physician George Beard (1839-1883). Beard specialized in diseases of the nervous system, and suggested that the demands of life may lead to an overload of the nervous system, described as

neurasthenia, or a weakness of the nervous system and nervous exhaustion (Beard, 1869, as cited in Cooper & Dew, 2008). Beard defined nervous exhaustion as the consequence of "a particular kind of social organization; it was as peculiar a product of the nineteenth century as the telegraph" (Rosenberg, 1962, p. 253). Though neurasthenia as a diagnosis had fallen out of favor by the early 20th century, Beard can be credited as contributing to the identification of the social environment as an influence on mental illness, and for his attempts to reduce the stigma attached to these illnesses (Cooper & Dewe, 2008).

The second prominent stress researcher of the 19th century is the French physiologist Claude Bernard (1813-1878). Bernard is considered the founder of modern experimental physiology, and is credited with discovering the glycogenic function of the liver, the role of the pancreas in secreting digestive fluids, and the vagal control of cardiac function (Gross, 1998). Regarding the concept of stress, Bernard is remembered for his theory of the *milieu intérieur,* or "environment within" (Bernard, 1872, as cited in Gross, 1998). In observing the functions of various organs and the parts of nervous systems that exert control over the constriction and dilation of blood vessels, Bernard theorized that the body is constantly attempting to maintain a steady and harmonious internal environment (Robinson, 2018). Though this idea gained little traction during his lifetime, it laid the groundwork for what is now known as homeostasis, which is the tendency for organisms to auto-regulate and maintain their internal environment into a stable state (Gross, 1998; Hine, 2015).

The third prominent stress researcher of the 19th century is the Canadian physician Sir William Osler (1849-1919). Osler's approach to medicine is credited as providing the basis for the Hippocratic rule, directing physicians to treat diseases rather than symptoms (Ghaemi, 2008). Osler observed that the human body's response to the environment may have long term health

consequences, describing the personality of typical heart disease patients, and noting that a person's temperament influenced their recovery from pathology (Robinson, 2018). Osler's recognition of the influence of cognition on health outcomes foreshadowed contemporary theories on the interaction between stress and overall wellbeing.

Twentieth century. Interest into the effects of stress increased with the arrival of the twentieth century and the advent of modern warfare. During World War I, the symptoms of trauma displayed by soldiers in the absence of any obvious physical injury, known as "shell shock", presented an irrefutable need to better understand the psychological impact of stress (Myers, 1916). Among the researchers focusing on gaining this better understanding was the American physiologist Walter Cannon (1871-1945). Previous to the war, Cannon had noticed that the digestion of cats and dogs paused when an animal was distressed, leading to an interest in the effects of emotional stimuli on internal functioning (Cannon, 1898, as cited in Cooper & Dewe, 2008). During the war, Cannon focused primarily on the human bodily changes that occur in response to pain, hunger, fear, and rage (Cannon, 1929a, as cited in Cooper & Dewe, 2008). Building on Bernard's *milieu intérieur* theory, Cannon proposed the concept of homeostasis to describe the functioning of the various systems organisms utilize to maintain internal stability in the face of challenging stimuli (Cannon, 1929b, as cited in Cooper & Dewe, 2008). Cannon suggested that the physiological events sustaining this desired stable state are so intricate that a distinct term should be used in referring to them, *homeostasis* being this term (Cooper & Dewe, 2008). Building upon his research on fear and rage, Cannon further proposed the release of adrenalin into the bloodstream as a primary homeostatic mechanism, with the intention of preparing the body for "Fight" or "Flight" in response to a stressor (Cannon, 1929a, as cited in Cooper & Dewe, 2008). These terms are still used today in describing nervous system response

to threat, and all theories of stress following Cannon's work refer in some way to the concept of homeostasis.

The first researcher widely credited as presenting a modern theory of stress is the Hungarian Canadian endocrinologist Hans Selye (1907-1982), according to Cooper and Dewe (2008). Rather than acute stressors, as in Cannon's work, Selye was interested in chronic stress (Robinson, 2018). Before the Second World War, while in medical school, Selye noticed a number of common physiological responses to any physical demand, and similarly that patients suffering from a range of pathologies shared common symptoms (Selye, 1960). After completing his education, Selye conducted several experiments in which he subjected rats to nocuous agents and adverse situations. In response to these manipulations, Selye observed what he termed a "non-specific reaction" to any type of stimulus demanding change from the organism (Selye, 1936, as cited in Cooper & Dewe, 2008). Non-specific refers to the generalized nature of this response to stressors. Selye went on to identify a three-stage pattern of physiological response, naming this pattern, "general adaptation syndrome" (Selye, 1936, as cited in Cooper & Dewe, 2008). He called the first stage of this pattern the alarm reaction, in which the body prepares to fight or flee. He called the second stage the resistance stage, in which the body attempts to counteract the specific stressor. He called the third stage exhaustion, in which the body has exhausted its resources, and resistance to the stressor may not continue. Selye notably proposed that prolonged exhaustion has a negative impact on long term general health (Selye, 1952, as cited in Cooper & Dewe, 2008). Attempting to find more in-depth biological mechanisms for this process, Selye conducted a number of studies aimed at detecting the hormones involved in the stress response, and successfully identified glucocorticoids and their influence on the HPA axis (Selye, 1943, as cited in Cooper & Dewe, 2008). Selye's glucocorticoid research set the stage for

contemporary research on the relationship between the HPA axis and chronic stress (Sapolsky, 2015). Selye's theories on stress generated intense debate within the scientific community, with opponents challenging both the proposed nature of stress, as well as how exactly to go about creating a taxonomy of stressors and stress responses (Viner, 1999). Through this debate Selye suggested four basic stress variations: good stress (eustress), bad stress (distress), overstress (hyperstress), and understress (hypostress) (Selye, 1974). The concept and functioning of good versus bad stress continues to be researched today (see Kluwe-Schiavon, Viola, Sanvicente-Vieira, Malloy-Diniz, & Grassi-Oliveira, 2017).

Contemporary Stress and Coping Research

By the end of the Second World War the scientific community had come to openly recognize the influence of psychological stressors in the development of some mental conditions and psychosomatic symptoms (Robinson, 2018). Postwar research saw rising interest in the influence of significant or critical life events on the etiology of disease, as well as a the effects of everyday stressors (Cooper & Dewe, 2008). This research took place within a scientific paradigm dominated by behaviorism, with a focus on the discovery of overarching stimulus-response laws. It was within this behavior-focused environment that the American psychologist Richard Lazarus (1922-2002) came to prominence. His theories now dominate contemporary research on stress and coping.

Despite the prevalence of behaviorism, Lazarus trained as a cognitive psychologist and introduced the idea that between stimulus and response existed the influence of the organism itself (Lazarus, 1993). He suggested that individual differences in goals, attitudes, beliefs, expectations, emotions, and motives produced variance in response to stress, and that cognition mediated this response. Lazarus maintained that rather than general laws and simple observation

of behavior in response to stimulus, the research of stress requires a unique, personalized approach (see Folkman & Lazarus, 1980). Beginning in the late 1950s and moving into the 60s while working at Berkley, Lazarus focused on laboratory experiments with individuals, and developed the transactional model of stress (Lazarus, 1966). This model centered on the psychology of stress, and introduced the concept of appraisal, or how a person thinks about an event, as the primary determinant of the impact of stress. Through the 1970s and into the 1980s Lazarus moved out of the laboratory and into everyday life settings, with a desire to more thoroughly explore appraisal and coping. Working closely with one of his doctoral students, Susan Folkman, he developed the *Hassles and Uplifts Scale,* and the *Ways of Coping Questionnaire* (Folkman & Lazarus, 1980). Together, Lazarus and Folkman went on to expand the transactional model of stress into the Transactional Theory of Stress and Coping (Lazarus & Folkman, 1984). This theory has become the dominant underlying theoretical approach in modern stress and coping research, and is used within the current study.

The Transactional Theory of Stress and Coping

Lazarus and Folkman's (1984) transactional model of stress and coping describes the interaction between environmental stressors, the way in which people appraise those stressors, the strategies they use to cope, and the degree of distress felt in response. Within this theory, stress is defined as a relationship between the environment and the person, in which the person appraises a situation as taxing, exceeding their resources, or endangering their well-being (Lazarus, 1993). To feel stress, a person must first perceive and assess a situation as containing stressors. Each person's unique resources and skills influence this assessment of stressors. The way in which a person appraises and responds, or copes, is neither inherently good nor bad, but may be more or less effective in any given situation. Depending on the effectiveness of a

person's coping strategy they may experience more or less distress as a result of the perceived stressor (Lazarus & Folkman, 1984). Individual perceptions of stress, coping strategy, and distress are the key elements in this transactional model. A review of these elements will be described in the following sections.

Perceived stress. Perceived stress refers to the degree to which events are appraised as stressful (Lazarus & Folkman, 1984). Differences in the personal situation, history, skills, self-efficacy, and resources of each person affect the amount of stress they perceived. As a result, the same event may be appraised as stressful to one person and not stressful to another. The appraisal process hinges upon the perception that important goals are being harmed, lost, or threatened (Folkman & Moskowitz, 2004). Lazarus suggests the existence of primary and secondary appraisals (Lazarus, 1966). Primary appraisals attempt to determine if the situation is benign, challenging, or harmful/threatening. Secondary appraisals seek to determine the effectiveness of the available coping resources.

Studies conducted in the wake of natural disasters provide insight into the individual variability involved with stress perception. In 2007, to explore the variability in perception of stressful events, a team of researchers conducted a large-scale study on reactions to Hurricane Katrina (Leon, Hyre, Ompad, DeSalvo, & Muntner, 2007). Six months after the hurricane, they gave 1542 faculty, staff, and administrators at a university in New Orleans a measure of perceived stress (The Perceived Stress Scale (S. Cohen, Kamarck, & Mermelstein, 1983)). Scores ranged from 0 to 16 (the maximum possible range), with a standard deviation of 3.1. As an example of this variability, in response to the question, "In the last month, how often have you felt confident about your ability to handle your personal problems?" 29.5 percent of respondents indicated "Very Often", while 27% indicated "Sometimes". This may be considered a substantial

degree of variability. Results of this study provide evidence for the theory that the degree of stress perceived varies from person to person.

Variability in the appraisal of stressful events has been found across numerous populations and environments (Lee, 2012), including those doing similar work and in similar environments to CMHWs (Sohn, Kim, Kim, & Han, 2006; Ting, Jacobson, & Sanders, 2011). Sohn, Kim, Kim, and Han (2006) studied the perceived stress levels of 263 Health Care Workers who had been accidentally stuck with a hypodermic needle possibly carrying HIV, Hepatitis B, or Hepatitis C while providing care for their clients. Participants completed the Perceived Stress Scale 10-Item Version and achieved an average score of 19.20 with a standard deviation of 3.20. Participant scores and standard deviations varied across age, education, job title, and gender. Results of this study indicated that health care workers experiencing a similar stressful event in a similar environment experienced varying levels of resulting perceived stress. Similarly, Ting, Jacobson, and Sanders (2011) looked at the perception of stress among 285 social workers that had encountered either fatal or non-fatal client suicidal behaviour. Participants completed the Perceived Stress Scale 10-Item Version (S. Cohen et al., 1983) and obtained an average score of 13.42 with a standard deviation of 5.42 and range of 30. Participant scores varied over gender, age, ethnicity, and years in practice. Results of this study again indicate a similar variability in the perception of stress by people doing mental health work, despite a similar stressful event and environment. These results line up well with theory behind perceived stress, in that participants with differing personal factors appraised a similar occupational event as containing differing levels of stress. Therefore, it is likely that those doing mental health work perceive stress with similar variability to the general population.

It should be noted that stress is not inherently negative, as a tolerable amount of stress may be appraised as a positive challenge that activates and engages the individual. In studies of executive functioning, it has been found that a tolerable, activating amount of stress is not only beneficial, but has been found to be necessary for optimal executive functioning (Kluwe-Schiavon et al., 2017). As a stressor causes nervous system arousal to reach a moderate level, noradrenergic signalling has been found to assist in activating executive control networks in the coordination of cognitive activity (C. B. Young et al., 2017). The recognized pattern follows the shape of an inverted-U as a function of stress severity (Sapolsky, 2015). Mild to moderate stress take up the left side of the U and are beneficial, while severe stress moves to the right side of the U and constitutes toxic stress. A complete absence of stress is under activating, while intense acute and chronic stress is overwhelming and damaging. Optimal levels of perceived stress are frequently classified as arousal, alertness, engagement, play, and stimulation.

Coping Strategies. Once a situation has been perceived as stressful, a person chooses how to respond, this response is defined as a coping strategy. It should be noted that coping strategies are not typically evaluated as universally good or bad, but in line with the subjective and transactional nature of the theory, are evaluated based upon the goodness of fit between the situation and the coping strategies employed (Lazarus, 1993). Rather than good or bad, a coping strategy may be considered effective or ineffective in reducing the distress resulting from a situation that has been perceived as potentially stressful.

In 1980, Folkman and Lazarus undertook an exploration of the strategies people use in coping and presented a measure cataloguing 68 ways that a person may respond to a stressor (The Ways of Coping Checklist (Folkman & Lazarus, 1980)). They broadly split the ways that people respond and cope into two categories: problem-focused and emotion-focused. Problem-

focused strategies seek to manage the source of stress while emotion-focused strategies seek to manage the resulting distress. Examples of problem-focused strategies include, “Made a plan of action and followed it” and “Got the person responsible to change his or her mind.” Examples of emotion-focused strategies include, “Tried to forget the whole thing” and “Accepted sympathy and understanding from someone.” This measure was given to 100 community members. The authors found that coping strategy employment is not limited to one strategy or type of strategy; rather, the majority of participants employed a combination of strategies (Folkman & Lazarus, 1980). They suggest that in the presence of an event perceived to be stressful a person will attempt to use a variety of coping strategies, sometimes at the same time, in order manage the stressful event. For example, appraisals of threat are frequently accompanied by negative emotions. The first task of coping may be to regulate these negative emotions (Folkman & Moskowitz, 2004). Once the involved emotions have been adequately coped with, problem focused or stressor resolving approaches may take place. As the stressful situation evolves multiple coping forms are alternated between.

Seeking to refine the categorization of coping strategies presented by Lazarus and Folkman (1980), Tobin (1989) applied hierarchical factor analysis to an adaptation of the Ways of Coping Checklist (Folkman & Lazarus, 1980). In total, 208 males and 316 females (N= 524) completed the measure. Two tertiary factors were found: Engagement and Disengagement, and four secondary factors: Problem Engagement, Emotional Engagement, Problem Disengagement, and Emotional Disengagement. In this conceptualization, Engagement strategies seek to address the stressor, problem solve, or make a change, while Disengagement strategies seek to distance the person physically or emotionally from the stressor (Tobin, 1989). Engagement approaches include problem solving, cognitive restructuring, expressing emotions, and seeking social

support. Disengagement approaches include problem avoidance, wishful thinking, self-criticism, and social withdrawal. This Engagement/Disengagement encapsulation of coping strategies is commonly utilized in the study of coping.

As previously noted, coping strategies are not considered to be inherently good nor bad, rather they are evaluated based upon their effectiveness in reducing distress. In evaluating the effectiveness of coping strategies, researchers have found a general trend towards a positive correlation between disengagement coping strategies and higher levels of distress. This is again illustrated through studies looking at people's responses to natural disasters. To investigate the relationship between coping strategy and distress Glass et al. (2009) gave 228 adult survivors of Hurricane Katrina a measure of coping strategies (The Brief COPE (C. Carver, 1997)) and measures of psychological distress and PTSD symptoms (The Brief Symptoms Inventory and The Impact of Event Scale-Revised) (K. Glass, Flory, Hankin, Kloos, & Turecki, 2009). Participants who used disengagement coping strategies had higher levels of psychological distress and PTSD symptoms. The relationship found between disengagement coping and distress was stronger than the relationships between any other variables included in the study. These results suggest that the use of disengagement coping strategies is correlated with higher levels of distress.

The strong relationship between distress and disengagement found by Glass et al. (2009) is borne out in research on Mental Health Workers. Chang et al. (2007) administered surveys to 320 nurses. These surveys contained a measure of workplace stress (The Nursing Stress Scale), coping strategy (The Ways of Coping Questionnaire), and both physical and mental health indicators (SF-36 Health Survey Version 2). A strong positive correlation was found between escape-avoidance coping strategies and poor mental health. Using stepwise regression, it was

found that poor physical and mental health scores were predicted by escape-avoidance coping strategies. Escape-avoidance falls within the disengagement categorization of coping strategies. The results of this study indicate that among those doing work similar to mental health workers a link between disengagement coping and distress exists. In a similar study, Acker (2010) gave 591 social workers a measure of coping strategy (Problem Focused and Emotion Focused Coping Scales adapted from Lazarus and Folkman, 1988) and distress (The Maslach Burnout Inventory (Maslach, Jackson, & Leiter, 1996)). A strong relationship between emotion-focused coping and distress was found. The author describes emotion focused coping as escape and avoidance efforts. This description lines up with the Disengagement category of coping strategies (e.g., problem avoidance, wishful thinking) and put the results of this study in line with similar past studies. People doing mental health work who use more disengagement focused coping strategies are also experiencing higher levels of distress.

As detailed above, the degree of distress felt depends on the effectiveness of the coping strategy. In general, high levels of distress have been linked low mood, mental and physical health problems, and lower overall functioning (DeLongis, Folkman, & Lazarus, 1988; Holahan, Moos, Holahan, Brennan, & Schutte, 2005; Morse et al., 2012). Within mental health and helping work distress resulting from work stress is conceptualized as Burnout (Maslach & Jackson, 1981). The burnout section of this literature review will describe this construct in detail.

Occupational Applications of the Transactional Theory of Stress and Coping.

Occupational applications of stress and coping theory typically inspect various personal and contextual aspects of the stress relationship. Two of these occupation focused theories dominate the literature: The Person Environment (P-E) Fit theory (French, Caplan, & Van Harrison, 1982), and The Job Demand-Control theory (Karasek, 1979). According to P-E theory

occupational stress is defined in terms of work features that create distress due to a lack of fit between the individual's abilities and attributes, and the demands of the workplace (French et al., 1982). This interaction may be between a person's desires concerning work, and the work's ability to provide for those desires, or between the demands of the job and the person's ability to meet those demands. In line with Lazarus's theories, P-E theories describe stress as not something inherent to the work environment, but rather the result of a poor fit between the worker and the work environment. This lack of fit creates strain that make it difficult for the worker to function long term. Demand-Control theories expand on P-E theories by targeting the joint effects of job demands versus job control (Karasek, 1979). Job demand refers to features of the work that require sustained physical or mental effort, such as workload, work hazards, physical or emotional stressors, and work conflict. Job control refers to the degree of decision-making latitude that the worker has (e.g., the degree of administrative control, control of outcomes, skill discretion, supervision, decision authority, or ideological control). Occupations which feature a high level of active demands on workers without also allowing those workers a high level of freedom over the use of time, skills, and decision making are likely to result in distress (Karasek, 1979). Karasek (1979) classifies jobs into four categories: passive jobs (low demands/low control), low strain jobs (low demands/high control), active jobs (high demands/high control), and high strain jobs (high demand/low control). These two variations on the transactional theory of stress and coping have been expanded to include additional elements, such as social support, efforts versus rewards, various job and person characteristics (Ganster & Perrewé, 2011), with a number of low-to-moderate personal, social, and physical risk factors as building up and overflowing into work related stress (G. W. Evans, Becker, Zahn, Bilotta, & Keesee, 2012).

Critiques of Stress and Coping Theory

Despite the dominance of the Transactional Theory of Stress and Coping's in contemporary stress research, it is not without its critiques and detractors. Lazarus himself (Lazarus, 2000) acknowledges the need to move beyond traditional methodological approaches to the study of stress and coping, suggesting that behavioural focused research springing from a logical positivist paradigm overly simplifies and generalizes the stress and coping process. Acknowledged issues with the methodology of stress and coping processes have been extended to include additional challenges with measurement, nomenclature, and the determination of coping effectiveness (Folkman & Moskowitz, 2004).

Measurement. Early attempts at measurement took the form of checklists of thoughts and behaviours people used in response to stressful events (see Amirkhan, 1990; Carver, Scheier, & Weintraub, 1989; Folkman & Lazarus, 1980; Moos, 1997). These measures typically ask respondents to either detail a retrospective report of how they coped with a specific situation, or to respond to stressful situation vignettes, with answers scored yes/no or on Likert scales. As detailed by Folkman and Moskowitz (2004), this approach has a number of limitations, including: (a) potentially burdensome length (Stone & Neale, 1984), (b) inadequate capture of coping strategies inherent to checklist approaches (Stone, Kennedy-moore, Newman, Greenberg, & Neale, 1992), (c) variations in the recall period, (d) changes in the meaning of a given coping strategy (logical analysis vs rumination), (e) unreliability of recall (Coyne & Gottlieb, 1996), and (f) confounding items with their outcomes (Stanton, Danoff-burg, Cameron, & Ellis, 1994). Exploratory, intra-individual, microanalytic, and longitudinal approaches have been suggested in meeting these challenges (Folkman & Moskowitz, 2004; Lazarus, 2000).

Narrative approaches have been suggested as an example in meeting these methodological challenges (Folkman & Moskowitz, 2004). Narrative accounts allow the research participant to provide information about what happened during a stressful event, as well as what the person was feeling, thinking, and what they did in response. Exploratory approaches allow for nuance in the discovery of situational factors and coping attempts that inventories are unable to provide. For example, Folkman et al.'s (1997) analysis of the narratives of caregiving partners of men with AIDS revealed multiple unique sources of stress that would not have been captured in an inventory. Similarly Moskowitz and Wrubel's (2000) analysis of 246 narratives generated through multiple interviews over the course of a year with HIV positive men identified a number of coping processes not typically included within coping inventories. It has been pointed out that narrative approaches are vulnerable to participants forgetting how exactly they coped without prompting (Folkman & Moskowitz, 2004). No approach is without its limitations, however, considering both the complexity and subjectivity of coping processes the inclusion of more open-ended approaches such as the one utilized within this study makes good sense.

Nomenclature. The number of identified coping strategies is in the hundreds, with a variety of approaches to grouping these strategies together attempted (Folkman & Moskowitz, 2004). The clustering of coping strategies together typically follows theory-based approaches, statistical analysis techniques, or a combination of the two. This has resulted in divisions such as emotion focused versus problem focused (Folkman & Lazarus, 1980), active cognitive versus active behavioural versus avoidance (Moos, 1997), the inclusion of meaning making (Pearlin & Schooler, 1978), social factors (Amirkhan, 1990), or engagement versus disengagement (Tobin, 1989). These groupings of coping strategies frequently overlap or correlate with each other (Folkman & Moskowitz, 2004). This presents problems in comparing findings across studies, as

each study may have its own grouping, leaving meaningful discussion at meta level difficult to engage in.

Coping Effectiveness. The situational nature of the stress and coping transaction present difficulties in determining the effectiveness of any given coping attempt (Somerfield & McCrae, 2000). What within a coping process is adaptive must be evaluated within the specific context of that process, with the possibility that a coping attempt may be effective in one situation, but not in another (Folkman & Moskowitz, 2004). In addition, that context may change throughout the interaction, requiring fluidity in coping strategy suggestion. For example, some emotional distancing may be necessary in processing the shock of an event, but that distancing may need to change to direct problem solving to successfully resolve the event. Further, the identification of a successful outcome is difficult. The reduction of emotional discomfort may be a successful outcome in the short term, while returning to prestress functioning may be a desirable long-term outcome. The success of one outcome may have a negative effect on the other. Some stressors may be permanent and unresolvable, making a successful outcome mastery rather than resolution. Finally, does the participant or the researcher identify what a successful outcome is? This difficulty in identifying appropriate outcomes speaks to the need to increase exploratory research, leading to our focus on asking participants themselves how successful coping in the form of wellness is experienced within the current study.

Burnout

The impact of long-term occupational stress in health, mental health, and social service professionals is known as burnout. This section will discuss the history and development of the burnout construct, its definition, the subjective experience of burnout, its prevalence, etiological theories, intervention/prevention, self-care, and engagement.

History

The term burnout first appeared in Freudenberger's (1974) discussion regarding the functioning of staff at drop-in community health clinics. Herbert Freudenberger (1926-1999) was an American clinical psychologist who spent time volunteering at these free clinics. He noted the term “burnout” as originally used by members of the illicit drug scene to describe the negative effects of chronic drug abuse, then borrowed in the 1970s by drug and alcohol counsellors to describe the results of their occupational stress (Maslach et al., 2009). Observing the burned out worker as appearing depressed, he defined burnout as a state of mental and physical exhaustion caused by one's professional life (Freudenberger, 1974). At the same time as Freudenberger was publishing his thoughts on staff burnout, a social psychologist by the name of Christina Maslach (born 1946) was studying how healthcare and human service workers were coping with the strong emotional arousal involved with their jobs (Maslach et al., 2009). During exploratory interviews, some workers described their psychological challenges at work in similar terms as Freudenberger’s clinic workers, using the term “burnout” (Maslach, 1976). Both Freudenberger (1974) and Maslach (1976) describe burnout as embedded in caregiving and service occupations, where the core of the job is interpersonal interaction and relationship. This relational context makes burnout more than a simple individual stress response, but rather the potential result of numerous relational transactions (Maslach et al., 2009, 2001).

Initial burnout research was descriptive and qualitative in nature, largely utilizing interviewing, case studies, and on-site observation. This research identified the relationship between high job demands and *emotional exhaustion* within workers, with participants describing attempts to get emotional distance by practicing detached concern and *depersonalization* towards clients (Maslach et al., 2001). High numbers of clients, negative

feedback, and scarcity of resources were identified as contributing to this emotional overload and exhaustion (Maslach, 1976). A desire for practical application and immediate solutions was present during this time period, resulting in the subsequent development of workshops as a form of both intervention and data source (Maslach et al., 2001; Schaufeli, Leiter, & Maslach, 2009). The initial description of burnout and early attempts at intervention prompted fierce discussion and debate regarding the validity and content of the construct, contributing to an eventual change in research approach.

The burnout term is populist in origin, having developed from the bottom up, and debate regarding initial research criticized it as pop psychology, unworthy of serious investigation (Maslach et al., 2009). Seeking to address these concerns, in the 1980s, research on burnout shifted to quantitative approaches, with a focus on burnout assessment (Maslach et al., 2001). Qualitative researchers had identified three primary dimensions: exhaustion, a negative shift in response to others, and a negative response towards oneself and one's accomplishments (Maslach et al., 2001; Schaufeli et al., 2009). Several attempts at creating a measure including these three dimensions were attempted, with factor analysis utilized to maximize the psychometric properties of these early measurement attempts (Schaufeli, Enzmann, & Girault, 1993). These efforts led to the development of the most widely used burnout measure to date, the Maslach Burnout Inventory (MBI) (Maslach & Jackson, 1981). By the end of the 1990's, the MBI had been used in 93%t of journal articles focused on burnout (Schaufeli et al., 2009). Research in the 1990s and into the 2000s saw the burnout construct extended into occupations outside the human services, with more sophisticated methodological and statistical tools put to use, and the identification of antecedents and consequences of burnout more thoroughly investigated (Bakker, Demerouti, & Sanz-vergel, 2014).

Quantification of Burnout

Quantitative consensus has established three dimension involved with burnout: the manifestation of the feeling of being depleted of one's resources, cynicism and detachment towards interpersonal relationships, and a lack of achievement and productivity (Maslach et al., 2009). These dimensions have been codified in the MBI as *emotional exhaustion* (EE), *depersonalization* (DP), and *personal accomplishment* (PA) (Maslach & Jackson, 1981). EE describes being emotionally overextended or exhausted regarding work. EE is the most obvious symptom of burnout, and when a person describes themselves as burned out they are frequently referring to their experience of exhaustion (Maslach et al., 2001). DP describes an unfeeling and impersonal response towards recipients of one's care or service. Depersonalizing behaviour is thought to occur as a coping strategy in response to exhaustion, with the hope that increased distance between the worker and their client will reduce the resources necessary to respond to client needs (Maslach et al., 2001). PA describes a lack of feelings of competence and successful achievement in one's work with people. As Maslach et al. (2001, p. 403) state, "It is difficult to gain a sense of accomplishment when feeling exhausted or when helping people towards whom one is indifferent." Aside from these three primary features, burnout has been associated with increased depression, anxiety, sleep problems, impaired memory, neck and back pain, alcohol consumption, flu-like symptoms, and gastroenteritis (Awa et al., 2010; J. Johnson et al., 2018). Burnout has been further connected with poor client outcomes, an increase in adverse work related events, and negative client safety indicators (Dreison et al., 2018; J. Johnson et al., 2018). On an organizational level, burnout has been associated with reduced commitment and negative attitudes toward the employing organization, absenteeism, high turnover, job dissatisfaction, low

staff group morale, sick leave, and reduced adherence to evidence-based practices (Morse et al., 2012).

In attempts to establish discriminant validity, the burnout construct has been compared with depression and anxiety. Results of these comparisons have found a distinction between the constructs, with burnout specifically related to a work context (Bakker et al., 2000; D. C. Glass & Mcknight, 1996; Leiter & Durup, 1994). In discriminating from depression, Maslach and Schaufeli (2017) noted these five distinguishing elements: (a) there is a predominance of dysphoric symptoms such as mental or *emotional exhaustion* and fatigue; (b) an emphasis is on mental and behavioural symptoms more than physical ones; (c) burnout symptoms are work-related; (d) the symptoms typically manifest themselves in people who did not suffer from an identified psychopathology before; and (e) decreased effectiveness and work performance occur because of negative attitudes and behaviours. These elements are similar to the ICD-10 (World Health Organization, 2016) diagnosis of "Work-Related Neurasthenia", with the MBI having been found to be able to distinguish psychiatric outpatients diagnosed with Neurasthenia from outpatients diagnosed otherwise.

The scoring of the MBI has proved problematic for researchers versus practitioners, with researchers preferring a continuous variable and practitioners desiring a dichotomous one (Maslach et al., 2009; Schaufeli, Bakker, Hoogduin, Schaap, & Kladler, 2001). As the MBI was developed with research in mind, it provides three separate subscales scores with no a-priori theory for how or if these scales should be combined. However, the MBI manual does provide cut offs, with scale scores divided into thirds (high, average, low). The high score cut off is similar to the requirements for a Neurasthenia diagnosis.

Lived Experience of Burnout

Those experiencing burnout report feeling their self-image as a competent professional threatened, a lack of trust in themselves, shame, confusion, and judgment from others (Ekstedt & Fagerberg, 2005; Y.-S. Lee & Tae, 2012; Severinsson, 2003; C. M. Young et al., 2015). It has been suggested that the individual experience of burnout involves finding meaning within work, and then feeling as though one has failed in this meaningful work (Pines, 2017). Supporting this suggestion is the finding that personal meaning may be a protective factor against burnout. For example, in 2009, Shanafelt et al., administered a survey evaluating work characteristics, career satisfaction, questions evaluating with professional activities were most meaningful, and containing the MBI to 556 physicians at the department of internal medicine at a large academic medical center. Participants that spent less than 20% of their time engaged with their most meaningful activity (patient care) showed the highest rates of burnout. Similarly, in 2014, Gama, Barbosa, and Vieira administered the MBI, the Adult Attachment Scale (Collins & Read, 1990), The Purpose and Meaning in Life Test (Crumbaugh, 1968), and the Death Attitude Profile (Wong, Reker, & Gesser, 1994) to 360 nurses from the internal medicine, oncology, haematology, and palliative care departments of five health institutions. A negative correlation was found between *emotional exhaustion*/*depersonalization* and meaning or purpose in life, leading to the authors to suggest that meaning and purpose in life may be protective factors against burnout.

People experiencing burnout report having made choices in their lives with the expectation of creating a meaningful career, only to find their choices within the helping profession are limited and their will to continue is fading into burnout (Judd et al., 2017; Pines, 2017). For example, Judd et al., (2017) conducted a thematic analysis on the data collected

through the interview of 12 disability support workers. The participants described a lack of decision-making power, low income, lack of management insight into the high expectations for care, staff shortages, and challenging client behaviour as major contributors to their feelings of stress and burnout. They reported that being able to follow through on the reasons they entered the field as being a protective factor against this burnout, with these reasons ranging from putting a smile on clients' faces to helping clients complete their goals. Similarly, Pines (2002) gave 681 teachers a survey containing a measure of burnout (The Burnout Measure) (Pines & Aronson, 1988) and open-ended questions on what childhood experiences influenced their decision to become a teacher, a painful childhood experience, goals, and expectations for entering the teaching field, and what the most burnout causing stresses at work are. Content analysis of the interview data found a negative correlation between the loss of feelings of significance in the participants' teaching work and burnout, as well as a positive correlation between feeling that their goals for teaching are being blocked and burnout. This matches with the study completed by Currid (2008), in which eight mental health nurses were interviewed on their lived experience with occupational stress, and the personal meaning of these experiences. Using a hermeneutical phenomenological analysis, it was found that the stressors at work led to the participants feeling professionally compromised, unrecognized, and under-valued. One participant stated, "As students we were taught so many things, you now realise that things are done differently . . . we always know that the patient should be put in the first place, but in the acute area, it is mostly financial position that is considered the most important" (Currid, 2008, p. 882-883). The lived experience of burnout appears to potentially carry with it a loss of the expected meaning in work.

As workers burn out, they may feel guilt and shame at not being able to follow through with their long-term career choices (Wallace, Lemaire, & Ghali, 2009). In a study looking at

physicians' attitudes regarding illness in themselves and their collogues, Thompson, Cupples, Sibbet, Skan, and Bradley, (2001) conducted interviews and focus groups with 27 general practitioners. Utilizing a grounded theory analysis, it was found that participants described a need to project a healthy image to their clients and colleagues. The acknowledgement that they may need assistance carried with it embarrassment and the perception of stigmatization, with participants identifying their professional training and position as reinforcing this perception. The researchers concluded that the perceived need to project this always healthy and together image is unrealistic, stressful, and a barrier to self-care. Similarly, Young et al. (2015) interviewed 12 midwives that had self-identified as experiencing burnout, asking them what lessons can be learned from their experience with burnout. Utilizing a phenomenological analysis, it was found that the experience of burnout was confusing and extremely painful for the participants. Participants described feeling judged for not managing their practices well, with feelings of shame subsequently leading to feeling isolated and unable to reach out for help.

As burnout develops, people may feel trapped, without choice, and powerless under developing symptoms, increasing the loss of will to actively combat these symptoms. Ekstedt and Fagerberg (2005) completed a study with eight people that had taken sick leave for more than three months and had scored in the high category on a measure of burnout (Shirom-Melamed Burnout Questionnaire) (Selmela-Aro & Näätänen, 2005). Using a phenomenological life world approach, the participants were encouraged to describe concrete lived experiences during the months preceding the acute phase of their burnout. Eight themes were found: inner incentive, feeling responsible, threatened self-image, cutting off, bodily manifestations, psychological manifestations, and fatigue/reaching the bottom line. Participants described feeling trapped between their sense of responsibility, inner incentive, and never-ending and conflicting

demands. Strain persisted despite efforts to meet these demands, resulting in a sense of failure, depletion, and threatened self-image, with the will to continue coping fading into exhaustion. It is interesting to note the similarity with Selye's (1936) general adaptation syndrome here. Participants recognize the threat, attempt to resist, feel trapped and notice exhaustion setting in. Eventually they submit to exhaustion and burnout.

Research on the lived experience of burnout further illuminates the personal costs involved. Discovering that burning out may prevent a person from living the meaningful life that they have chosen to pursue appears to have devastating consequences, and provides potential explanation for the related depression, anxiety, physical health concerns, and relational difficulties associated with burnout. Further, considering the perception that it may be something within the workers them-selves that is potentially not handling the work may multiply the difficulty involved (Reynolds, 2011). Supporting this idea is the finding that those who witness a threat to their clients are more likely to identify subsequent PTSD symptoms as being due to personal weakness (Alden, Regambal, & Laposa, 2008). The burnout experience is isolating. Acknowledgement of burnout symptoms invite stigma, and have been connected with a fear of potential career damage (Wallace et al., 2009; C. M. Young et al., 2015). In combating burnout, the duty of self-care is largely placed on workers, and when a worker is experiencing burnout there is often an implicit belief that perhaps they are failing in in their own self-care, or unsuited to the work (Reynolds, 2011; Thompson et al., 2001). This fearing of negative repercussions for admitting struggles with stress can result in further isolation and subsequent burnout. While the three dimensions used in the quantitative measurement of burnout (EE, DP, PA) may sound difficult enough to manage, underneath these simplified dimensions, workers are facing a cascade of associated personal and social challenges. Discovering how workers manage these

challenges requires research approaches that have the capacity to go beyond the boundaries inherent to quantitative classification and into people's subjective, lived experience.

Prevalence

Prevalence rates on some burnout dimensions within health care fields are estimated as high as 78% (J. Johnson et al., 2018; Morse et al., 2012)**.** In a meta-review of burnout in mental health workers, Morse et al. (2012) found that across four studies with over one thousand participants, between 21 and 67% of mental health workers experience high levels of burnout. Participants included CMHWs, directors of community mental health centers, social workers, and forensic mental health workers, and burnout was primarily measured using the MBI. The most significant of the studies reviewed is Siebert's (2005) survey of 751 social workers. Participants were given a 7-item version of the EE subscale of the Maslach Burnout Inventory. Thirty-four percent of respondents scored above the high burnout threshold score of 16 on this modified subscale. These results indicate that nearly 1 in 3 of the participants surveyed were experiencing a high level of Burnout. This prevalence level has been found to be higher in populations doing community focused work. In 1999, Webster and Hacket gave 151 CMHWs the Maslach Burnout Inventory. Fifty-four percent of participants scored above the 21-point cut-off for high burnout on the EE scale, and 38% scored above the 9-point cut-off for high burnout on the DP scale. These results indicate that 1 in 2 participants were highly emotionally exhausted, and 1 in 3 were experiencing high levels of DP towards their clients. The high prevalence levels found in these studies mark burnout as a common result of stress within mental health worker populations. This high prevalence rate has carried over into current studies. In an update to their 2011 study, Shanafelt et al. (2015) surveyed 6880 physicians and a probability-based sample of the general US population on burnout and work-life balance. An increase from

45.5% to 54.5% of the physicians reported at least one symptom of burnout. Similarly, satisfaction with work-life balance shifted from 48.5% to 40.9%. In contrast, the rates of burnout and satisfaction in the general population had held steady at less than 25% for burnout symptoms and around 60% for satisfaction with work-life balance. Similarly, Westwood, Morison, Allt, & Holmes (2017) administered a survey assessing burnout and job characteristics to 201 psychologists, finding a prevalence of burnout rate of 68.6%. These prevalence rates are startling and speak to the high need to understand what is causing burnout, and what is keeping people well in the face of these prevalence figures.

Etiology

Early Burnout conceptualizations described the construct as developing in response to the chronic interpersonal stressors involved with human service work (Maslach, 1976). Core to the conceptualization of Burnout is the acknowledgement that the context is important to the experience. Early research looking to identify the causes of Burnout therefore primarily focused on situational factors that correlated with construct, with later research beginning to identify individual correlates (Maslach et al., 2001). Bringing these two elements together, most contemporary theories of burnout etiology typically focus on the goodness of fit between the person and the environment, with a mismatch between the demands of the job and the resources of either the job environment or the worker resulting in stress and eventual burnout (Bakker et al., 2014). This explanation is in line with the transactional theory of stress and coping, in which stress is defined as a relationship between the environment and the person, whereby which the person appraises a situation as taxing, exceeding their resources, or endangering their well-being (Lazarus & Folkman, 1984). A short review of identified environmental and individual factors follows.

Environmental factors

In 1996, Lee and Ashforth completed a meta-analysis of burnout correlates that included 66 studies published between 1982 and 1994. It was found that job demands were more likely to predict burnout symptoms than were a lack of job resources. Role ambiguity, role conflict, role clarity, role stress, stressful events, workload, and work pressure were found to be the most damaging. The authors theorize that job demands were more strongly predictive because they required the use of job resources to counter. Similar results were found by the meta-analysis of 231 published studies completed by Alarcon (2011). However, Alarcon (2011) found a relationship between a lack of resources and low feelings of *personal accomplishment*. Job resources were listed as a sense of control over job tasks, autonomy in completing tasks, and social support from management and coworkers. Finally, the recent meta-analysis by Aronsson et al. (2017) also found similar results. Limiting their studies to those that included a baseline measurement at the start of employment, and time two assessment sometime between one and five years later, resulted in 25 appropriate publications between 1990 and 2013. High demands, low job control, high workload, low reward, and job insecurity were found to be linked to Burnout. Considering the number of studies finding similar results, it is likely that burnout develops in work environments with low rewards and high job insecurity, in which there is too much work for the available time, where there is role conflict or ambiguity, and where stressful events are commonplace.

Individual Factors

Early research on burnout found that as age and experience increase, levels of burnout decrease (Maslach & Jackson, 1981). In testing the reliability and validity of the MBI, the measure was administered to 1025 human service workers in a wide range of occupations.

Participants aged 17-29 scored an average of 3.52 on EE, 2.48 on DP, and 4.90 on PA. Participants aged 59 and over scored 2.49 on EE, 0.78 on DP, and 5.21 on PA. Participants from each age category reported higher burnout as that category increased in age. It was theorized that burnout is likely to occur within the early years of one's career, and therefore people with more years of experience have found effective ways to cope with job stresses and reduce burnout within themselves, or they have left the profession and removed themselves from potential study. Current studies with populations doing mental health related work back up this early link between advanced age and reduced burnout (Ray, Wong, White, & Heaslip 2013) gave 169 frontline mental health care professionals the Maslach Burnout Inventory. While they did not report the participant's mean scores according to experience in the field, they did report a significant negative correlation between experience and EE ($r=-.19$, $p<.01$). Similarly, Lizano and Mor Barak (2012) completed a three-wave longitudinal study examining the effect of workplace demands on EE and DP. 335 Public Child Welfare Workers were given the Maslach Burnout Inventory at six- month intervals. A negative correlation was found between years of experience at work and EE. Using growth curve analysis and with all other variables constant, a one-unit increase in years of experience resulted in a decrease of 0.27 in EE scores. The authors suggest that as the time workers have spent at work increases, they burnout and either leave work or adapt their coping to keep burnout at a manageable level.

Gender has not been found to be predictive of Burnout levels. Throughout various studies conducted by Maslach no meaningful difference regarding gender has been found (Maslach et al., 2001). Similarly, a meta-analysis conducted by Purvanova & Muros (2010) reviewing 183 studies and including participants across a large variety of occupations including but not limited to those doing mental health work found no major difference in Burnout levels across gender.

Several personality traits have been examined in searching for individual vulnerabilities to Burnout. A meta-analysis conducted by Alarcon, Eschleman, & Bowling (2009) focused on the relationship between personality variables and Burnout. Across 114 publications, emotional stability, extraversion, conscientiousness, and agreeableness were found to be negatively related to Burnout. Neuroticism was found to have a positive relationship. Self-esteem, self-efficacy, locus of control, positive affectivity, negative affectivity, optimism, proactive personality, and hardiness were also found to have a significant relationship with burnout. The authors suggest that personality may dispose workers to self-select into more manageable work environments, and to be more emotionally stable, flexible, and likely to perceive their work environments as sustainable. Conversely, those high in neuroticism may be less able to perceive and utilize strengths in their work environment and be more prone to psychological distress in general.

A Job-person Model of Burnout.

In order to better consider the relationship between the job and the person specific to burnout, Maslach and Leiter (1997) and Maslach (2001) have suggested six areas of job-person that when mismatched contribute to burnout. These are: workload, control, reward, community, fairness, and values. Workload mismatch typically involves an excessive overload, but may also involve the wrong kind of work or work that people lack the appropriate skills or interest in. This is especially challenging when the work requires displays of emotion inconsistent with worker's feelings. Control mismatch involves insufficient control over resources necessary to do a person's work, or insufficient authority to approach work in the way they believe most effective. Being committed to do some meaningful work, but without the control to do it well, can be challenging. Reward mismatch involves insufficient rewards for the amount of work or effort put in. These rewards may be financial, social, or intrinsic. Community mismatch involves a lack of

positive connection with others in the workplace. Isolation, impersonal social contact, or chronic and unresolved conflict may produce symptoms of burnout. Fairness mismatch involves inequity of workload, pay, inappropriate evaluations or promotions, or ineffective grievance and dispute resolution. A fairness mismatch may result in EE and a sense of cynicism. Values mismatch involves job constraints that feel unethical, are outside of a person's values, are outside of personal career aspirations, or a discrepancy between an organizations mission statement and actual practice. Maslach (2001) suggests that each individual may weigh the importance of a match on each of these areas according to their personal preferences. Though job demand-resource models have gained more attention from researchers than Maslach's model, studies have connected high burnout symptoms with mismatches in these six areas and the current study's results are contrasted with these areas (Bakker et al., 2014; Lasalvia et al., 2009; Ray et al., 2013).

Burnout Intervention/prevention

Initial attempts at burnout prevention typically took the form of workshops with organizations and their employers, attempting to educate people on the common experience of Burnout (Maslach et al., 2001; Schaufeli et al., 2009). Since the 1980's, burnout interventions have typically focused on the individual, the organization, or a combination of the two (J. Johnson et al., 2018). Individual interventions usually utilize cognitive behavioral and mindfulness-based approaches to increase individual resources, or attempt to provide education on burnout, stress, coping, personal development, and self-care. Organizational interventions center on increasing training, reducing role ambiguity, improving the quality of supervision, decreasing work-loads, promoting self-care as an organizational value. Typically, a theoretical approach in designing and implementing these interventions is not explicitly stated, however a

job demands versus resources approach frequently appears to be implicitly endorsed. In most studies examined, little time is devoted to discussing stress and coping theory, with the relational nature of the stress interaction frequently being lost in favor of clearly delineated intervention targets. A summary survey of the effectiveness of burnout intervention studies follows.

In a recent meta-analysis, Dreison et al. (2018) analyzed 27 studies published between 1980 and 2015 representing 1894 mental health workers. Intervention types targeted either the individual, the organization, or some combination of the two. The majority of interventions targeted the organization (70%), typically with a job training/education focus. Mean differences in burnout reduction were between 0.13 and 0.22, with effect sized greater for individual focused interventions, when a second post-test measurement was used, and when studies used controlled designs. Dreison et al.'s (2018) finding that individual focused interventions are more effective contrasts with the findings of previous meta-analyses. In 2016, West, Dyrbye, Erwin, and Shanafelt completed a review of 52 articles examining burnout intervention with 3630 physicians. Overall burnout scores decreased an average of 10% across studies, with no difference in effectiveness between intervention targets. Similarly, Panagioti et al. (2017) compared 20 studies examining burnout intervention with 1550 physicians. A small average effect size was found (8.97), with organization focused interventions showing larger effect sizes. Interestingly, Awa et al.'s (2010) meta-analysis of 25 intervention studies with 1349 participants that had indicated interest in burnout prevention programs found that person focused interventions were effective in the short term (6 months or less), while interventions combining person and environment focus had longer lasting effects (12 months of longer). These frequently conflicting results regarding the target of intervention display the lack of coherence occurring within burnout intervention research.

Several explanations have been provided for the lack of coherence and effectiveness in burnout prevention research. These include a lack of person-environment relational focus (J. Johnson et al., 2018), a lack of accounting for measurement issues in stress and coping research resulting in misinformed designs (Folkman & Moskowitz, 2004), a lack of inclusion of personal resources beyond those internal to the individual (Morse et al., 2012), a lack of consultation with workers on their perspectives (Awa et al., 2010; J. Johnson et al., 2018), lack of grounding in the literature (West et al., 2016), insufficient collaboration between universities and organizations (J. Johnson et al., 2018), and various methodological issues including lack of detail on the sample and intervention, lack of uniformity in burnout measurement, lack of intervention fidelity, lack of follow up studies, small sample sizes, high attrition rates, lack of longitudinal designs (Awa et al., 2010; Dreison et al., 2018; J. Johnson et al., 2018; Morse et al., 2012; Panagioti et al., 2017; West et al., 2016). Taken together, it is clear that increased research attention on burnout intervention and prevention is needed. Following the above critiques of burnout intervention and those made of stress and coping research in general, this increased attention should keep in mind the subjective and relational nature of the stress intervention, with an eye to what individual workers are identifying as helping or hindering their ability to mitigate Burnout threat and symptoms and designing interventions based upon this identification.

Self-Care

Self-care has been defined in a variety of ways. In general, self-care in the context of similar workers to the participants in this study refers to, “activities or processes that are initiated and managed by the worker for the purpose of supporting one’s health and well-being, attending to one’s needs, or providing stress relief” (Bressi & Vaden, 2017, p. 34). Self-care is typically considered to be multi-dimensional and holistic, with strategies in a variety of areas (physical,

professional, relational, emotional, psychological, and spiritual) employed by the individual (Butler, Mercer, McClain-Meeder, Horne, & Dudley, 2019; Richards, Campenni, & Muse-Burke, 2010). An emerging body of literature withing the social work field emphasizes the need to engage in self-care strategies specific to the "self in the professional role" (J. J. Lee & Miller, 2013). These authors suggest following areas of the "self in the professional role": (a) workload and time management, (b) attention to professional role, (c) attention to reactions to work, (d) professional social support and self-advocacy, (e) professional development, and (f) revitalization and generation of energy. In addition to these areas the authors suggest that strong boundaries around engaging in thoughts and discussions regarding work while at home must be maintained. Figley (2002) similarly suggests boundaries of this type in avoiding burnout and secondary traumatic stress. Recent critique of this "self in the professional role" conceptualization point out that this separation of self and professional is difficult and potentially detrimental in working with vulnerable and marginalized clients (Bressi & Vaden, 2017). These authors suggest that the definition of self-care must be broadened to include activities that specifically allow workers to manage the affective and identity dysregulation that occurs when working closely with their oppressed and suffering clients, and that assist in making meaning from the way that workers selves are changed by this work. This is in line with suggestions that contact with traumatic events when ruminated on and coped with in a supportive environment can lead to post-traumatic growth (Morris & Shakespeare-Finch, 2011; Tedeschi, Shakespeare-Finch, Taku, & Calhoun, 2018a). The self-care construct has also been criticized for putting too much emphasis on the individual's efforts and ignoring organizational and wider structural contexts (S. Collins, 2021; Reynolds, 2011). This critique will be further reviewed in the section

on social justice critiques of the burnout construct below. Personal, professional, relational, and contextual elements of self-care are considered in the analysis of the results of this study.

Engagement

Burnout is characterized as a negative psychological state. As detailed above, it is characterized by exhaustion, personal distancing, feelings of shame and guilt, and a lack of feelings of self-esteem and accomplishment. Research on the negative aspects of burnout have led some researchers to ask what it's positive opposite might be (Maslach et al., 2001). The concept of engagement has been selected as this potential opposite. Introduced by Kahn (1990), engagement is the "harnessing of organization members' selves to their work roles; in engagement, people employ and express themselves physically, cognitively, and emotionally during role performances" (p. 694). In contrast to burnout, engaged employees view their work as challenging rather than demanding and draining, and approach it with a sense of energy and effective connection (Bakker, Schaufeli, Leiter, & Taris, 2008).

Two approaches have been taken in operationalizing engagement. Maslach and Leiter (1997) have characterized engagement as energy, involvement, and efficacy. The authors suggest that these three dimensions are theoretical direct opposites to EE, DP, and PA, and may therefore be indicated through a pattern of low scores on the MBI. Alternately, Schaufeli et al. (2002) have suggested that work engagement is an independent and separate construct that is negatively related to burnout. They suggest that engagement can be characterized by vigor, dedication, and absorption. Vigor is the presence of high levels of energy and mental resilience while working, the desire to invest in one's work and persist when work is challenging. Dedication is a sense of significance, enthusiasm, and challenge, resulting in strong involvement in work. Absorption is being fully concentrated and deeply engrossed in one's work, with time passing quickly, with

difficulties detaching from work. These dimensions have been quantified in the Utrecht Work Engagement Scale (UWES) (Schaufeli & Bakker, 2003). Three arguments have been put forward in utilizing the UWES over the MBI in operationalizing work engagement (Schaufeli & Bakker, 2004). First, defining engagement through energy, involvement, and efficacy alone disregards important elements of the engagement construct. The authors suggest that there is more to engagement than these three dimensions alone. Second, engagement as nothing more than the opposite of burnout is too simplistic a definition and does not allow for the independence of engagement. Third, the MBI only captures negative psychological states, and does not allow for the measurement of positive ones.

Work engagement as a goal to strive for in opposition to burnout continues to be researched, without having reached an ideal consensus on the construct (Maslach et al., 2009). Still, success in researching antecedents of engagement has made important contribution to the literature, with job resources and certain personality features having been found to correlate with engagement (Bakker et al., 2014). Regarding job resources, task variety, task significance, autonomy, feedback, social support from colleagues, a high-quality relationship with supervisors, and transformational leadership have been found to be positively associated with work engagement (Christian, Garza, & Slaughter, 2011). Regarding personality, emotional stability, extraversion, conscientiousness, self-efficacy, optimism, and self-esteem have been found to be positively associated with work engagement (Mäkikangas, Feldt, & Kinnunen, 2013). These job and personality resources may assist workers in maintaining engagement, and wellness, in facing conditions that commonly lead to burnout at work.

Secondary Traumatic Stress

Secondary traumatic stress is frequently connected with burnout. Workers providing care and support to traumatized individuals face unique challenges. They must provide empathy and

understanding to clients that are experiencing intense distress, while frequently bearing witness to stories containing unimaginable and overwhelming narratives. In hearing these stories of pain and suffering, the workers themselves may also feel pain and suffering. Interested in the effects on workers of supporting traumatized clients, the American psychologist Charles Figley (1944 – present day) noticed something more than burnout taking place. He coined the term compassion fatigue to describe the effects of long term work with traumatized individuals (Figley, 1995). In reviewing the literature, it appears that Figley and others use the term compassion fatigue, vicarious trauma, and secondary traumatic stress synonymously. No explanation for this variance in term is provided, and the three terms appear to be used interchangeably. For the purposes of this review the term secondary traumatic stress (STS) will be used. The definition, theory, a discussion of STS as it relates to burnout, measurement of STS, and a critique of STS follow.

Definition

STS is "the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other—the stress resulting from helping or wanting to help a traumatized or suffering person" (Figley, 1995, p. 7). The worker suffering from STS experiences symptoms that match the symptoms of post-traumatic stress disorder. The worker experiences tension and preoccupation with their traumatized clients, re-experiencing their traumatic events, avoiding and numbing reminders of the events or clients, and is in a constant state of persistent arousal regarding the clients. It has been suggested that STS can cause changes in a worker's view of the world, spirituality, self-capacities and abilities, psychological needs and beliefs, and feelings about safety, trust, esteem, intimacy, and control (Saakvitne et al., 1996).

Theory

Figley (2002) has suggested ten variables that contribute to the development of STS. They are: (a) empathic ability, or the aptitude of the worker for noticing the pain of others; (b) empathic concern, or the motivation to respond to people in need; (c) exposure to the client, or experiencing the emotional energy of the suffering of clients through direct exposure; (d) empathic response, or the extent to which the psychotherapist makes an effort to reduce the suffering of the sufferer through empathic understanding; (e) compassion stress, or the residue of emotional energy from the empathic response from the empathic response to the client and the on-going demand for action to relieve suffering; (f) sense of achievement, or the extent to which the worker is satisfied with his or her efforts to help the client; (g) disengagement, or the extent to which the worker can distance themselves from the ongoing misery of the client when not in contact with them; (h) prolonged exposure, or the ongoing sense of responsibility for the care of the suffering, over a protracted period of time; (i) traumatic recollections, or memories that trigger the symptoms of PTSD and associated reactions, such as depression and anxiety; (j) life disruption, or the unexpected changes in schedule, routine, and managing life responsibilities that demand attention. The availability of social and professional support within the employing organization, as well as the past trauma history of the worker and propensity for counter-transference have been suggested as contributing to the development of STS (Hensel, Ruiz, Finney, & Dewa, 2015; Ivicic & Motta, 2017; Sabin-Farrell & Turpin, 2003).

STS and Burnout

In defining STS, Figley (1995) recognized the potential for overlap with the burnout construct. The difference between the gradual development of burnout versus the ability for STS to emerge suddenly is a major differentiating factor. Later work has suggested that burnout and

STS typically occur concurrently, and burnout may be required to develop STS. In a study assessing the underlying dimensions of the Figley's Compassion Fatigue Scale with 236 social workers following the events of September 11th, 2001, found that two underlying dimensions were being measured, STS and burnout (R. E. Adams et al., 2006). Good reliability, concurrent and predictive validity were found within the scale. The theory that burnout and STS occur concurrently is supported by high correlation (.69) found between burnout and STS found in meta-analysis (Cieslak et al., 2014).

Measurement of STS

Measurement of STS within workers typically takes place via questionnaire. Figley's (1995) book on the subject contains a "Compassion Fatigue Self-Test for Psychotherapists" with 40 items assessing the clinician and their thought/feelings regarding their work environment. As described above this scale attempts to measure both STS and burnout. In addition, the Trauma Stress Institute Belief Scale has been developed to assess disruptions in beliefs related to self and others as a result of STS (K. B. Adams, Matto, & Harrington, 2018). However, the majority of research regarding STS uses measures of PTSD to assess symptoms (Sabin-Farrell & Turpin, 2003). Prevalence rates between 7% and 40% have been found among intensive care unit workers (van Mol, Kompanje, Benoit, Bakker, & Nijkamp, 2015), between 21% and 52.3% in nurses (Beck, 2011), and 15.2% among workers supporting clients with trauma in general (Bride, 2007).

Critique of STS

In general, quantitative research evidence in support of the validity of the STS construct suffers from challenges with rigour and construct inconsistencies, with a reliance on small variable correlations between STS symptoms and trauma exposure. Agreement upon a consistent

terms, sets of symptoms, discrimination from other conditions, and standardized measurement have been suggested in meeting these challenges (Sabin-Farrell & Turpin, 2003). Conversely, qualitative methods have begun to be explored in relation to the investigation of STS and have provided more consistent evidence for the existence of the condition than quantitative studies have managed. Quantitative evidence for the existence of STS symptoms, and specific population beliefs about their causes is clear (Benatar, 2000; Iliffe & Steed, 2000). However, these studies are small in number and the need for increased qualitative exploration has been suggested (Beck, 2011; Kapoulitsas & Corcoran, 2015). The current research answers this call for increased STS research through its focus on a population at risk for the development of STS.

Post-Traumatic Stress Disorder

Post-Traumatic Stress Disorder (PTSD) is a mental health disorder that develops following life-threatening events, serious injury, or sexual assault, and involves re-experiencing the event, active avoidance, disturbed emotional states, alterations to arousal and reactivity, and numbing (American Psychiatric Association, 2013). The World Health Organization defines PTSD as a "delayed or protracted response to a stressful event or situation (of either brief or long duration) of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone" (World Health Organization, 2016). Though none of the participants in this study are known to have a formal PTSD diagnosis, they are actively responding to life threatening and often fatal overdoses of people frequently known to them, and it is therefore appropriate that a short review of PTSD is included here. The history, diagnostic definition, theory, prevalence, predictors/prevention, and critique of PTSD will be briefly reviewed in the following sections.

History

As discussed earlier in this review, adverse reactions to stress have been acknowledged for centuries. However, the codification of a debilitating psychological disorder in response to traumatically stressful event is recent (Turnbull, 1998). Conditions similar to PTSD had being recognized in soldiers and survivors of industrial accident during the late 19th, taking on names such as railway spine, stress syndrome, nostalgia, soldier's heart, shell shock, battle fatigue, combat stress reaction, and traumatic war neurosis (Parry-Jones & Parry-Jones, 1994). The social changes brought by the American-Vietnam war, increased psychological interest in traumatic stress, frequent delayed onset of veteran psychological symptoms, and slow reduction of stigma regarding negative stress responses has led to the adoption of PTSD as a diagnostic category within the American Psychological Association's Diagnostic and Statistical Manual of Mental Disorders third edition (DSM-III) in 1980 (Andreasen, 2010; Crocq & Crocq, 2000; Judith, 1992). The diagnostic criteria of the PTSD diagnosis have evolved in each iteration of the DSM since that time with the most current criteria (DSM-5, 2013) involving at least one stressor involving direct, witnessed, or indirect trauma (death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence); at least one intrusion symptom; at least one avoidance symptom; at least two negative alterations to mood; at least two alterations to arousal and reactivity; symptoms lasting for more than one month; symptoms creating distress or functional impairment; and the symptoms not being due to medication, substance use, or other illness.

Theory

PTSD has been conceptualized as occurring in response to the cascade of biological and psychological responses activated by fear related brain systems (Yehuda, 2002). These brain

system activations are a normal response to threat, but are considered disordered when they persist longer than a month after the threatening event or situation (Zohar, Juven-wetzler, Myers, & Fostick, 2008). Those suffering from PTSD are conceptualized as holding an implicit memory of the trauma in the stress related areas of their brains and bodies, with those memories expressing themselves through PTSD symptoms (Rothschild, 2000; van der Kolk, 2014). The pathway for the development of PTSD is currently thought of as involving a threatening event or situation, the activation of the stress-response areas of the brain (resulting in a fight/flight/freeze response), and the prevention of this stress-response cycle finishing (parasympathetic rest and restore) due to continued stressful events and/or negative social response to the expression of stress symptoms (Maercker & Horn, 2013; Ozer, Best, Lipsey, & Weiss, 2003). In essence, the typical stress response cycle is interrupted or prevented from completing, resulting in the belief by the stress-response parts of the brain that the traumatic event has not ended, and safe equilibrium has not been restored.

Prevalence

At the DSM-5's publication, projected life-time risk for PTSD in the United States was 8.7% (American Psychiatric Association, 2013). Twelve-month prevalence within the United States was 3.5%, with most countries outside of North America being between 0.5% and 1%. PTSD rates jump to between 1/3rd to more than half among survivors of rape, military combat and captivity, and those subjected to ethically or politically motivated internment and genocide. Professional first responders, police, firefighters, ambulance personal, and health care professionals have been found to have experience higher rates of PTSD than other groups aside from veterans (Skogstad et al., 2013). A recent meta-analysis of PTSD among healthcare providers found a prevalence rate of 14.8%, with a range of 4.4% to 28% across 9 studies

(Sendler, Rutkowska, & Makara-Studzinska, 2016). In a survey of 1029 United Kingdom ambulance personal 22% were discovered to qualify for a PTSD diagnosis (Bennett, Williams, Page, Hood, & Woollard, 2004). In a similar survey of American social workers, 15.2% were found to meet PTSD criteria (Bride, 2007). A meta-analysis looking to compare prevalence rates across first responders across 28 studies and 20424 participants found ambulance workers to have higher prevalence rates than police or fire workers, with the authors suggesting that paramedics often have closer contact with their clients, potentially increasing identification with them and subsequent guilt when their attempts to help are not successful (Berger et al., 2012). These numbers indicate an increased risk of developing PTSD among workers experiencing occupational stressors that overlap with those faced by CMHWs. Unfortunately, at the time of writing no studies specifically examining PTSD among CMHWs was found, however similarly elevated levels are likely present.

Predictors and Prevention

Given that this study focused on participants that self-identify as doing well, a review of what predicts/prevents PTSD is included here. While prevalence rates are concerning, most individuals exposed to traumatic events to not develop PTSD. Researcher attention has attempted to discover what risk factors might predict PTSD, and what protective factors may prevent it. In a meta-analysis including 68 studies looking at predictors of PTSD across population types (veterans, first responders, accident survivors, assault survivors) 7 factors were explored: (a) prior trauma, (b) prior psychological adjustment, (c) family history of psychopathology, (d) perceived life threat during the trauma, (e) post-trauma social support, (f) peritraumatic emotional responses, and (g) peritraumatic dissociation (Ozer et al., 2003). Though all factors yielded significant effect sizes, family history, prior trauma, and prior adjustment revealed the

smallest effect, while peritraumatic dissociation yielded the largest. The researchers suggest that while prior characteristics play a role, the processes occurring around the time of the trauma and afterwards are stronger known predictors of PTSD. The factors detailed in this study line up with the list of risk factors included in the DSM-5 (American Psychiatric Association, 2013), and subsequent meta-analysis (DiGangi et al., 2013).

In a review of work-related PTSD, lack of social support, unacceptable organizational conditions at work, and individual coping factors were found to be associated with higher PTSD symptoms among ambulance personnel (Skogstad et al., 2013). This study also found that health care professionals in general experienced similar levels of PTSD symptoms when either experiencing a direct threat to themselves or in witnessing a threat to their patients, but those witnessing a threat to their patients were more likely to attribute their PTSD symptoms to a personal weakness on their own part (Alden et al., 2008; Skogstad et al., 2013). As discussed earlier in this review, the lived experience of burnout features a similar belief that the symptoms being experienced by the worker are due to personal failings, rather than an appropriate response to systemic failure (Reynolds, 2010). A systematic review including 111 studies focused on various occupational groups (including social workers and nurses) involved with emergency disaster response divided the factors identified as contributing to the development of traumatic stress into pre, during, and post-event categories (S. K. Brooks, Dunn, Amlôt, Greenberg, & James Rubin, 2016). Pre-event factors included occupational factors, specialized training and preparedness, life events, and personal health. During-event factors included exposure, duration, emotional involvement, peri-traumatic distress/dissociation, role-related stressors, perceptions of safety, threat and risk, harm to self or to close others, social support, and professional support. Post-event factors included professional support, impact on life, life events, media, and coping

strategies. The authors identify appropriate training and social support, particularly from colleagues, as key resources in reducing the psychological effects of traumatic occupational events. They recommend that organisations have clear policy frameworks for protecting staff during traumatic events, that managers should be aware of key risk factors, that employees are trained in psychological first aid and specialized training, that workshops on emotional/psychological well-being are provided, and that organizations provide opportunity for simulated crisis training. The current study considers the predictors and preventative factors involved with PTSD during data analysis and discussion.

Critique

The PTSD construct has a rich history of critique followed by subsequent conceptual and clinical criterion change. The PTSD diagnostic category itself was constructed in part in response to critical demand for a new disorder describing debilitating traumatic response (Burstow, 2005; Judith, 1992). Moving from the title Critical Stress disorder in the first and second editions of the DSM to PTSD in the third edition and undergoing criteria revisions in the fourth and fifth, the diagnosis and its boundaries, criteria, utility, and prevalence continues to undergo hot debate (Pai, Suris, & North, 2017; Spitzer, First, & Wakefield, 2007).

The DSM-IV and DSM-IV-TR critiques focused on concerns with the definition of trauma, the symptoms included in the manual and their grouping, and the validity of the diagnosis, and resulted in substantial changes with within the DSM-V. The diagnosis was moved from the Anxiety Disorders category into a new category termed Trauma and Stressor-related Disorders, criteria A was changed to focus on definitions of trauma rather than subjective responses, symptom groups were increased from three to four and the number of symptoms was increased from 17 to 20 with the avoidance and numbing symptoms separated into their own

groups, both wording changes and in some cases more foundational changes were made to the symptoms themselves, and various specifiers were deleted and/or changed (Pai et al., 2017). These changes have been shown to significantly change the identification of PTSD cases (Hoge, Riviere, Wilk, & Weathers, 2014). These changes have been criticized as being the result of a methodologically flawed, secretive and ethically conflicted process within the APA DSM-V task force that has resulted in difficulty generalizing the existing research base on PTSD with little trade off in increased diagnostic accuracy, clinical utility, or client care (Hoge et al., 2016; Welch, Klassen, Borisova, & Clothier, 2013). Debates regarding the diagnostic definition of PTSD are likely to continue through DSM revisions.

Aside from diagnostic criticism and discussion, the diagnosis itself has been criticized as pathologizing valuable coping strategies that are being justifiably utilized in response to traumatic events (Burstow, 2005). In line with this suggestion are recent comments from Palestine's mental health services, stating that:

> "PTSD better describes the experiences of an American soldier who goes to Iraq to bomb and go back to the safety of the United States. He's having nightmares and fears related to the battlefield and his fears are imaginary. Whereas for a Palestinian in Gaza whose home was bombarded, the threat of having another bombardment is a very real one. It's not imaginary… I see patients with PTSD after a car accident. Not after imprisonment, not after bombardment or being labeled as a person against the law and having a relationship with prison like revolving door. The effect is more profound. It changes the personality, it changes the belief system, and it doesn't look like PTSD." (Goldhill, 2019).

Various voices within the literature make similar suggestions, pointing out that the PTSD diagnosis ignores the social and cultural context in which trauma responses take place along with the fact that for many peoples trauma is constant and ongoing (Nicolas, Wheatley, & Guillaume, 2015; Zur, 1996). Questions of this nature may be relevant within CMHW populations, where the trauma from the overdose crises is similarly ongoing, and cultural norms around processing that trauma may not exactly fit into psychiatric definitions of healthy or pathological traumatic responses.

Wellness, Subjective Well-being, and Post-traumatic Growth

The following sections contain a review of the literature on wellness, subjective well-being, and post-traumatic growth. These constructs are commonly nested within the field of positive psychology and so a brief history and definition of this field will be presented first.

Positive Psychology

History and definition. The shift within psychology away from health and positive functioning and towards identifying and eliminating pathology that took place during World War II is commonly identified laying the roots for the field of positive psychology (Christina & Henderson, 2016; Henry, 2007; Seligman & Csikszentmihalyi, 2000). In response to this shift, the first use of the term "positive psychology" in the literature appeared in book chapter by Maslow (1954) in which he describes psychology as being more successful in revealing shortcomings and illnesses over than positive potentials, virtues, and aspirations, and suggests that this must change. Positive psychology as a formal contemporary discipline is recognized as having solidified with Seligman and Csikszentmihalyi's (2000) article formally defining the term and outlining a program of research aimed at legitimizing the field (Christina & Henderson, 2016; Shane J. Lopez & Gallagher, 2009). They describe positive psychology as, "a science of

positive subjective experience, positive individual traits, and positive institutions (that) promises to improve quality of life and prevent the pathologies that arise when life is barren and meaningless" and go on to state that "the aim of positive psychology is to begin to catalyze a change in the focus of psychology from preoccupation only with repairing the worst things in life to also building positive qualities" (Seligman & Csikszentmihalyi, 2000, p. 5). This definition and aim is widely accepted in the field, often accompanied by lists of positive emotions, strengths, outlooks, coping approaches, and developmental features seen as falling within positive psychology's scope (Henry, 2007; Shane J. Lopez & Gallagher, 2009). Since this time positive psychology has grown as an area of enquiry, most recently expanding scope to be more inclusive of context, culture, the role of hardship and deeper meaning involved with personal growth, and the inclusion of more expansive and pluralistic research methods (Wong & Roy, 2019).

A wide variety of literature, both historical and contemporary, is credited as contributing to the positive literature base. This includes Terman's work on marital happiness, Watson's work on effective parenting, Jung's work on the meaning of life, Maslow's work on actualization, Roger's work on the fully functioning person, Bandura's work on self-efficacy, Argyle's work on happiness, Seligman's work on optimism, Csikszentmihalyi work on creative flow, Vallaint's work on positive aging, and a wide variety of research looking at wellness and well-being (See Henry, 2007; Seligman & Csikszentmihalyi, 2000). The remainder of this section focuses on a review of the wellness and well-being literature that relates to the current study.

Psychological Wellness

A brief history of the Psychological Wellness construct, details of common wellness conceptualizations, and a critique of the wellness literature is presented below.

History

While the concept of psychological wellness may be considered widespread now, its discussion is relatively recent in the psychological literature (Roscoe, 2009). The concept has been identified as growing out of the mental hygiene and mental health movements of the second half of the 19th century and first half of the 20th (Bertolote, 2008). Informed by these movements, in 1951 the World Health Organization's (WHO) expert committee defined mental hygiene as all attempts to encourage and maintain mental health, and mental health as a fluctuating condition influenced by biological and social factors that enables the individual to synthesize their potentially conflicting instinctual drives, form and maintain relations with others, and make constructive changes in the social and physical environment (World Health Organization, 1951). Early references to wellness specifically appear in the WHO's 1967 constitution, defining wellness as not solely the absence of illness, but involving a state of complete physical, mental, and social well-being (World Health Organization, 1967).

Contemporary research on wellness can be traced to the founding of the National Wellness Institute (NWI) in 1977. Initiated by the faculty at the University of Wisconsin-Stevens Point, the institution sought to pursue the idea that "humans could live better, healthier lives through the principles of balance and awareness" (National Wellness Institue, 2021). Research taking place at the NWI in the late 1970's resulted in Hettler's (1980) proposal of six interdependent dimensions of wellness (social, emotional, physical, intellectual, spiritual, and occupational). Subsequent approaches to the conceptualization and definition of wellness have been similar in their attempts to identify and define various dimensions that contribute to wellness (Miller & Foster, 2010; Roscoe, 2009). Research on the wellness construct has largely involved the creation and use of quantitative measures corresponding to the specific conceptual

wellness dimensions (Bart et al., 2018). A brief review of commonly identified dimensions follows below.

Wellness Dimensions

Subjective, Dynamic, and Holistic. As stated above, since the 1970s, numerous attempts to identify the various dimensions involved with wellness have taken place. Before detailing these dimensions it should be noted that most wellness approaches share the idea that wellness is a subjective and holistic experience, best thought of on a dynamic continuum rather than as a static on/off condition (Bart et al., 2018; Miller & Foster, 2010; Roscoe, 2009). The various dimensions involved within wellness are seen as connected and inter-dependant, with wellness manifesting through the shifting, holistic equilibrium between these dimensions. Wellness from this perspective involves the daily pursuit and maintenance of these dimensions within personal, interpersonal, and environmental contexts, rather than success or failure in attaining a concrete and permeant state of wellness. The interconnected wellness dimensions frequently included across conceptualizations are social, emotional, physical, intellectual, spiritual, occupational, and environmental. These will be briefly described below.

Social. In general, social wellness definitions focus on the individual's level of satisfaction and fulfillment regarding their interdependent connections with others. Specific definitions range between living in mutual, respect, cooperation, and harmony with others (Hettler, 1980), the extent to which and value that an in individual puts into giving and receiving social support (Adams, Bezner, & Steinhardt, 1997; Renger et al., 2000); and acceptance, altruism, attachment, and skills related to social interactions (Durlak, 2000).

Emotional. In general, emotional wellness definitions focus on emotional awareness, acceptance, and positivity towards oneself. Specific range between awareness and acceptance of

emotions within the self and others along with the ability to express and manage emotions (Hettler, 1980); the degree to which one possesses a secure and positive self-image (Adams et al., 1997); the degree of satisfaction, interest, and positive anticipation regarding one's life (Renger et al., 2000); and positive use of coping, self-awareness, and use of self-disclosure (Crose, Nicholas, Gobble, & Frank, 1992).

Physical. In general, physical wellness definitions focus on efforts to maintain subjectively optimal levels of physical activity, nutrition, health, and self-acceptance. Specific definitions range between maintenance of physical fitness, diet, awareness, and health-care (Crose et al., 1992; Hettler, 1980; Renger et al., 2000); positive subjective perceptions/expectations of health (Adams et al., 1997); and a balance between physical health indicators, behaviours, and management of physical health challenges (Durlak, 2000).

Intellectual. In general, intellectual wellness definitions focus on personal perceptions of ideal intellectual activity. Specific definitions range between engaging in creative and simulating pursuits, lifelong learning, critical thinking, and sharing of knowledge (Hettler, 1980); cognitive style, flexibility, and attitude towards learning (Crose et al., 1992); engaging in subjectively optimal amounts of intellectually stimulating activities (Adams et al., 1997); an orientation towards personal growth, education, and achievement (Renger et al., 2000), and developing talents, learning, and higher order thinking skills.

Spiritual. In general, spiritual wellness definitions focus on the process of finding meaning, purpose, values, and personal beliefs in life. Specific definitions range between a unifying worldview that facilitates meaning, purpose, an appreciation for the breadth and depth of life, and acceptance of the unknown (Hettler, 1980); spiritual and religious involvement, life satisfaction, and beliefs about death (Crose et al., 1992); positive interpretations of meaning and

connection in life (Adams et al., 1997); and finding purpose and fulfillment in life, giving and receiving of support and love, and recognition of the relationship between self, others, and nature (Renger et al., 2000).

Occupational. In general, occupational wellness definitions focus on satisfaction and enhancement from work and career. Specific definitions focus on the degree to which one's work facilitates the expression of personal values, levels of satisfactions gained through work, and balance between work and other life pursuits (Hettler, 1980) as well as attitudes towards time put into work versus leisure (Crose et al., 1992).

Environmental. In general, environmental wellness definitions focus on the reciprocal interaction between the individual and the environment, with the environment being broadly defined to include home, work, the broader community, nature, etc. Specific definitions focus on the balance between home and work life, interactions with community and natural resources, time spent maintaining and elevating environmental causes, and the accessibility of greenspace and supportive community environments (Anspaugh, Hamrick, & Rosato, 2011; Renger et al., 2000).

Critique

Critique of the wellness construct focuses on two aspects: definition and measurement.

Definition. Critiques of the wellness construct regarding definition point out that wellness does not have a clear, unified definition within the literature (Bart et al., 2018). While various conceptualizations share common features, each has its own unique dimensions and definition of those dimensions along with attempts at empirical quantification of those dimensions. This makes clarity in research a challenge and suggests the need for more

exploratory, qualitative research. This matches well with the second critique of the wellness literature.

Measurement. Most research on wellness involves the validation and use of various quantitative wellness dimension measures. These measures are largely created to match the conceptualization of wellness that they correspond with, however, in most cases these conceptualizations were created out of theory without prerequisite exploratory, qualitative research (Harari, Waehler, & Rogers, 2005; Roscoe, 2009). As a result most wellness measures may be evaluated in terms of how well they measure the model they correspond with, but validity beyond internal psychometric properties is a challenge (Bart et al., 2018). The nature of quantitative measurement itself does not match well with the subjective, fluid, and holistic nature of wellness. Qualitative exploration has been suggested as a better match for the proposed nature of personal wellness, with the added benefit that a refocused prioritization on qualitative approaches will address the need for refinement and unification of theoretical wellness conceptualizations (Lorion, 2000; Roscoe, 2009). The current study responds to this suggestion through asking participants what personal wellness means to them.

Subjective Well-Being

History

The concept of subjective well-being shares much of its origin with the concept of wellness. As with wellness, early modern research into well-being grew out of the desire to re-focus psychology away from its pre-occupation with negative states post-World War II (Diener, Suh, Lucas, & Smith, 1999). Academic interest into the term began to pick up during the late 1970's and has grown steadily since then, with 131 related studies recorded in 1981 and over 12000 in 2012 (Diener, 2013). Debate about the definition of SWB has taken place throughout its academic history, with researchers largely split on conceptualizing it in hedonic (balance of

pleasant versus unpleasant experiences) or Eudaimonic (making progress towards one's potential, living a meaningful life) terms (Maddux, 2017). With this debate in mind, early researchers identified three components of SWB: life satisfaction, positive experiences, and negative experiences (Diener, 1984). Modern researchers largely maintain these components, expanding them to include a sense of control, sense of purpose, the development of one's potential, and positive relationships (Huppert, 2009; Ruggeri K, Garcia-Garzon E, Maguire Á, Matz S, & Huppert F, 2020). Debate has also taken place about if subjective well-being may be best measured with single or multidimensional instruments, with most measures being criticized for a lack of theoretical basis for their creation (Huppert, 2009). In response to early criticisms of this kind, Ryff (1989) proposed 6 literature based and theory derived dimensions of well-being. These dimensions will be considered in the analysis of the current study and are reviewed in the following section.

Ryff's Six Well-Being Dimensions

In a landmark pair of articles, Ryff (1989a, 1989b) outlines the need for a multidimensional, theory based approach to the conceptualization and measurement of SWB. She describes previous attempts at the measurement as being derived from instruments developed for other purposes and criticizes research at the time as focusing on defining the structure of SWB according to these flawed measures. In attempting to reconceptualize SWB, Ryff drew from numerous positive psychological functioning and humanistic psychology sources. These include Roger's concept of the fully functioning person, Jung's formulation of individuation, Allport's concept of maturity, Erikson's psychosocial stage model, Buhler's basic life tendencies, Neugarten's descriptions of personality change in adulthood and old age, and Jahoda's positive criteria of mental health (Ryff, 1989b, 1989a). Six dimensions were derived

from this literature base (self-acceptance, positive relations with others, autonomy, positive relations with others, environmental mastery, purpose in life, personal growth) and operationalized into a measure (The Psychological Well-Being Scale or PWB) containing 16 positive and 16 negative items per domain. This measure showed good construct validity, internal consistency, and test- retest reliability (Ryff, 1989b). Since its inception the PWB has been utilized and validated with a wide variety of diverse groups, and undergone confirmatory factor analysis (Ryff & Keyes, 1995). Though debate on its factor structure and construct validity continue, the PWB continues to be the most dominant measure of SWB (Maddux, 2017; Ryff, 2014; Ryff & Singer, 2006; Springer, Hauser, & Freese, 2006). A description of the six domains within the PWB is below.

Self-acceptance. The theme of self-acceptance was drawn from numerous psycho-analytic, developmental, optimal-functioning, and mental-health theories (Ryff, 1989a, 1989b). High self-acceptance equates to positive attitudes towards the self, acknowledgement of good and bad aspects of the self, and positive feelings about past life. Low self-acceptance involves feelings of dissatisfaction with self, disappointment with the past, and dissatisfaction/lack of acceptance of personal qualities.

Positive relations with others. Warm, trusting interpersonal relationships are similarly identified as a key feature of numerous psycho-analytic, developmental, optimal-functioning, and mental-health theories (Ryff, 1989a, 1989b). High positive relations with others are seen as involving warm, intimate, satisfying, trusting relationships; displaying concern and empathy for others; and understanding the give and take of human relationships. Low positive relations is seen as having few close, trusting relationships; difficulty being warm, open and displaying concern for others; and being unwilling to compromise.

Autonomy. Self-determination, independence, and being able to regulate behaviour from within is seen as a key feature of healthy functioning and positive personal development (Ryff, 1989a, 1989b). High autonomy involves resisting social pressures to think and act in certain ways, evaluating self by personal standards, and displaying self-determinant and independent behaviour.

Environmental Mastery. Ryff (1989a, 1989b) identifies the ability to participate in and master the environment as common across positive psychological functioning theories. High environmental mastery equates to having a sense of competency in managing the environment, ability to control various external activities, making effective use of surrounding opportunities, and the ability to choose or create an environment that meets personal needs and values. Low environmental mastery involves difficulty with everyday affairs, feeling unable to change the environment as needed, and lacking a sense of control over the external world.

Purpose in life. Having goals, a sense of direction, meaning, and values is recognized across mental health, developmental, and therapeutic theories as an aspect of positive mental health (Ryff, 1989a, 1989b). High functioning in the purpose in life domain involves having goals, a sense of direction, a sense of meaning to the present and their past life, has beliefs that inform a sense of purpose in life, and has objectives for their life. Low functioning involves a lack of sense of meaning, goals, aims, direction, purpose, and beliefs that inform meaning in life.

Personal Growth. Continued development is frequently identified as a sign of positive mental health (Ryff, 1989a, 1989b). High personal growth equates to seeing the self as growing, expanding, realizing one's potential, and continuing to develop; being open to new experience, improving in self and behaviour over time; and increasing in self-knowledge and effectiveness.

Low personal growth involves feelings of personal stagnation, feeling unable to develop new attitudes and behaviour, and feeling bored and uninterested in life.

Critique

Critiques of the SWB construct largely continued lack of agreement on measurement, methodological concerns in the study of SWB, and suggestions that SWB definitions are biased towards western cultures. First, as noted above, though the PWB continues to be highly utilized, debate continues on how many dimensions are involved with SWB, which aspects of SWB are most important, and if there is a common underlaying SWB factor (Huta & Waterman, 2014; Maddux, 2017). This makes comparison across studies and generalizability a challenge. Second, the majority of studies are correlational and cross-sectional in nature, opening up the study of SWB to the effects of transient mood states and disallowing the determination of causality regarding SWB (Maddux, 2017). Finally, the SWB construct has been criticized as highly individualistic and supportive of western, middle-class values (Carlisle & Hanlon, 2007, 2008). Indicators of well-being from diverse cultures, such as contributions to family and broader groups and tranquil emotional states must be taken into account when considering the subjectivity of well-being as a construct (Maddux, 2017). As the current study is exploratory in nature, no definition of wellness or well-being was provided to the participants. Rather, they were asked if they believed that they are successfully maintaining their wellness and what wellness means to them. Areas in which their responses converge and diverge with Riff's (1989a, 1989b) six domains are evaluated in the discussion section.

Post-traumatic Growth

The term post-traumatic growth (PTG) refers to the psychological exploration of positive changes that individuals may potentially experience as a result of struggle with major loss or

trauma (Calhoun & Tedeschi, 2001). The following sections will review the history, definition, theory, measurement, and critiques of PTG.

History

The idea that suffering and distress can be a source of positive, desirable transformative change has been present within religious traditions for thousands of years. Consider the suffering and transformation of Job in the biblical Old Testament, Jesus in the New Testament, Muhammad in the Quran, the four noble truths and the eightfold path within Buddhism, or karma and reincarnation within Hinduism. Similarly, the meaning and function of suffering has been a common theme within philosophical and literary inquiry. Consider the hedonistic, utilitarian, stoic, and humanistic schools of thought, or the work of Nietzsche and his antecedents. In one of his many meditations on suffering Nietzsche wrote:

> "You have the choice: either as little displeasure as possible, painlessness in brief… or as much displeasure as possible as the price for the growth of an abundance of subtle pleasures and joys that have rarely been relished yet? If you decide for the former and desire to diminish and lower the level of human pain, you also have to diminish and lower the level of their capacity for joy." (Nietzsche & Kaufmann, 1974)

The field of psychology began discussing the ability for individuals to harvest redeeming value from life's crises in earnest during the mid-20th century. Viktor Frankl's work on existential therapy and the role of meaning in suffering was born out of his experiences in World War II concentration camps (Frankl, 1946), with Irving Yalom greatly expanding on the importance Frankl lay on suffering and existential themes to healthy human functioning (Yalom, 1980). Meanwhile, influential psychologist Abraham Maslow emphasised the need for psychology to study optimal psychological health and functioning, coining the term "positive

psychology", and stating that psychology did not have an accurate understanding of human potential due to its focus on dysfunction rather than our ability to overcome and aspire (Maslow, 1954). In the 1960's, Gerald Caplan proposed a crisis intervention theory in which attempts at regaining homeostasis following a crisis may result in the person refining new and better adaptive strategies that may be utilized during future crisis (Caplan, 1964). During the 1970's, in reviewing the results of major life events, Norman Finkel found that an event did not have to be positive in nature to produce positive change (Finkel, 1974).

Contemporary psychological research on the potential for growth in response to negative events has been pioneered by professors Lawrence G. Calhoun and Richard G. Tedeschi out of the University of North Carolina. During the late 1980's and early 1990's both professors became inspired by anecdotal stories of people changing and growing following terrible accidents, medical diagnosis, natural disasters, and similar experiences of tragedy and began investigating positive change following traumatic events through (Tedeschi & Calhoun, 2004). They first used the term PTG during the development of an inventory designed to measure this growth (Tedeschi & Calhoun, 1996), subsequently creating a variety of publications systematically studying the growth process (Tedeschi, Shakespeare-Finch, Taku, & Calhoun, 2018b).

Definition

Tedeschi and Calhoun define PTG as "long-term positive psychological changes experienced as a result of the struggle with traumatic or highly challenging life circumstances" (Tedeschi, Shakespeare-Finch, Taku, & Calhoun, 2018b p. 3). These authors describe a constructivist philosophical perspective as foundational for the PTG construct, in that it is assumed that people utilize individual interpretations of experience to create core beliefs about

themselves, others, and the world, and that growth occurs in response to a challenge to what a person believes to be true in their lives. In addition, the authors cite existentialist traditions as influencing the construct, with the meaning ascribed to traumatic events as influencing their ability to promote positive growth. Calhoun and Tedeschi define trauma broadly, treating the terms trauma, crisis, and major stressor as synonymous (Tedeschi & Calhoun, 2004). In their definition, these terms may refer to any circumstance that "significantly challenges or invalidates important components of the individual's assumptive world" (Lawrence G. Calhoun & Tedeschi, 2006 p. 3). Within this context an event (or series of events) does not need to be *life-threatening* to be traumatic, it may simply be fundamentally *life-altering* within the subjective estimation of the individual (Tedeschi et al., 2018f). The change that takes place afterwards is seen as transformative, with alterations to cognition, emotions, and behaviour being possible (Tedeschi & Calhoun, 1996). This change is seen as occurring as a result of the struggle with the aftermath of crisis, and has the potential to create positive growth (Tedeschi et al., 2018f). It is important to note that PTG and PTSD are not considered as opposite ends of the same spectrum (adaptation vs trauma) (Zoellner & Maercker, 2006). PTG does not necessarily indicate a decrease in distress and increase in well-being, actually a person may experience PTSD and PTG simultaneously (Tedeschi & Calhoun, 2004). Rather, PTG indicates growth in several areas that is instigated by distress.

Theory

A number of models explaining PTG have been proposed, including Joseph and Linley's (2005) conceptualization of PTG as an increases in happiness and well-being, Pals and McAdams's (2004) model of PTG as change in life narrative, and Hobfoll et al. (2007) action-focused growth' theory focusing on increases in social and psychological resources**.** However,

Tedeschi and Calhoun's model is the most prevalent and will be focused on in this review (Jayawickreme & Blackie, 2014). Tedeschi and Calhoun first proposed a theoretical model to describe PTG in 1995, and have updated the model regularly as research has progressed (Tedeschi & Calhoun, 1996; Tedeschi et al., 2018b). They base this model upon a number of principles: that schema change is the basis for growth, that different types of trauma produce different potential growth outcomes, that growth is dependent upon variable personality characteristics, that the traumatic situation must assume a central place in an individual's life story, and that wisdom is a product of growth. Their current model contains nine broad components: (a) the person pre-trauma (moderate well-being; nascent schemas for development post-trauma; complex, active, open, hopeful cognitive style as characteristics that allow more efficient movement toward PTG), (b) seismic traumatic event (what is traumatic varies in individual circumstances), (c) challenges (to higher-order goals, higher-order beliefs, and ability to manage emotional distress, therefore defining what "seismic" is for an individual), (d) rumination (more automatic and intrusive than deliberate), (e) coping success (disengagement from unreachable goals and untenable beliefs; decreased emotional distress through effective emotion regulation strategies), (f) rumination (more deliberate than automatic and intrusive), (g) social support (sources of comfort, new schemas, adaptive coping behaviors represented in "expert companionship" rather than general support), (h) posttraumatic growth (relating to others, new possibilities, personal strength, spiritual change, appreciation of life), narrative development, and wisdom, (i) some enduring distress from trauma (that can keep the focus on change and growth) (Tedeschi et al., 2018a). The process involves a traumatic circumstance severely challenging key elements of a person's worldview and goals followed by difficulty managing emotional distress and subsequent recurrent rumination and coping behaviour.

Rumination on the traumatic circumstance begins as automatic, but once emotional distress subsides to a manageable level may become purposefully focused on the trauma and its meaning. It is this purposeful cognitive processing with a focus on searching for or making meaning combined with high emotional content that is theorized as facilitating growth. Analysis of the new situation, making of new meaning, and re-appraisal of self, the world, and others takes place during this emotionally charges cognitive processing (Tedeschi & Calhoun, 2004).

Support for the PTG model has been presented as existing within a number of studies (Tedeschi et al., 2018b). Support for deliberate rumination assisting in core belief change, especially with social support, has been found (Cann et al., 2011; Morris & Shakespeare-Finch, 2011). The utilization of emotional-regulation and problem-focused coping has been found to potentially result in growth (Park, Aldwin, Fenster, & Snyder, 2008). In examining the presented pathway to PTG deliberate rumination, a sense of control in the present, and the centrality of the stressful event to a person's life have been shown to have a strong relationship with PTG (M. Brooks, Graham-Kevan, Lowe, & Robinson, 2017).

Several characteristics of the person pre-trauma have been found to influence PTG: (1) age or developmental stage, (2) personality pre-trauma, (3) pre-trauma mental health and stress exposure, and (4) pre-trauma assumptive world and core beliefs. Regarding age and developmental stage, an inverse relationship between age and PTG has been found (Manne et al., 2004; Meyerson, Grant, Carter, & Kilmer, 2011). This inverse relationship is theorized to be due to schemes not being fully developed in children and young adults, and there for being shaped by stressful events, rather than changed. Regarding personality, pre-trauma, extraversion and openness to experience (Shakespeare-Finch, Gow, & Smith, 2005; Sheikh, 2004), as well as hope (Calhoun & Tedeschi, 1998), creativity (Forgeard, 2013), and secure attachment style

(Schmidt, Blank, Bellizzi, & Park, 2012) has been found to be related to PTG. Regarding pre-trauma, mental health and stress exposure as well as persons experiencing challenges to their mental health prior to a traumatic event have been found to experience less PTG (Gil, 2005). The likelihood of being too overwhelmed to manage emotional distress and initiate cognitive processing, along with the higher potential to use avoidance coping is theorized as preventing the development of PTG in these cases. Regarding pre-trauma assumptive world and core beliefs, when the trauma challenges an individual's belief about the degree of control over what happens to them, their motivations, relationships, capabilities, expectations of the future, self-worth, and the meaning of their lives the possibility for PTG is theorized to increase (Tedeschi et al., 2018a). In addition, women have been found to show a small increase in likelihood of PTG, with it being theorized that gender influences both post-trauma self-disclosure and religiosity (Vishnevsky, Cann, Calhoun, Tedeschi, & Demakis, 2010). The connection between these characteristics and PTG is in clear need of increased study.

Social Support and PTG

Disclosure and social support have been found to have significant impact on the development of PTG (Tedeschi et al., 2018a). Disclosure includes talking to others about traumatic events and their impact, writing about them, and more creative forms of expression such as drawing, music, and dance. Disclosure is thought to assist in alleviating the initial emotional distress of the event, bring unconscious thoughts and feelings forward, foster cognitive processing, and identify willing supportive others. People that disclose the impact of significant events have been found to report higher levels of PTG than those who do not (C. Dong, Gong, Jiang, Deng, & Liu, 2015). Disclosure has been shown to increase reflection on what happened, what the events mean to the self and relationships, and to increase both acceptance and insight

(Calhoun, 2006; Pennebaker, 1995). Disclosure about traumatic events have been shown to change self-perception, resulting in a more resilient self-concept and higher psychological well-being (Hemenover, 2003).

Social support has been connected to PTG in several ways. The perception that social support is available has predicted growth in firefighters (Sattler, Boyd, & Kirsch, 2014). Similar results have been found with women struggling with infertility and colorectal cancer survivors (X. Dong et al., 2017; Yu et al., 2014). Having role models to draw guidance and normalization from has been linked with PTG in breast cancer survivors (Morris, Shakespeare-Finch, & Scott, 2012). Emotional support in general has been linked with PTG in emergency medical dispatchers (Shakespeare-Finch, Rees, & Armstrong, 2015), while instrumental support has been linked to TPG in stem cell transplant survivors (Nenova, DuHamel, Zemon, Rini, & Redd, 2013). In addition, a meta-analysis including 103 studies found a consistent positive relationship between social support and PTG (Prati & Pietrantoni, 2009). The authors of this study suggest that seeking social support is an active coping strategy, simultaneously providing both emotional relief and instrumental problem-solving assistance.

The belief that social support is available in the workplace appears particularly important in fostering PTG within difficult work environments. In examining the sense of belonging experienced by 250 fire fighters, Armstrong, Shakespeare-Finch, and Shochet (2016) found a significant connection to PTG through the degree to which participants felt that they are respected and valued by their peers and supervisors, and their sense of belonging within the organization. Similarly, in a study of 740 paramedics, Shakespeare-Finch and Daley (2017) found that once common factors were controlled for, sense of belonging and of support by colleagues and superiors was the most important variable in predicting PTG. The need for

recognition, acceptance, support, and a sense of belonging in the workplace has been well documented in populations similar to CMHWs, for example nurses (Baggett et al., 2016), elder care workers (Persson, Lindström, Pettersson, & Andersson, 2018), emergency medical service providers (Austin, Pathak, & Thompson, 2018), and counsellors (Somoray, Shakespeare-Finch, & Armstrong, 2017).

The response to the request for social support, and the person's response to that response, have a relationship with PTG (Calhoun & Tedeschi, 2006). Higher levels of PTG have been reported by individuals that perceive the person or group supporting them to mutually disclose difficulties of their own than by individuals that perceive a negative reaction in response to requests for support (Taku, Cann, Tedeschi, & Calhoun, 2009). People that receive emotional or instrumental support have been found to sometimes share stories of receiving support when providing support themselves (Tedeschi et al., 2018a). It is perhaps no surprise then, that the experience of PTG has been found to contribute to some individual's becoming positive role models for others going through similar challenges, developing new empathy and compassion for others (Morris et al., 2012; Shakespeare-Finch & Copping, 2006). Similarly, the stronger sense of connectedness with others and with community that sometimes develops in managing a stressful situation may be considered a form of PTG on its own (Tedeschi et al., 2018a).

Quantitative Enquiry

Early research into PTG was anecdotal and qualitative in nature, but was quickly turned towards creating a quantitative measure, the posttraumatic growth inventory (PTGI) (Tedeschi & Calhoun, 1996). In conducting a literature review, the researchers created items based upon three broad outcome categories: changes in self-perception, changes in interpersonal relationships, and a changed philosophy of life. Frequently items were created directly from quotes taken from

individuals thought to have responded in particularly adaptive ways following trauma. These preliminary items were administered to 604 individuals that identified as experiencing a significant negative life event during the past five years, and a factor analysis was completed utilizing their responses. Five domains in which posttraumatic growth occurs were found: (a) personal strength, (b) relating to others, (c) new possibilities, (d) appreciation of life, (e) spiritual and existential change (Tedeschi, Shakespeare-Finch, Taku, & Calhoun, 2018d). Personal strength refers to an increase in sense of self-reliance, sense of strength and confidence, perception of self as survivor or victor, and motivation to engage in new and potentially challenging experiences. Relating to others refers to positive attitude and behavioural changes in relationships, conscious decisions to spend more time with friends and family, increased expression of affection, and pruning of relationships that are not positive or beneficial. New possibilities refer to the development of new interests, activities, habits, career changes, and the desire to see and enact new possibilities for a person's life. Appreciation of life refers to an increase in gratitude and appreciation for life, the feeling that a second chance at life has been granted and noticing of the small pleasures within life. Spiritual and existential change refers to changes in a person's religious, spiritual, or existential/philosophical beliefs. The PGTI has displayed strong reliability across divers samples (Brunet, McDonough, Hadd, Crocker, & Sabiston, 2009; Moore et al., 2011; Morris, Shakespeare-Finch, Rieck, & Newbery, 2005). The scale shows concurrent validity with measures of disrupted core beliefs and intrusive/deliberate rumination (Calhoun, Tedeschi, Cann, & Hanks, 2010; Cann et al., 2011; Taku & Oshio, 2015; Tedeschi, Cann, Taku, Senol-Durak, & Calhoun, 2017; Triplett, Tedeschi, Cann, Calhoun, & Reeve, 2011). Construct validity has been provided with a relationship being found between the PTGI factors and measures of positive behavioural changes in each factor (Shakespeare-Finch &

Barrington, 2012). Convergent validity has been shown through the correlation between self-reports and reports made by a third person in close relationship with the respondent before, during, and after the challenging experience (Shakespeare-Finch & Barrington, 2012; Shakespeare-Finch & Enders, 2008; Taubman–Ben-Ari, Findler, & Sharon, 2011; Tzipi Weiss, 2002).

Prevalence

The prevalence of PTG varies across samples is highly dependent on what cut-off criteria is used in determining growth (Tedeschi, Shakespeare-Finch, Taku, & Calhoun, 2018c). Most PTG instruments ask participants to endorse levels of positive change in various domains, and researches may set the criteria for growth at a low level (endorsement of a single item) or at a high level (endorsement of every item). Tedeschi et al., (2018c) suggest that change in a single domain can have a significant positive impact on a person's life and should be regarded as growth but acknowledge that not all researchers endorse this view. This perhaps contributes to wide ranging PTG prevalence finding, for example a meta-analysis found rates ranging from 3% in bereaved persons to 98% in females with breast cancer (Linley & Joseph, 2004). A more recent review widening the criteria to include self-perceived growth found rates of 58% to 83% (Jayawickreme & Blackie, 2016). While it is clear that growth can occur, methodological challenges make determining prevalence rates difficult. The critique section of this review discusses these challenges further.

Qualitative Enquiry

Despite a large focus on the PTGI, Tedeschi, Shakespeare-Finch, Taku, & Calhoun, (2018d) acknowledge qualitative research as important in understanding PTG. They describe the construct as constructivist in nature and therefor highly dependent on the individual and their

social context in its manifestation. The ability of qualitative research to discover individualized as opposed to group level information not thought of *a priori* to investigation is key in describing how PTG is experienced from person to person. Early qualitative research grew out of Tedeschi and Calhoun's interest in anecdotal stories of growth, and became more formalized as they attempted to identify themes that might be suitable for quantification (Tedeschi et al., 2018e). However, being constructivist in nature, the universal quantification of PTG is inherently impossible, and the PTGI is intended to be used as a very general measure. Following the constructivist roots of PTG, since the creation of the PTGI, qualitative enquiry has been largely utilized to discover how PTG manifests in various diverse populations, and with various specific events. Examples of this type of work include studies looking at the unique elements of PTG related to severe injury (Kampman, Hefferon, Wilson, & Beale, 2015), life-threatening illness (Hefferon, Grealy, & Mutrie, 2009), cancer (Morris, Wilson, & Chambers, 2013), ex-offenders in South Africa (Guse & Hudson, 2014), non-western interpreters who experienced trauma in their country of origin (H. Johnson, Thompson, & Downs, 2009), refugees from Myanmar (Shakespeare-Finch, Schweitzer, King, & Brough, 2014), survivors of the 9/11 World Trade Center attack (Dekel, Hankin, Pratt, Hackler, & Lanman, 2016), and survivors of childhood sexual abuse (Shakespeare-Finch & de Dassel, 2009). Qualitative enquiry of this kind frequently discovers themes similar to those used in the PTGI, but with their own cultural or population specific meaning or description attached (Tedeschi et al., 2018e). For example, in Woo, Chan, Chow, and Ho's (2008) study of Chinese widowers in Hong Kong, growth was defined by participants as human learning rather than "growth", and using grounded theory three themes were discover: intrapersonal growth (e.g., feeling more comfortable being a vulnerable human being, becoming more comfortable embracing negative emotions), interpersonal growth (e.g.,

adopt a more holistic view when perceiving human beings, greater appreciation of relationships with people), and transpersonal growth (e.g., better appreciation of life and death). While these themes are similar to those used within the PTGI, without culturally specific language and understanding of these themes current instruments may not have detected them. These finding highlight the need for continuous qualitative exploration of PTG with the current study providing a response to this need.

Critique

Critiques of the PTG construct centre on challenges to its definition and conceptualization, its measurement, and the methodologies used to study it. Regarding the definition and conceptualization of PTG, the lack of a concrete agreed upon name and definition has been pointed out as a weakness (Jayawickreme & Blackie, 2014). While Tedeschi and Calhoun's PTG term is predominant, the construct is called by a variety of names within the literature, including: (a) benefit finding (Tomich & Helgeson, 2004), (b) stress-related growth (Park, Cohen, & Murch, 1996), (c) positive illusions (S. E. Taylor & Armor, 1996), (d) thriving (Epel, McEwen, & Ickovics, 2010), (e) positive psychological changes (Yalom & Lieberman, 1991), and (f) adversarial growth (Linley & Joseph, 2004). Each of these terms comes with their own competing theoretical explanations and accompanying mechanisms of growth. For example, Affleck and Tennen's (1996) suggestion that rather than the outcome of coping with a distressing event, PTG is a coping strategy itself. These authors point to the subjective perception of growth being primarily measured in the literature and that believing one has grown may be an effective way to deal with the terribleness of distressing events. The lack of consensus on what constitutes growth, how to describe it, what instigates it, and how to explain it, illustrates the need for continued research regarding PTG.

The methodology used to measure and investigate PTG has been critiqued in several ways. Regarding quantitative measurement, it has been pointed out that the PTGI relies on self-reported perceptions of change and growth within their personality, however previous research has found people's self-reported perceptions of change unreliable in measuring actual personality change (Henry, Moffitt, Caspi, Langley, & Silva, 1994; Herbst, McCrae, Costa, Feaganes, & Siegler, 2000; Robins, Noftle, Trzesniewski, & Roberts, 2005). The PTGI asks participants to (a) evaluate their current standing on a dimension (e.g., closeness to other people), (b) recall their previous standing on the same dimension, (c) compare their current and previous standings, (d) assess the degree of change, and (e) determine how much of that change can be attributed to the traumatic event (Frazier et al., 2018). This is a complex task, with doubts being expressed by critical researchers regarding how accurately people are capable of recalling their experiences (Nolen-Hoeksema & Davis, 2013). Further, there is danger of potential priming effects within the construction of the PTGI, as no questions on the scale involve the reporting of negative effects of the distressing event (Frazier et al., 2018). A fair picture of positive and negative changes is not possible, with the likelihood of a positive response bias high (Tomich & Helgeson, 2004), resulting in exaggerated positive reports of growth (Park & Lechner, 2006). In addition, the domains utilized within the PTGI were derived from U.S. based samples, and critiques about these domains generalizing to other samples have been made (Weiss & Berger, 2010). As stated previously in this review, qualitative research has been recommended and is being utilized in addressing this limitation.

PTG study designs are typically cross sectional, with little comparison to control groups (Frazier et al., 2018; Jayawickreme & Blackie, 2014). This design makes it difficult to identify the causality or permanence of self-reported growth. The distressing event may have caused or

contributed to the self-reported growth, but so may any number of other uncontrolled factors (Zoellner & Maercker, 2006). Further, this design may reflect the ability of people to take an adaptive perspective on hardship rather than actual growth, especially given that the predominant PTG instrument (PTGI) only measures positive responses (McFarland & Alvaro, 2000; Tennen & Affleck, 2002). With this growth frequently measured at one time period and without a control group it is difficult to determine timelines for growth, and if growth is permanent or momentary. Robust mixed method longitudinal designs are suggested in meeting these critique (Frazier et al., 2018). As described by Jayawickreme and Blackie (2014), and ideal study would look at growth trajectories across PTG, distress, and related constructs among a group likely to experience a distressing event in the near future, patients with breast cancer for instance.

Despite these critiques it is clear that the belief that one is experiencing positive change as a result of distress is common, and that this perceived growth is playing some positive role in a person's development (Frazier et al., 2018; Tedeschi et al., 2018d). The qualitative exploratory nature of the current study provides an opportunity to contribute to the literature on growth in the face of adversity. As such the concept that the distress felt by workers in responding to overdoses may be both causing harm and spurning personal growth is acknowledged and discussed within the discussion section of the current study.

Community Mental Health Workers

Community mental health workers (CMHW) are a subset of mental health workers (MHW) that work directly in their client's communities. They frequently work in homeless shelters, community drop-in centres, low-barrier housing units, community-based health clinics and outreach teams, and safe-injection sites. Job duties include efficient, effective, and professional response in crisis situations, performance of first aid services, taking notice of and responding to behaviour that may indicate decompensation or drug overdose, maintaining the

cleanliness and security of work sites, advocating with other service providers on behalf of clients, and engendering a sense of community by getting to know all clients and engaging with them daily. These workers may have training in a variety of disciplines with job titles ranging from the general community mental health worker, shelter worker, or front desk worker through to more professional designations such as social worker or community mental health nurse. The unifying feature of this group is working in and integrating with client communities. The clients within these communities frequently experience challenges caused by marginalization, addiction, trauma, and an increasingly unsafe drug supply. With this is mind, CMHWs face a work environment containing high demands, low control, and high risks to their personal, social, and physical health.

Burnout and Traumatic Stress Prevalence in CMHWs

In a meta-analysis of burnout in mental health workers, Morse et al. (2012) found that across four studies with over 1000 participants, between 21 and 67% of mental health workers experience high levels of burnout. Participants included CMHWs, directors of community mental health centers, social workers, and forensic mental health workers, and burnout was primarily measured using the MBI. As previously stated, notable among these studies is Siebert's (2005) survey of 751 social workers. Participants were given a 7-item version of the EE subscale of the MBI. Thirty-four percent of respondents scored above the high burnout threshold score of 16 on this shortened subscale. The burnout prevalence level among MHWs has been found to be higher in populations doing community focused work. In 1999, Webster and Hacket gave 151 CMHWs the MBI. Fifty-four percent of participants scored above the 21-point cut-off for high burnout on the EE scale, and 38% scored above the 9-point cut off for high burnout on the DP scale. These results indicate that 1 in 2 participants were highly emotionally exhausted, and 1 in

3 were experiencing high levels of DP towards their clients. Studies since this time, across geographic location, have match these high burnout rates. In 2004, Lloyd and King administered the MBI to 304 Australian CMHWs. Fifty-seven percent of participants scored high in EE, and 32.7% scored high on DP. In 2006, Evans et al. gave the MBI, the Karasek Job Content Questionnaire (Karasek, 1979), and a job satisfaction measure (Andrews & Withey, 1976) to 237 CMHWs in England and Wales. Forty-Seven percent showed significant distress. In 2009, Lasalvia et. al. administered the MBI, the Areas of Worklife Scale (Leiter & Maslach, 2003), the Evaluation of Changes Scale (Leiter & Maslach, 2003), and the Management Areas Scale (Leiter & Maslach, 2003) to 2000 Italian CMHWs. Nearly two-thirds of participants reported high levels of EE, and one in four reported high levels of DP and low levels of PA. One in five participants suffered from high scores in all burnout dimensions. Social workers reported the highest scores and were identified as the most community involved. In addition to high levels of burnout previous research has found elevated levels of traumatic stress in CMHW populations. In a study including 472 individuals who work in frontline positions in homeless shelters in 23 different organizations traumatic stress symptoms were found to be 33% higher than the general population (Waegemakers Schiff & Lane, 2019). The high prevalence levels found in these studies mark burnout as a common result of stress within mental health worker populations in general and is higher in CMHWs. Further, the increased levels of burnout symptoms within CMHWs mark them as population in high need of researchers' attention and support.

Community Mental Health Worker Stressors

Potential work place stressors experienced by mental health workers include unclear expectations in the workplace (Lizano & Mor Barak, 2012), conflict with service users, coworkers and supervisors (Savaya, 2014), stigma in the field and low pay (Rössler, 2012), high

workloads, and low training (Coffey, 2004). Community mental health work has been found to involve similar stressors to mental health work but in greater number and with increased resulting distress. In 2006, Sørgaard, Ryan, Hill, and Dawson administered the MBI, the Mental Health Professional Scale (Cushway, Tyler, & Nolan, 1996), and the psychosocial work environment and stress questionnaire (Agervold, 1998) to 204 acute inpatient psychiatric workers and 209 community mental health staff. Community workers reported more organisational problems, higher work demands, less contact with colleagues, but more control and better social relations than inpatient workers. Similarly, in 2013, Salyers et al. completed a study exploring the differences between MHWs at an inpatient veteran's health centre and CMHWs at a community health centre. The researchers gave 86 Veterans Health Administration (VA) staff and 86 CMHWs a survey containing measures of burnout (MBI) and job satisfaction (The Job Diagnostics Survey and the Consumer Optimism scale (Hackman & Oldham, 1974)). They found that the VA staff reported greater job satisfaction and accomplishment, less EE and less desire to leave their jobs than the CMHW staff. The staff in a community setting was less satisfied with their work and showed symptoms of burnout. It is suggested that greater funding, with better pay, benefits, and training opportunities for VA staff may be responsible for this difference. These suggestions line up with the theory that an increase in job resources may result in less distress, and mark CMHWs as having less resources than MHWs. The authors findings above also line up well with a meta-analysis conducted by Edwards, Burnard, Coyle, Fothergill, & Hannigan (2000). Their review included seventeen studies with a total of 2000 nurses working on community mental health teams. Studies included measures of distress and asked participants to identify the specific significant demands or pressures that they perceive as stressful. Participants identified confusion around role and responsibility, a lack of supervision, increases

in workload and administration, time management, inappropriate referrals, safety around volatile, violent and suicidal clients, and higher levels of client trauma as significant stressors in their workplaces. The authors in each of these studies suggest that to best support CMHWs an increase in research looking at the challenges they face and how they respond to them is needed.

In a review of the literature on job satisfaction, stress and burnout in community mental health teams Onyett (2011) identified professional designation, lack of resources and workload impeding effectiveness, challenging aspects of clinical work, team work and contact with colleagues, team and personal role clarity, autonomy and choice, leadership, management and supervision, demographic factors, and site location as areas of importance for CMHWs. Professional designation refers to the differences in stress found across disciplines. Social workers were found to be particularly vulnerable, with feeling undervalued, excessive work demands, limited latitude in decision-making, and unhappy about the place of mental health social workers in contemporary services being highlighted as stressors (S. Evans et al., 2006). Lack of resources and workload impeding clinical effectiveness included lack of resources, work overload, organizational frustrations, and lack of access to connected services for clients as stressors preventing effectiveness at work (King, Lloyd, & Holewa, 2008; Sørgaard et al., 2007). Challenging aspects of clinical work included a fear of violence and difficulty working with violent clients, unsafe work environments, psychotic symptoms, drug use in the presence of workers, caseload size, and feeling constantly responsible for their clients as stressors (Reid et al., 1999; Walsh, 2001). As a protective factor, CMHWs have also reported that contact with their clients rewarding (Mctiernan & Mcdonald, 2015; Reid et al., 1999). Team work has been identified as a major protecting factor against burnout, having the ability to share and contain work related stress (Crawford, Adedeji, Price, & Rutter, 2010; Lloyd, King, & Chenoweth,

2002). Similarly, a high degree of team and personal role clarity was identified as a protecting factor (Carpenter, Schneider, Brandon, & Wooff, 2003; K. Collins et al., 2000). Autonomy and choice were identified as either a stressor or a protective factor in that higher degrees of autonomy and choice were associated with being able to choose work location and manage caseloads (Borrill & Haynes, 1999; Ward & Cowman, 2007). Leadership, management, and supervision includes the challenging experiences when management is perceived to be unsupportive (Dallender & Nolan, 2002; Hannigan, Edwards, Coyle, Fothergill, & Burnard, 2000b). Demographic factors included increased age and work experience being associated with higher morale and being single with dependent children associated with increased distress (Hannigan et al., 2000b; Kumar, Fischer, Robinson, Hatcher, & Bhagat, 2007; Reininghaus & Priebe, 2007). Site location refers to where the work site is situated, with those working in urban settings reporting a higher degree of stressors (R. Hill et al., 2006; Reininghaus & Priebe, 2007). Each of these factors fit well into resource-demand models of job stress.

Seeking to explore causes of stress and distress in frontline community mental health care professionals, Ray et al. (2013) explored the relationship between Maslach and Leiter's (1997) six areas of job-person match (see the job-person model of burnout section in this review) and levels of burnout, STS, and compassion satisfaction with 430 CMHWs in southwestern Ontario. Higher levels of compassion satisfaction, lower levels of STS, and increased person-job match in the six areas of work life predicted lower levels of burnout. Participants with a history of trauma showed higher levels of STS. Full time workers, and workers with less experience were found to be at greater risk for burnout in general. The authors suggest evaluation of work life congruence as a starting point for discovering supportive interventions and suggest further research on what is helping community workers keep these areas in balance. Seeking information on CMHW

related coping Mette, Wirth, Nienhaus, Harth, and Mache (2020) asked 26 social workers serving refugee and homeless individuals what coping strategies they use, what workplace social supports they have access to, and what health promotions are available to them. Participants described both emotion focused and problem focused coping, with a greater emphasis on emotion coping in circumstances in which the circumstance of the client's lives could not be changed. They also described workplace social support as important and needing improvement. These coping related themes are further explored within the current research.

Additional Stressors Specific to the Targeted Population

Vancouver contains a high number of CMHWs. A report published in 2014 detailing the 260 agencies that provide social services within the city's downtown east-side (DTES) community found that more than 100 of these agencies are housing providers, and 30 of them are public health care providers (Culbert & McMartin, 2014). These agencies are staffed primarily by a broad cross-section of community based mental health workers. This makes Vancouver an ideal place to research the experiences of CMHWs.

History of Vancouver's Downtown East-side

The high rates of addiction, marginalization, and mental health challenges within the communities that CMHWs frequently work put these workers at high risk for harmful long-term stress outcomes in general (Lasalvia et al., 2009; Morse et al., 2012; Salyers et al., 2013). The potential for these harmful long-term stress outcomes is amplified within Vancouver's Downtown East-side (DTES). The neighborhood has a long history with drug abuse challenges; It was known as "the epicenter of the heroin scene in the 50's" (Zeidler, 2016). During the late 1980s and early 1990s the neighborhood became known as "skid row" and was rumored to be the poorest zip code outside of a reserve in Canada (see Lupik, 2017a). Low property values,

lack of developer interest, and the closures of British Columbia's mental health institutions in the 1980s resulted in a high number of people with mental health, addictions, and poverty challenges overwhelming the area. In 1993, a potent strain of heroin (China White) caused the overdose deaths of 300 people in the area (Zeidler, 2016). The inevitable spread of HIV through needle sharing led to a public health care emergency being declared in 1997, with approximately 1000 people rapidly dying of the disease. At the same time, the emergence of crack cocaine increased the neighborhood's addictions challenges. In response to these challenges, a social justice and harm reduction ethos has developed (Lupick, 2017). Low barrier housing, healthcare, and community supports have seen the best success in meeting the challenges presented by DTES residents, exemplified by the well documented success and worldwide recognition of Vancouver's safe injection site (Insite) (MacQueen, 2015).

The Fentanyl Overdose Crisis

Despite these services, Vancouver is in the midst of another public health emergency. The current and ongoing fentanyl overdose crisis has resulted in the deaths of over 1400 British Columbia residents in 2018 and an additional 1700 residents since 2019, putting strain on the CMHWs that are working to save their lives (British Columbia Ministry of Public Safety and Solicitor General, 2017; Lupik, 2017b; Nagy & Jones, 2021). From 2016 to the present, illicit drug deaths have killed more people than automobile accidents each year, and more than 120 overdose related deaths have been recorded each month (British Columbia Coroners Service, 2021, Lupik, 2016). In 2021, as of May, the province recorded 170.2 overdose related deaths per month. In comparison, an average of 204 overdose deaths per year was recorded from 2001 to 2010. The overdose crisis has significantly increased the stressors that CMHWs in the DTES face, with local organization making federal calls for increased worker support (Lupik, 2017b).

Workers are witnessing people that they have been supporting for years, often from within tightly connected residential communities, overdosing and dying suddenly. In this sense, CMHWs in Vancouver's DTES have become first responders, needing to intervene mid-overdose to keep their clients alive. An increase in burnout, STS, and PTSD is likely to follow. Considering that burnout levels in Vancouver's CMHWs have been found to be higher than similar populations before the onset of the overdose crisis, this increase in distress has the potential to be devastating (McDaniel & Haney, submitted). Aside from the potential discovery of valuable information regarding wellness in the face of a difficult work environment that this population may provide us, we as researchers and psychologists have an ethical duty to pay attention and support these important workers.

Social Justice Perspective

The population of interest in the current study is serving clients that are typically marginalized and oppressed; therefore, through their acts of advocacy, service, and caring, CMHWs are doing social justice work. In attempting to learn about wellness within difficult work environments from these workers, it is appropriate to consider a social justice perspective. Psychology as a discipline has an appalling history of supporting and reproducing power relations within society, resulting in the frequent complicit maintenance of approaches to working with people that exclude, marginalize and oppress (Fox, 2003). For example, in a recent response to the Truth and Reconciliation Commission of Canada's report, the Canadian Psychological Association acknowledged that Canadian psychology has openly contravened the ethical principles of respect for rights and dignity of persons and people, responsible caring, integrity in relationships, and responsibility to society through its collusion with racist policy and laws, and through discriminatory assessment and treatment of indigenous people's (CPA, 2018). With a paradigm focused on the individual, psychologists have been historically prone to

ignoring environmental and structural factors, resulting in a monocultural perspective that has predominantly judged everyone against white, middle class, heterosexual men (Fassinger & Richie, 1997; Palmer & Parish, 2008; Isaac Prilleltensky & Nelson, 2002). Similarly, historical research within psychology has, by default, assumed a positivist stance, presenting itself as value-free and objective, consequently ignoring its contribution to the maintenance of unjust societal power structures (Ponterotto, 2005). As a result, psychology has frequently been complicit in the reinforcement of societal institutions that promote inequality and injustice.

Despite the historical failure of psychology to act with social justice ideals in mind, psychology is well positioned to move forward with better societal awareness. Social justice is, in fact, baked into psychology's ethical code and definition. The Canadian Psychological Association's Code of Ethics (CPA, 2017), Principle I: Respect for the Dignity of Persons dictates that counselling psychologists utilize a social justice base in their activities:

> Psychologists appreciate that the innate worth of human beings is not enhanced or reduced by their culture, nationality, ethnicity, colour, race, religion, sex, gender, marital status, sexual orientation, physical or mental abilities, age, socioeconomic status, or any other preference or personal characteristic, condition or status. Psychologists also recognize that as individual, family, group or community vulnerability increase, or as the power of individual persons to control their environment or their lives decreases, psychologists have an increasing responsibility to seek ethical advice and establish safeguards to protect those less able to protect themselves. These responsibilities have special significance in a society which is becoming more diverse culturally and economically and which has not achieved gender equality (p. 8).

Among the various psychological disciplines, counselling psychology is best positioned to lead this pivot towards ethical social behaviour. In attempting to identify which central values differentiate counselling psychology from other psychological disciplines, Gelso, Williams, and Fretz (2014) identify five overarching themes. The third of these themes is, "a commitment to advocacy and social justice, maintaining an ongoing awareness of the importance of environmental context and culture." This is described as an emphasis on person-environment interactions, with specific attention to cultural contexts. In addition, health and wellness-promotion, psychoeducation, illness prevention, and remediation of client concerns have also been described as central tenants of counselling psychology, and are important domains from a social justice perspective (Kennedy & Arthur, 2014). These authors go on to claim that recent years have seen a great increase in counselling psychology research, interest, and commitment to social justice principles. Indeed, recent counselling psychology research has begun utilizing a broader group level view on society's dominant social positions, and how these positions systematically create susceptibilities to marginalization in individuals and groups, resulting in negative impacts on their mental health (Alderson, 2012; C. Y. Chang, Crethar, Ratts, & Editors, 2010; Kennedy & Arthur, 2014; Vera & Speight, 2003). In addition, calls to continue including more social justice focused research in counselling psychology have been made (Kennedy & Arthur, 2014; Palmer & Parish, 2008; Sinacore & Ginsberg, 2015a). The current study adheres to this call through the goal of discovering information that may support those in difficult environments (the target population) and the consideration of social justice perspectives in analysing the results.

Definition and Theoretical Foundations

In utilizing a social justice perspective, a definition of the term and its theoretical foundations is important. Social justice in a counselling psychology context springs from three areas: critical psychology, feminist psychology, and multicultural theorists (Fox, 2003; Palmer & Parish, 2008). Each of these areas will be briefly reviewed here.

Critical Psychology. Critical psychology is, "an approach that challenges the discipline to question its allegiance to the societal status quo and to construct ways to promote mental health in conjunction with social justice" (Prilleltensky & Prilleltensky, 2003, p. 273). Growing out of post-war baby boomer unrest and the German student movement during the 1960s, critical psychology as a discipline is commonly credited as beginning with the work of Klaus Holzkamp (1927-1995) at the Frieie Universitat Berlin (Teo, 1998). Heavily influenced by the works of Karl Marx, Holzkamp suggested that psychology has served the elite classes of society by ignoring societal context and at the same time convincing people that they must change, because their life circumstances, and society itself, is fixed and unchangeable (Holzkamp, 1985, 1992). Critical psychologists since Holzkamp have sought to challenge oppressive and unjust institutions and discourse, raise intersectional awareness, emphasize client control and power, de-emphasize pathology and diagnosis, focus on strengths and engage in social justice efforts within social structures, ideologies, communities, and organizations, rather than with individuals alone (Palmer & Parish, 2008; Prilleltensky & Nelson, 2002; Sloan, 2001). It is difficult to sum up an approach this broad, but in attempting to do so, critical psychologist Ian Parker (1999) has suggested four elements key to the approach:

1. The systematic examination of how some varieties of psychological action and experience are privileged over others; how dominant accounts of "psychology" operate ideologically and in the service of power.
2. The study of the ways in which all varieties of psychology are culturally historically constructed, and how alternative varieties of psychology may confirm or resist ideological assumptions in mainstream models.
3. The study of forms of surveillance and self-regulation in everyday life and the ways in which psychological culture operates beyond the boundaries of academic and professional practice.
4. The exploration of the way everyday ordinary psychology structures academic and professional work in psychology and how everyday activities might provide the basis for resistance to contemporary disciplinary practices.

Parker (1999, p. 16) goes on to state, “The identity of the critical psychologist here, however, is an identity that is given by the attempt to understand what psychology does, rather than membership of a club that thinks it already knows.” Thus, in engaging with critical psychology, researchers and practitioners are made aware of the responsibility to ask themselves how they are or are not actively contribute to a just society, integrating an awareness of the power relations involved with their studies, actions, and position.

Feminist Psychology. Feminist psychology is informed by the feminist movement, and emphasizes the study of women, gender, race, class, sexual orientation, and ability, and the need for social change (Greene et al., 1997; Wilkinson, 1997). Feminist psychology is considered to have originated with the German psychoanalyst Karen Horney’s (1885-1952) work during the 1920s and 1930s (Horney, 1967; Miletic, 2002). Critiquing Freud’s theories as male-dominated

and therefore harboring phallocentric views, Horney pointed at social power as the primary driver of pathology rather than sexual dynamics. Feminist psychology continues this critical tradition through examination of the ontologies and epistemologies of psychological research, critiquing the individualistic focus of contemporary psychological practice, and identifying the cause and maintenance of psychological distress within societal power structures while advocating for the empowerment of vulnerable populations (Grant, Finkelstein, & Lyons, 2003; Palmer & Parish, 2008; Yoder, 1999).

Among the notable contributions of feminism, in general, is the theory of intersectionality. Developed by Black feminists Crenshaw and Collins in the late 1980s as a conceptual lens with which to analyse the oppression faced by women of color in the United States, intersectional theory describes these women as experiencing the result of multiple intersecting forms of societal oppression (Crenshaw, 1989; Crenshaw, 1991; Pereira, 2015). These intersecting forms of oppression (i.e., race, sexual identity, gender, class, disability, etc.) combine in unique ways across social groups and within individuals creating overlapping and interdependent systems of discrimination and privilege. As a result, no oppressive factor in isolation can be taken as indicative of a person's experience; instead, the experience of privilege and oppression is the result of a combination of constantly interacting and overlapping factors. Feminist psychology has attempted to integrate an intersectional framework into psychology writ large, and as a result has wrestled with the friction between the conventional and hegemonic largely positivist philosophical approach embedded in mainstream psychology (Marecek, 2015). In pursuing this end, Maher and Tetreault (2001) suggest (a) developing a "third eye" or self-reflective awareness of the changing contexts in which oppression and empowerment occur; (b) being observant of the complex intersections of power, privilege, race, class, gender, sexual

orientation, and how they affect the learning process; and (c) using this information to deal with difference effectively and develop flexible, "situated" ways of seeing ourselves and the world. In working with people from this perspective, Morrow and Hawxhurst (1998) have suggested focusing on three dimensions of empowerment: personal (power within the person), interpersonal (power with others), and social/political (power in society). They suggest that to become empowered, an individual must experience permission (May I? Am I worthy?), enablement (Can I? Am I Able?"), and information (What do I need to know?) in each of these dimensions.

Multicultural Theory. Multicultural theorists emphasise the need for multicultural awareness, inclusion, competency development, and advocacy, with an increased awareness of the impact of race and diversity in the marginalization of individuals and groups (Delgado-Romero, Galván, Maschino, & Rowland, 2005; Fox, 2003; Palmer & Parish, 2008). Historically, psychology has viewed cultural influences as not significant enough to warrant serious attention, however, the expansion of civil rights to historically oppressed groups during the 1960s and 1970s and subsequent increase in the number of individuals from diverse backgrounds attaining graduate degrees spurred a shift in views about the influence of differing cultures on an individual's psychology (Smith & Trimble, 2016). Though becoming increasingly normative, multicultural psychology may be considered an emerging discipline, with the establishment of guidelines for cultural competency not beginning until 1992 with Sue and colleagues' tripartite model of multicultural counselling competencies. This model describes the need for an awareness of personal attitudes and beliefs about racial and ethnic minority individuals; knowledge of individuals' worldviews, including information on diverse cultural groups and a recognition of sociopolitical influences on human experience; and the skills necessary to deliver

culturally appropriate therapeutic interventions (Sue, Arredondo, & McDavis, 1992). These guidelines continue to be refined, researched, and updated to this day, with a focus on acknowledging that individuals develop and express themselves within a cultural context and that meaningful understanding of an individual is not possible without also understanding their context (Pedersen, Crethar, & Carlson, 2009).

With the broad nature of these theoretical influences in mind, no clear definition of social justice within counselling psychology has been decided upon (Arthur, Collins, McMahon, & Marshall, 2009). However, social justice proponents generally agree that the all individuals should have equal opportunity to reach their potential across life domains, and be free from barriers in society is important (M. Adams et al., 2007). The right to quality education, appropriate health care services, and equal employment opportunities regardless of individual characteristics or group membership is also highlighted, as is the fact that our clients and participants do not exist independent of society, culture and context (Crethar & Ratts, 2008; Lewis et al., 2011).

Arthur, Collins, McMahon, and Marshall (2009) have suggested three core components to a social justice approach: (a) fair and equitable distribution of resources and opportunities, (b) direct action to ameliorate oppression and marginalization within society, and (c) full inclusion and participation of all members of society in a way that enables them to reach their potential. Sinacore and Ginsberg (2015) discuss three levels of social justice activity: individual, community, and macro. Individual level social justice involves experiences of personal competence, empowerment, and freedom of self-determination leading to positive life outcomes. Community level social justice involves the manifestation of protection and valuing of a community's norms and customs, with community members having the ability to influence

broader socio-political arenas designed to justly govern and provide for the community's needs. The macro-level involves advocating that all national and governmental processes ensure the fundamental equity and protection of human rights at all levels. The theoretical bases and broad suggestions of these authors regarding social justice is considered throughout all stages of the current study, including conceptualization, data collection, data analysis, and uses for the information gained.

Social Justice Critique of Burnout

Although acknowledgements of contextual factors is core to the original conceptualizations of burnout, the construct has been critiqued for being overly individually structured (Reynolds, 2011). Even with the acknowledgement of context, workers' difficult relational interactions with their clients have been identified as causing burnout, and the burnout experience is typically the responsibility of the worker to identify and manage. This implies there may be something individual specific that allows us to measure up to helping work, or not. Reynolds writes:

> Burnout sounds like we're toys with disposable batteries that are used up. As if we're not doing enough yoga or drinking enough water and these are important things, I do yoga and I drink water, but self-care is not enough to offset the issues of poverty, violence, and basic dignity people struggle with." (2011)

As is the case with the population targeted by the current study, helping work frequently takes place within unjust contexts, where no amount of individual effort or worker self-care will change the system that frames and maintains a client's pain. From Reynold's perspective burnout is conceptualized as the understandable reaction of a frustrated and exhausted human. More than the inadequacy of a worker's self-care, or the difficulty experiences with a client, or the lack of

support within an organization, or some mismatch between the person and their work, it is the injustice within society that causes burnout (Reynolds, 2011).

Research on the lived experience of burnout (previously detailed in this review) fits well into Reynold's burnout critique. Those experiencing burnout report feeling their self-image as a competent professional is threatened, a lack of trust in themselves, shame, confusion, and judgment from others (Ekstedt & Fagerberg, 2005; Y.-S. Lee & Tae, 2012; Severinsson, 2003; C. M. Young et al., 2015). They report feeling judged for not managing their practices well, with feelings of shame resulting in isolation hampering their ability to reach out for help (Ekstedt & Fagerberg, 2005; Y.-S. Lee & Tae, 2012; C. M. Young et al., 2015). They further report feeling that they are unable to follow through on the career full of meaningful action that they were expecting to maintain, due to the realities of working in the field and limited choice in addressing the challenges involved (Currid, 2008; Judd et al., 2017; Pines, 2002). The personal meaning of helping work has been found to be an important motivator to take care of oneself and continue within the profession (Gama, Barbosa, & Vieira, 2014; Pines, 2002; Shanafelt, 2009), and it has been suggested that the individual experience of burnout lay within the existential need to see our lives as meaningful, and that we are useful and important (Pines, 2017) . Without the acknowledgement that unjust social conditions have set the stage for burnout, workers may understandably take too much responsibility and end up feeling isolated and overwhelmed in their stress reaction.

Burnout Sustainability Through Justice Doing. In addition to critiquing the individual nature of burnout, Reynolds (2009, 2010, 2011, 2012) has suggested that sustainability in the face of burnout may be increased through consideration of four themes: *justice doing, collective*

ethics, spiritual pain, and *solidarity*. These areas will be considered in analysing the data obtained by the current study.

Justice Doing. Reynolds (2011, 2012) describes *justice doing* as integral to the helping professions. With the feminist idea that "the personal is political" (Hanisch, 1969) in mind, every action within the helping professions may contain an element of *justice doing.* CMHWs may reframe their role as that of intentional allies as their clients are faced with unjust systems through their everyday lives. *Justice doing* provides an explicit description of what the worker finds meaningful in the work. While a worker's subjective experience will provide personal color to this identification of meaning, the explicit recognition that the worker is contributing to justice allows for conscious decision making in their attempts to honor this meaning. This has the potential to move the goal posts regarding what an individual may take responsibility for. Work becomes a process of doing justice whenever possible, and feelings of burnout may be attributed to the difficulty in maintaining justice in an unjust system, rather than to personal failings on the part of the worker.

Collective Ethics. *Collective ethics* are described as "those important points of connection that weave us together" (Reynolds, 2009, 2011). Reynolds suggests that these are frequently unnamed between workers but represent the shared meanings that have been ascribed to the work of helping others. While it is not important that *collective ethics* exist in complete harmony, as the discussion of differences can expand worker usefulness, it is important that shared ethics are explicitly acted upon (Reynolds, 2011). *Collective ethics* provides a shared touchstone for both relationship and meaning between workers. The importance of this relational connection is further described in the *solidarity* section of this paper.

Spiritual Pain. Reynolds (2011) uses the term *spiritual pain* to identify the result of social structures and limited resources forcing workers to behave in ways that go against their ethics. This concept is analogous with the idea that finding meaningful work, and then failing at that work, causes burnout (Pines, 2017). Rather than placing the blame for this failure solely on workers, Reynolds suggests that the resources needed to complete this work are frequently not available.

> Fostering sustainability in the face of spiritual pain is difficult when the unjust conditions of people's lives do not improve, and we experience our work as shovelling water. We're working hard and working harder isn't working. The smell of particularly individual incompetence begins to creep in. The dirty work of isolation." (Reynolds, 2009, p. 7.)

CMHWs may do what they can to improve the lives of their clients, but the problem is much bigger than any one worker can fix on their own. Recognition and validation of the *spiritual pain* caused by this situation may reduce the isolation and lack of social support that workers feel.

Solidarity. Reynolds (2009, 2010, 2011, 2012) points out that a group is more useful than even particularly powerful individuals. Helping work is at its core a connective and interpersonal practice, and it is meant to be done together. *Justice doing* requires interconnection, and should be done with support from others, while offering support to others (Reynolds, 2010). The limitless need, systemic failure, and oppressive elements inherent in helping work can cause workers to think more must be done, and it must done on their own (Reynolds, 2011). However, a person alone cannot be responsible for this massive need. Rather, only what is in front of them and what they are able to do. The concept of *solidarity* shifts the responsibility for the helping task from individuals to the group. By making *collective ethics* explicit, by sharing *spiritual*

pain, and by doing justice together sustainability becomes a collective task rather than an individual one. Further, envisioning the task of helping work as one of *solidarity* allows this meaningful work to go on should the worker need to move on. The load is shared. The themes are discussed in relation to the results within the discussion chapter of the current study.

Justification for the Current Study

This study asked a crucial, yet unanswered question: *How do CMHWs maintain wellness while responding to the fentanyl poisoning crisis?* This review has drawn together several threads pointing to the need for the current study. These include:

- the call for more open-ended stress and coping research that acknowledges the subjective and multi-faceted nature of the stress and coping transaction (Cooper & Quick, 2017; Folkman & Moskowitz, 2004; Lazarus, 2000);
- the need for increased high-quality qualitative research regarding burnout, STS, and PTG (Burstow, 2005; Kapoulitsas & Corcoran, 2015; Sabin-Farrell & Turpin, 2003; C. M. Young, Smythe, & Couper, 2015);
- the high prevalence rates of burnout and STS within this population (Johnson et al., 2018; Lasalvia et al., 2009; Lloyd & King, 2004; Morse et al., 2012; Webster & Hackett, 1999);
- the call for an increase in social justice focused research (Kennedy & Arthur, 2014; Palmer & Parish, 2008; Sinacore & Ginsberg, 2015a);
- the amplified, high stress environment CMHWs are faced with (Lasalvia et al., 2009; Lupik, 2017b; Morse et al., 2012; Salyers et al., 2013; Wirth, Nienhaus, Harth, & Mache, 2020);
- the gaps in knowledge regarding what workers themselves identify as supporting their wellness;

- the ongoing fentanyl overdose crisis (British Columbia Coroners Service, 2021);
- the valuable information regarding wellness within difficult work environments that CMHWs possess.

Chapter Three: Methods

This chapter describes the methodology used in this study. The origins, evolutions, and philosophical underpinnings of the enhanced critical incident technique (ECIT) will be described followed by a researcher subjectivity statement and discussion of the suitability of this method for the present study. This chapter will end with a description of the procedures employed and sample obtained.

Origin of the Critical Incident Technique

During World War II, John C. Flanagan and a team of psychologists with the Aviation Psychology Program of the US Army Air Forces were tasked with developing an approach that would aid in selecting and classifying aircrews (Flanagan, 1954). Reflecting the predominantly positivist and behavioural focused thinking of the time, this technique was a "set of procedures for collecting direct observations of human behavior in such a way as to facilitate their potential usefulness in solving practical problems and developing broad psychological principles" (Flanagan, 1954, pg 327). Looking to identify specific descriptions of the causes of failure in flight school, failures in bombing missions, problems in combat leadership, disorientation during flight, and necessary improvements to instruments, Flanagan developed procedures for identifying and analyzing behavioural incidents critical to these targets.

After the close of the war, Flanagan and colleagues formed the American Institute for Research with the intention of continuing scientific and educational work focused on human behavior (Flanagan, 1954). The procedures originally developed with the Aviation Psychology Program were formalized, extended, and given the title "critical incident technique". In partnership with the University of Pittsburgh, Flanagan and his students carried out a number of critical incident technique (CIT) studies across a number of industries, and in a number of

domains, leading up to his 1954 article codifying the method's development and procedures (Flanagan, 1954).

Flanagan's Method

Flanagan's original CIT refined the technique developed with the armed forces into a set of "procedures for collecting observed incidents having special significance and meeting systematically defined criteria" (Flanagan, 1954, p. 327). An incident is defined as an observable behaviour that is complete enough for an observer to make inferences and predictions about the person engaging in the behaviour. An incident is considered special (or critical) if the purpose and intent of the behaviour is clear enough to evaluate the consequences and effects. The CIT does not rigidly dictate how these incidents should be collected, but rather describes a set of flexible principles that may adjusted to fit their context (Flanagan, 1954).

Flanagan (1954) outlines five major steps to the CIT:

1. *General Aim:* The CIT's first step is to develop a general statement of objectives, frequently expressed in a brief statement. This statement specifies what is necessary if the activity is to be judged successful or effective and ensures that incidents are interpreted appropriately. Flanagan suggests consulting with experts on the activity in formulating the general aim.
2. *Plans and Specifications:* Specific standardized instructions for identification, evaluation, and classification of incidents assists in focusing attention on the targeted activity. Flanagan suggests that the degree of clarity in these specifications has a direct effect on the objectivity of the recorded incident observations, and suggests the following details are made explicit:
    a. *The situation observed:* including the place, the persons, the conditions, and the activities.

b. *Relevance to the general aim:* relevance of potential incidents to the general aim must be described.

c. *Extent of effect on the general aim:* the degree of significance, positively and/or negatively, that the effect has on the general aim must be described.

d. *Persons to make the observations:* observers should be familiar with the activity, with training on the general aim and specifications provided.

3. *Collecting the data:* Flanagan suggests that data are best collected through direct observation of the targeted activity, with reports on the observed incidents made as soon as possible afterwards. However, noting that direct observation is costly in terms of time and resources, recall of incidents is also acceptable. In order of preference, incidents may be collected from observers through direct interview, group interviews, questionnaires, or review of records. Flanagan suggests that, in all cases, reporting is more likely to be accurate if the details preserved are full and precise, with everyone participating in the research aware of the general aim, plans, and specifications of the study. A running total of the number of new critical incidents collected should be kept. Data collection may be considered sufficient when two or three new incidents are being recognized for every 100 incidents collected. In addition, the acquisition of an adequately detailed definition of incidents should be considered in determining sufficient data collection. The number of total incidents collected may vary widely depending on the type of targeted activity.

4. *Analyzing the data:* The purpose of data analysis within Flanagan's CIT is to "summarize and describe the data in an efficient manner so that it can be effectively used for many practical purposes" (p. 344). The CIT produces a large amount of data that must be

synthesised in a useful way without losing comprehensiveness, specificity, or validity. Three problems in achieving this goal are recognized:

a. *Frame of reference:* Classification of incidents should be made with the general aims and specifications of the study in mind. Ease and accuracy, pre-existing classification systems, and potential interpretation and reporting should also be considered.

b. *Category formulation:* Flanagan notes that, despite his desire for objectivity, category formulation is a subjective and inductive process largely dependent on the skill and sophistication of the formulator. Submission of categories to others for review may reduce this subjectivity. A small sample of incidents is sorted into categories relating to the frame of reference. Definitions are created, and additional incidents are sorted into these categories. The redefinition of old categories and development of new categories proceeds as new incidents require. Large categories may be divided into subcategories once all incidents have been placed.

c. *General behaviour:* With the general aim and intended uses in mind, the level of generality and specificity in data reporting is determined. The level of generality and specificity in reporting may vary widely depending on the intended usage, but maximizing practicality is considered a primary goal of data reporting.

5. *Interpreting and reporting:* To obtain a functional description of the targeted activity, the analysed data must be interpreted and reported. This is the most likely stage for errors to occur, as any biases throughout the CIT process must be recognized, stated, and

considered as best as possible. Flanagan underlines the need for well thought out and transparent reasoning during this stage.

Reliability and Validity of Flanagan's CIT

According to Butterfield et al.'s (2005) review of the origin and evolution of the CIT, studies by Andersson and Nilsson (1964) and Ronan and Latham (1974) are often cited regarding the reliability and validity of Flanagan's CIT.

In assessing the CIT, Andersson and Nilsson (1964) focused on the job and training requirements of store managers at a Swedish grocery company. Interviews and questionnaires were distributed to each participant within four groups: superiors, store managers, assistants, and customers. A total of 1847 incidents were collected and sorted into three major areas, 17 categories, and 86 subcategories. To check the comprehensiveness of these categories, the last 215 incidents collected were separately classified and fit well into the existing classification system (Andersson & Nilsson, 1964). To test that adequate data saturation had been reached, a quantitative analysis regarding the progress of subcategory creation was completed. It was found that the number of subcategories created slowed as incidents were collected, with 95% of subcategories having been created when about two-thirds of the total incidents had been collected (Andersson & Nilsson, 1964). Statistical analysis found no significant differences in the number and types of incidents between interviewers and data collection methods. To test the effectiveness of the categorization, 24 psychology students were asked to place 100 incidents into corresponding categories. Students were found to commonly place incidents into similar categories. Comparison of the categories and subcategories to previously created training literature and ratings of the importance of the categories and subcategories by the participants is listed as provided validity evidence for the method. Based upon these results, the CIT was

concluded to be both reliable and valid (Andersson & Nilsson, 1964). A decade later, Ronan and Latham (1974) completed a study with pulpwood producers seeking to similarly test the method's reliability and validity. Inter-rater reliability, intra-observer reliability, inter-observer reliability, test-retest reliability, content validity, relevance, construct validity, and concurrent validity were evaluated, with positive results reported.

Evolution of the CIT

Since its introduction, the CIT has been adopted for use across a large number of diverse areas including, but not limited to: group process, work motivation, evaluation of clinical practicum, psychological aspects of nursing, American quality of life, communications, nursing, job analysis, counselling, education and teaching, medicine, marketing, organizational learning, performance appraisals, social work, nuclear power plant operations, design engineering, computer programming, and anesthesiologist performance (e.g., Butterfield et al., 2005; Shattuck & Woods, 1994; Woolsey, 1986b). Within Butterfield et al.'s (2005) summary of the 50-year history of the CIT, four primary departures since Flanagan's original CIT are identified. They are discussed in the following paragraphs.

The first major departure from Flanagan's original method is the inclusion of psychological states as a potential area of focus. Flanagan defined a critical incident in terms of observable behaviour (Flanagan, 1954). However, researchers immediately began applying the CIT to inferred constructs, such as emotional immaturity (Eilbert, 1953, 1957), work motivation (Herzberg, Snyderman, & Mausner, 1966), and the link between cognitions and emotions (Weiner, Russell, & Lerman, 1979). In a landmark (1986) article, Woolsey underlined the goodness of fit between the CIT and counselling and psychotherapy research. The method's flexibility, with an ability to collect data on factual happenings, qualities, and attributes is cited as matching the needs of counselling psychology (Woolsey, 1986b). The technique's exploratory

nature is pointed to as particularly useful in psychological theory and model building (Woolsey, 1986b). The method's requirements are consistent with the skills, experience, and values of counselling psychology (Woolsey, 1986b, 1986a). The CIT has been utilized to study a wide variety of psychological topics in the years following Woolsey's article (Butterfield et al., 2005).

The second major departure involves the shift from direct observation to retrospective self-report (Butterfield et al., 2005). Although Flanagan states that retrospective self-report could be used, his original article largely focuses on direct observation (Flanagan, 1954). In contrast, most studies completed since 1987 utilize retrospective self-report (Butterfield et al., 2005). While this data collection method may reduce the labor required by direct observation, clear and detailed descriptions of critical incidents must be maintained in order to ensure accuracy of reporting (Flanagan, 1954; Woolsey, 1986b).

The third major departure involves data analysis (Butterfield et al., 2005). Flanagan described data analysis as a subjective and interative process in which the researcher attempts to create categories from the data that relate to the study's frame of reference (Flanagan, 1954). However, the majority of studies utilizing CIT neglect to include detailed information on how this category creation process has taken place (Butterfield et al., 2005). This lack of information suggests the possibility of variability in analysis techniques.

The fourth major departure regards the use of credibility and trustworthiness checks (Butterfield et al., 2005). Flanagan's original article underlines the importance of establishing the credibility of a CIT study, and these checks have been instituted with this importance in mind (Flanagan, 1954). Over time, nine CIT related credibility checks have been proposed and put into practice (Butterfield et al., 2005). These are: (1) audio recording the interviews, (2) interview protocol fidelity, (3) independent extraction of critical incidents, (4) calculating exhaustiveness,

(5) calculating participation rates, (6) placement of incidents into categories by an independent judge, (7) cross-checking by participants, (8) expert reviews, and (9) theoretical agreement (Butterfield et al., 2009).

In addition to these departures, two additions have been integrated into the CIT. The first addition is to begin the data collection interview with contextual questions designed to provide background information to the CIT data. These questions not only allow the data to be better situated in context, they also assist in participant's accurate recall of incidents, and in building the interviewer rapport necessary for in depth participant disclosure (Butterfield et al., 2009). The second is the inclusion of questions regarding wish list items. Potential wish list items include "people, supports, information, programs and so on, that were not present at the time of the participant's experience, but that those involved believed would have been helpful in the situation being studied" (Butterfield et al., 2009, p. 267). The inclusion of these departures and additions into the CIT has been titled the enhanced critical incident technique (ECIT) (Butterfield et al., 2009).

The current study makes use of one further adaptation to the CIT. In a study completed by Butterfield, Borgen, Amundson, and Erlebach (2010), a positive psychology approach was applied to investigating the experience of workers managing change. Data collection was focused on what workers who self-identified as doing well during periods of change recognize as helping and hindering their well-being. This participant inclusion criteria recognizes that those doing well within difficult environments have insight to offer regarding naturally occurring resilience. In addition, comparing what workers believe wellness to be in their lives with past literature on personal wellness and effective coping allows for an increase in our lived experience understanding of effective functioning in difficult work environments.

Philosophical Underpinnings of the ECIT

No method exists without philosophical assumptions underpinning its procedures and utilizing a method without considering the philosophical principles behind its procedures can lead to incorrect inferences and misleading conclusions (Ponterotto, 2005; Willig & Stainton-rogers, 2010). As the ECIT has developed, its methods, data collection targets, and intended uses have evolved. In an effort to contribute to ongoing development of the ECIT, the author of the current research published an article on the philosophical underpinnings of the ECIT (McDaniel, Borgen, Buchanan, Butterfield, & Amundson, 2020). In this article the ECIT is described as leaning towards a rigorous post-positivist philosophical approach, but also containing a flexible ontological position. The ECITs' philosophical approach and how it relates to the current research will be elaborated on here.

Five anchors are commonly used in describing a method's underpinnings, they are: ontology, epistemology, axiology, rhetorical structure, and methods. Ontology questions the nature of reality, the nature of existence, and the nature of being in the world (Crotty, 1998; Jacquette, 2002; J. Ponterotto, 2002). Epistemology regards the nature of knowing, how knowledge is acquired or constructed, how it is justified, and the nature of the quest for knowledge (Carter & Little, 2007; Hansen, 2004; Moon & Blackman, 2014). A key epistemological consideration within the social sciences is the nature of the relationship between participant and the researcher; do the values and biases of researcher and participant influence each other, and is this potential influence important (Guba & Lincoln, 1994; Ponterotto, 2005). Axiology regards the role and influence of researchers' and participants' values, assumptions, and beliefs in conducting research (Carter & Little, 2007; Ponterotto, 2005). Rhetorical structure involves the language used in expressing the details of the research study, and typically matches the epistemological and axiological perspective taken by the researcher (Ponterotto, 2005).

Rhetorical structure is significant to the issues of representation of research findings and considers elements such as form, voice, power. Methods are the specific techniques, procedures, and tools of research (Harding, 1987; Schwant, 2000).

Ontology

The ECIT shift in data collection target is key to the ECIT's ontological stance (McDaniel et al., 2020). The original target of observable behaviour matches a positivist research approach, being realist in nature and implying an objective, independently knowable, and measurable reality being inspected by researchers. However, targeting participant's perceptions through retrospective self-report makes room for ontological approaches beyond realism/positivism. Participant's self-reporting of their perceptions are subjective, being influenced by personal factors, context, and interactions with the researcher. This subjectivity could be seen as needing to be recognized and controlled for in an attempt to get as close to objectivity as possible, matching post-positivist approaches. It could also be seen as inherent to the relativistic nature of reality, therefore valid and not requiring control, matching constructivist or critical theory philosophical paradigms. This study endorses this second relativistic ontology, taking a constructivist ontology. The participants are not expected to be reporting on an objective reality, but rather a constructed reality dependant on their subjective personal factors, context, and interactions with the researcher during data collection.

Epistemology

ECIT interviewing techniques and credibility checks and their intent illuminate the method's epistemological stance (McDaniel et al., 2020). Interviewers receive interview training, follow an interview guide, and every third or fourth interview is checked by an ECIT expert for fidelity to the method. This rigor in interviewing may be interpreted as an attempt to remove

undesirable bias within the data created by uncontrolled interactions between researcher and participant. This fits within the objectivist/dualist perspective taken within post-positivist paradigms. The extensive credibility checks employed by the ECIT may be taken as attempts to further reduce bias and detect the objective truth within the data. However, the ontological position of the researcher may change the intent of these interviewing techniques and credibility checks. Given a constructivist ontological position, these checks may be employed with the intent of honoring the participants' reality and clearly capturing their intended expression, while acknowledging what the researcher's own subjective reality is adding to this relative reality. As discussed by Maxwell (1992), validity here stems from assessing the strength of inferences made rather than how close the research is to an objective truth. From this perspective, the trustworthiness of an ECIT study stems from the audit trail created by these credibility checks, allowing the reader to evaluate the trustworthiness of the researcher's analysis while acknowledging that the researcher's values and bias are contributing rather than taking away from this credibility. Having taken a constructivist ontology, the current study takes a hybrid post-positivist-constructivist epistemology, maintaining that interview protocols and credibility checks are being utilized to honor participant perspectives and to aid readers in evaluating the trustworthiness of the analysis. Following the suggestions made by McDaniel et al. (2020) and to aid in this evaluation, the researcher's subjectivity will be discussed in a section to follow.

Axiology

As with its epistemological approach, the ECIT's maintenance of interview protocols and credibility checks indicates the axiological acknowledgement that the researcher's values have some effect on their work (McDaniel et al., 2020). As with its epistemological approach, the intent of these protocols and checks is important in making the axiology of the current study

clear. The current study takes a hybrid post-positivist-constructivist axiological approach, maintaining that it is impossible to remove the influence of the researcher's values and that these values are contributing something important that must be acknowledged in evaluating this research. Interview protocols and credibility checks are utilized to honor participants subjective reality. A researcher subjectivity statement is included in a section to follow with the intention of allowing the reader to include knowledge of the researcher's subjective reality in evaluating this study's data analysis.

Rhetorical Structure

As with its epistemology and axiology, the ECIT's rhetorical structure depends on the intent of the researcher (McDaniel et al., 2020). The ECIT presents results as categories, often in table form, and uses concise language in describing data collection and analysis. This rhetoric may indicate a positivist structure, however, the ECIT also frequently includes quotes in the participants' voices; typical of post-positivist or constructivist approaches (Guba & Lincoln, 1994; Ponterotto, 2005). In this study, the presentation of categories, category descriptions, tables, concise descriptions, and extensive participant quotes are utilized to allow the reader to evaluate the inferences made by the researcher and honor the participant's voices rather than to eliminate bias and reach an objective truth. The inclusion of a researcher subjectivity statement is included similar aim.

Methods

As with the ECIT's epistemology, axiology, and rhetorical structure, the intent of its methods is dependent upon the ontological perspective of the researcher (McDaniel et al., 2020). The ECIT dictates a semi-structured interview protocol, with probes and clarifications permissible (Butterfield et al., 2009). Within this study, the semi-structured protocol is utilized

with the intention of keeping the interview focused on the participants' experience and in making sure that areas of discovery are similar across participants. Probes and clarifications are utilized with the knowledge that they will increase the influence of researcher subjectivity within each interview. This researcher subjectivity is not seen as distorting the data, but rather as a valid element of the reality described by this study. The researcher subjectivity section to follow is intended to assist the reader in evaluating influence of this subjectivity.

Philosophical Underpinnings Conclusion

The current iteration of the ECIT is an inductive method, with a flexible ontological stance, and a rigorous post-positivist epistemological approach (McDaniel et al., 2020). Ontologically, the ECIT leaves room for the possibility that participants may be actively constructing their own apprehensible and equally valid realities. The reality that the participant is experiencing may be brought forward through reflection, with the data collection interviews attempting to capture this reflected reality. The ECIT employs rigorous post-positivist leaning credibility checks to ensure that every effort to honor participants' intended meaning is made, however, the interaction between the researcher and the participant is bound to influence this emerging meaning. Similarly, the values and lived experience of the researcher are likely to have some influence during the inductive analysis of participant data. Complete elimination of this influence is impossible, however, acknowledgement of researcher subjectivity and transparency in situating the researcher allows those that evaluate and utilize this research to do so in an informed manner.

Researcher Subjectivity Statement

My interest in how CMHWs maintain wellness within a difficult work environment is directly linked to my personal experience as a CMHW. Between 2005 and 2012, I was employed first as a CMHW and eventually as a front-line community-based project manager. My work

involved offering support to clients facing challenges related to marginalization, trauma, and substance addiction, across a variety of work sites, with a variety of service delivery objectives. I observed in others, and experienced first-hand, the personal wellness challenges involved with these types of stressful work environments.

I believe that work supporting marginalized communities is a matter of ethical and social responsibility and supporting those providing care to those communities is an integral element of this ethical responsibility. I entered graduate school with a desire to contribute to an improved understanding of what helps and what hinders people maintain wellness despite the occupational difficulties involved in stressful supportive work. The interest and experience I have in this area provide me with an insider's perspective, and unique access to potential participants. While this provides a positive contribution to the current research, the potential for personal researcher beliefs and attitudes to create preferences in data analysis is present. I made every attempt at acknowledging these pre-existing perspectives and experience throughout data collection and analysis, while relying on the extensive credibility checks to ensure that participants' intended meanings are made clear.

Suitability of ECIT for this Research Topic

The ECIT was chosen as a method for the present study due to its methodological match with the research question and previous usage with similar populations, with similar purposes. CMHWs are considered an under-researched and under-supported population (Morse et al., 2012; Onyett, 2011), making research that is both exploratory and empowering important. ECIT is an exploratory and inductive method, suitable for use in under-researched areas (Butterfield et al., 2005, 2009; Woolsey, 1986b). The shift from behavioral observation to retrospective self-report allows for exploration of what the population themselves identify as helping and hindering their wellness. The adaptation of the CIT for use with psychological constructs, emotions,

attitudes, and motivations matches well with the target of the current study. Furthermore, the ECIT is seen as assisting in the empowerment of the target group through its focus on participant perspective and practical uses of the gathered data (Burns et al., 2008; Butterfield et al., 2005, 2009; Douglas et al., 2009; Gremler, 2004; Woolsey, 1986b). Finally, the flexibility of the interview format and consistency with the values of counselling psychology supports the facilitation of CMHWs voices being heard (Woolsey, 1986b).

The functionality of using the CIT with populations similar to CMHWs is well documented. The ECIT technique has been used with a wide variety of similar populations facing similar occupational challenges, including, but not limited to: social workers (Mills & Vine, 1990; Savaya et al., 2011), nurses (Hosie et al., 2014; Schluter et al., 2008), paramedics (Mulholland et al., 2015), doctors (Humphery & Nazareth, 2001), and police officers (Conn & Butterfield, 2013).

Finally, the ECIT is an appropriate method for studying stress and coping. Stress has been shown to be tied to the interpretation of specific potentially distressing events (Lazarus, 2000). As ECIT involves the coding and analysis of interview data based on the identification of critical events that help or hinder the participant, it is an ideal stress investigation tool (Butterfield et al., 2009; Flanagan, 1954). Conn and Butterfield's (2013) study exploring the factors that help, hinder, and would have helped police officers experiencing secondary traumatic stress ably demonstrates the viability of the ECIT in studying stress and coping in a population experiencing similar stressors to the target population of the current study. Utilizing the ECIT procedures outlined by Butterfield et al. (2009), Conn and Butterfield (2013) interviewed 10 general duty officers from policing agencies in the Vancouver area. 156 critical incidents were gathered and sorted into 74 helping, 62 hindering, and 20 wish list items. With the intention of

complementing existing research, offering a voice to participants, and informing organizational policy and counselling practice, Conn and Butterfield's (2011) study emphasized factors that were primarily helpful, or would have been helpful, in reporting the study's findings. Credibility and trustworthy checks indicated that participants found the categories reflected their experience, and the findings were consistent with theory.

Procedures

The research question for this study is: *How do CMHWs maintain wellness while responding to the fentanyl overdose crisis?* The ECIT method, with the addition of the adaptation utilized by Butterfield et al. (2010), was utilized in investigating this question.

Inclusion Criteria

- Currently engaged in community mental health work with populations directly affected by the ongoing fentanyl overdose crisis.
- Self-identify as maintaining wellness despite the pressures involved in their work environment.

Additional Factors

- Efforts were made to recruit individuals with diverse gender, cultural, and work experience.

Exclusion Criteria

- Individuals that self-identify as not doing well were to be excluded; however, all individuals that asked to participate self-identified as doing well.

Participant Recruitment

Recruitment was conducted via snowball sampling. Third party individuals connected with the target population were contacted with a letter requesting their assistance in recruiting

study participants (see appendix C). The third-party individuals contacted were provided with a recruitment letter containing information about the study, including the research methods, purpose of the study, time commitments required, participant criteria, and potential outcomes. The third-party individuals contacted were given the choice to circulate this information to their networks and to potential participants, or to decline assistance. Third-party individuals were instructed to not tell the researcher who they have contacted. Third party individuals were not considered for participation in this study.

Potential study participants were asked to contact the researcher directly, who then screened them to determine whether they met the study criteria. To establish eligibility, the researcher asked potential participants if they are currently engaged in community mental health work with populations directly affected by the ongoing fentanyl overdose crisis and if they self-identify as maintaining wellness despite the pressures involved in their work environment.

Those individuals who were considered eligible to participate in the study were provided with an informed consent form (see appendix D), a letter containing information about the study (see appendix E), and the initial interview was scheduled. Potential participants were informed that they may consider if they would like to participate before scheduling an interview and that they may contact the researcher to schedule an interview if they decided they would like to proceed.

Description of the Sample

Sixteen individuals participated in the current study. Participant age ranged from 29 to 62 years of age with an average age of 36.5. Seven participants identified as male and 9 identified as female. One participant identified as Cree, 1 participant identified as Nigerian, and 14 identified as Caucasian. Participants had spent between half a year and 10 years in their current position,

with an average of 7 years. Participants had spent between 2 and 30 years doing community mental health work in total, with an average of 9 years. Job titles included: CMHW, Youth CMHW, CMHW/Counsellor, CMHW/Clinician, Community Support Worker, Women's Community Support Worker, Infant Development worker at a female drop-in, Youth Worker and Casual Social worker at a drop-in, Drop-in Case Manager, low barrier female building Supervisor, Addictions Services Worker, Social Worker, Mobile Needle Cleanup and Exchange Worker, and Supervised Injection Site Worker. Self-identified personal wellness ratings ranged from 3.5 to 10, with an average of 6.75 (with 1 being very poor and 10 being very good). Table 1 provides a summary of participant demographics.

Table 1

Summary of Participant Demographic Information

Demographics	Participant Characteristics
Age (in years)	Range = 25 – 62 Mean = 36.5 Median = 34
Gender	Female = 9 Male = 7
Ethnicity	Cree = 1 Nigerian = 1 Caucasian = 14
Time Spent in Current Position (in years)	Range = .5 – 10 Mean = 7 Median = 1.75
Time Spent Doing CMHW in Total (in years)	Range = 2 – 30 Mean = 9 Median = 9
Personal Wellness Rating (1 – 10, with 1 being very poor and 10 being very well)	Range = 3.5 to 10 Mean = 6.75 Median = 7

Procedures for Data Collection and Analysis

ECIT studies are conducted through the five following steps: (1) ascertaining the general aims of the activity being studied; (2) making plans and setting specifications; (3) collecting the data; (4) analyzing the data; (5) interpreting the data and reporting the results (Butterfield et al., 2009; Flanagan, 1954).

Step 1: Ascertaining the general aims of the activity being studied. In ascertaining the general aims of the activity being studied, two questions are suggested: (1) what is the objective of the activity, and (2) what is the person who engages in this activity expected to accomplish (Butterfield et al., 2005, 2009)? The purpose of this study was to discover the self-renewing strategies used by workers that self-identify as doing well despite working in a stressful environment. Participants were selected based upon self-reporting that they are doing well despite work stress, that they are willing to talk about what is helping and hindering their personal wellness, and that they are available for data-collection interviews. Data-collection interviews attempted to identify the strategies used by these workers to explore what successful workers identify as helping or hindering their wellness, and what might be helpful. Therefore, the objective of the activity to be studied was to maintain wellness, and the expectations regarding accomplishment of the activity was defined by participants.

Step 2: Making plans and setting specifications. Flanagan (1954) suggests the following definitions are identified when making plans and setting specifications: (1) the types of situations to be observed, (2) the relevance to the general aim, (3) the extent of the effect that the critical incident has on the general aim, and (4) who will make the observations.

The types of situations to be observed (self-reported) were any relating to helping or hindering the wellness of the participants. The relevance of these incidents and their effect on the

general aim was explored with participants. The creation of an interview guide is recommended in fulfilling this step, and in order to assist in focusing the interview and ensure adequate exploration of identified incidents. (Butterfield et al., 2009). The interview guide was piloted with student colleagues. Interview questions are as follows:

- *On a scale of 1-10 how would you rate your personal wellness?*
- *Could you tell me how long you have been doing community mental health related work?*
- *What is your current job, and how long have you held this position?*
- *What other mental health related jobs or positions have you held?*
- *What brought you to this type of work?*
- *Have you been present during a drug overdose within the last year?*
- *You volunteered to participate in this study because you feel that you are successfully maintaining personal wellness despite stress at work. What does personal wellness mean to you?*
- *Tell me about something that has helped you in maintaining personal wellness while working with clients affected by the fentanyl overdose crisis?*
- *Tell me about something that has not helped you in maintaining personal wellness while working with clients affected by the fentanyl overdose crisis?*
- *I'm interested in knowing what might have been helpful in maintaining wellness, and what might be helpful in the future. Can you think of anything that might be helpful in this regard?*

Open ended prompts intended to assist participants in describing the incident in detail included:

- Exactly what happened that you found helpful or hindering?
- How did you know?
- What went on before/after?
- How did it turn out?
- Can you tell me more about that?

A copy of this interview guide is included in appendix A.

Step 3: Collecting the data. Data collection took place through in-person interviews. All interviews were conducted by the researcher. Interview location was discussed with participants ahead of time with the goal of providing privacy and quiet. Interviews ranged from one and a half to two and a half hours. Interviews began with an overview of the interview process, informed consent discussion, and audio-recording procedures discussion. Participants that wished to continue were asked to sign a consent form (see appendix D). As in the following interview guide, participants were invited to share their experiences, focusing on the following: (1) rapport building and contextualization (regarding their work experience), (2) identifying helping and hindering factors, (3) identifying wish list items, and (4) demographic information. At the close of each section of the interview, a summary of the information shared was provided to confirm understanding with the participant and cue them to any details they wished to add. These summaries provide a check of internal credibility for the interview (Butterfield et al., 2009). Demographic information included: age, gender, ethnicity, job title, and time spent at current position as well as time spent doing CMHW in general (See Appendix B). The interview was closed with a check in with the participant regarding any personal disturbance as a result of the interview. Appropriate referral resources were available for participants that indicated distress, but all participants indicated that the interview produced a positive effect.

Each interview's audio recording was transcribed verbatim. These transcripts were compared with audio recordings to ensure accuracy and add any important nonverbal information (quiet, loud, tears, laughter, etc.). Every third or fourth taped interview was reviewed by an expert (a student in the counselling psychology doctoral program with experience utilizing the ECIT) to ensure that the CIT method was being followed, the interviewer was not asking leading questions, and that the interview guide was followed (Butterfield et al., 2009). The audio recordings, transcriptions, and information entered into interview guides was stored in a double locked cabinet. Participants were assigned an identity code to protect their anonymity and demographic information was kept separately from interview data.

Participant recruitment and data collection interviews continued until exhaustiveness was reached in the data. After each data collection interview, the CIs and WL items identified were grouped together into preliminary sorting categories. To determine the point of exhaustiveness, a log of each interview with its CIs and WL items placed within this emerging category set was kept. Exhaustiveness was reached when all CIs and WL items from an interview was accounted for by the developing preliminary category set, without needing to add any new categories to the set (Butterfield et al., 2009). Interviews continued past the point of exhaustiveness by one interview as an additional participant had already been scheduled.

Step 4: Analyzing the data. Flanagan describes the purpose of CIT data analysis as being to increase the potential efficient utility of the data for practical purposes (Flanagan, 1954). The CIT data analysis procedure includes three steps: 1) determining the frame of reference, 2) formulating categories, and 3) determining the level of specificity or generality to be used in reporting the data (Flanagan, 1954; Butterfield et al., 2005; Butterfield et al., 2009).

A software program (Atlas TI) was utilized in organizing and analysing the data. This program allows for easy highlighting, coding, and grouping of pertinent information within transcriptions. Before beginning coding, the researcher read through each transcript to familiarize himself with the perspective of the participant. The researcher then re-read the transcript, coding anything that appeared to be a critical incident. Once collected, these CIs were examined to make sure they are sufficiently clear, complete, and with consequences clearly relating to the purpose of the study (Flanagan, 1954). Incidents that did not meet these criteria were marked for follow-up in the participant cross-check and excluded from final results if criteria were not met.

Incidents were then divided into three parts: the context of the incident, the experience described, and the meaning of the incident to the participant (Butterfield et al., 2009). Information on the meaning of the incident assisted in understanding why it was helpful or unhelpful. Dividing incidents in this way helped in grouping them into categories. This category creation and grouping was iterative in nature, with the purpose - to discover the self-renewing strategies used by workers that self-identify as doing well despite working in a stressful environment - kept in mind throughout. Categories were descriptive in nature, identifying actions taken either by the participant, or by some element of their environment, that helped, hindered, or would have helped. Initial categories were checked for credibility and trustworthiness utilizing the techniques outlined in the following section. The level of specificity/generality of the categories was determined with the goal of making the information gathered usable for practical purposes.

Once initial category sorting had taken place, a second interview was scheduled with participants to cross-check the data. This interview allowed participants to review and confirm

the interpretations made by the researcher, confirm the identified CIs and WL items, review the categories that CI and WL items were placed into, comment on how accurate the category titles are, and in general ensure that participants' voices are honored (Butterfield et al., 2009). Typically taking place via phone call and email, this second interview also allowed the researcher to follow up on any questions arising from analyzing the participant's data. The following items outlined by Butterfield et al. (2009) were covered:

1. Are the helping/hindering CIs and WL items correct?
2. Is anything missing?
3. Is there anything that needs revising?
4. Do you have other comments?
5. Do the category headings make sense to you?
6. Do the category headings capture your experience and the meaning that the incident or factor had for you?
7. Are there any incidents in the categories that do not appear to fit from your perspective? If so, where do you think they belong?
8. Follow up on any questions/clarifications that arose from the first interview.

In order to provide an audit trail, the CI and WL items and categories were emailed to the participant before the phone interview, and notes on the second interview were sent to the participant afterwards for review, approval, or further revision (Butterfield et al., 2009).

Step 5: Interpreting the data and reporting the results. To increase the trustworthiness and credibility of the results of this study, the nine credibility checks proposed by Butterfield et al. (2009) were utilized throughout the research project, and before interpreting and reporting the results. These credibility checks are detailed below.

Audiotaping interviews. Interviews were audio-recorded to accurately capture the participant's words. Verbatim transcripts were created from these audio recordings.

Interview fidelity. An expert in the CIT research method (A recent graduate of the counselling psychology program at The University of British Columbia that utilized the ECIT within their dissertation and has published work utilizing the ECIT) listened to every third or fourth taped interview to ensure that the CIT research method was being followed, the interviewer was not asking leading questions or prompting the participant, and that the interview guide was being followed.

Independent extraction of CIs. Three individuals other than the researcher (doctoral students enrolled in the counselling psychology program at The University of British Columbia independently) extracted CI and WL items from 25% of the total transcripts. These transcripts were chosen by rolling dice. This independent extraction was compared with the researcher's extraction and a percentage of agreement was computed. Incidents that do not match were discussed and resolved.

Exhaustiveness. Procedures for determining exhaustiveness of data collection are detailed in the above section on data collection.

Participation rates. Each participant's number was included with each CI or WL item as they were added to each pertinent category. This information was used in calculating what percentage of participants input is included in each category. This process assisted in assessing the relative strength of each category (Borgen & Amundson, 1984).

Placing incidents into categories by an independent judge. The researcher selected 25% of the incidents within each category and sent them to an independent judge (a doctoral student enrolled in the counselling psychology program at The University of British Columbia), along

with the category headings and operational definitions. This person independently sorted the incidents into each category, and this categorization was compared and discussed with the researcher's until 80% agreement on categorization was reached.

Cross-checking by participants. Procedures regarding cross-checking with participants are detailed within the above section on data analysis.

Expert opinions. After participant cross checking, the categories created during data analysis were submitted to two experts in the field. These experts held each held professorships at North American universities and had published extensively regarding the area being studied. They were asked to provide responses on the following questions:

1. Do you find the categories to be useful?
2. Are you surprised by any of the categories?
3. Do think there is anything missing based on your experience?

Expert feedback was incorporated into revision and finalization of the categories.

Theoretical agreement. The assumptions underlying this study and the emergent categories generated by it were compared with relevant scholarly literature within the discussion chapter. The assumptions and their relation to the relevant literature are described in the literature review section of this dissertation. Instances in which emergent categories were not supported by the literature were also explored within the discussion chapter and highlighted for future study.

Once credibility checks were completed, category and sub-category titles were finalized, along with concise descriptions. Example incidents in the participant's own words are included in describing each category. As the intention of this research is to provide information that may

be of practical use to workers in difficult professions, the results are presented with potential use in mind.

Analysis of Contextual Questions

The contextual results were analyzed using the thematic analysis following Braun and Clarke's (2006) method. Braun and Clarke's method describes six step-by-step phases for data analysis. These six phases were adhered to as follows. Thematic analysis began through orientation to the data by reading through participant responses (phase 1), after which initial codes were then generated (phase 2). Initial codes were then organized according to similarities with reference to the contextual questions (phase 3). Next, the coded groupings were reviewed and were clustered/sorted into categories that were meaningful and related (phase 4), with several iterations of this category system created by refining and integrating similarly defined categories, resulting in the generation of main themes and sub-themes. Finally, the themes were defined and named (phase 5). Data within each theme was reviewed and checked for consistency. The themes were reported in the results chapter (phase 6). The careful application of this method involving all the six phases contributes to the trustworthiness of this method of analysis.

Conclusion

In this chapter, the origins, evolutions, and philosophical underpinnings of the enhanced critical incident technique (ECIT) were described. A researcher subjectivity statement was provided and the suitability of this method for the present study was discussed. Finally, a description of the procedures employed, and sample was provided.

Chapter Four: Results

Overview of Results

In this chapter, the summary of participant responses is presented pertaining to the two main components of the interview: the contextual component, and the ECIT results.

Contextual Results

The contextual questions were expected to contribute to this study in three specific ways. The first was to help participants feel comfortable in the interview setting while building rapport and fostering open communication. The second was to provide background regarding the participants' work experience and motivations for working in this area. Questions regarding length of time in the field, current and past jobs, age, gender, ethnicity, and what brought them to this type of work were asked. The majority of this information is reported within the participant section of the methods chapter, with the exception of participant replies to the last question. Participant frequently provided in depth responses to this question (What brought you to this type of work?). Their responses often connected with what they stated helps and hinders their wellness. Out of respect for the importance participants placed on this question, a thematic analysis of their responses is presented in this section. The third purpose was for them to articulate in their own words what personal wellness means to them. A thematic analysis of these results is also presented here. This information is expected to enable a broader understanding of the critical incident portion of the interviews

What Brought You to this Type of Work?

When participants were asked what brought them to this type of work, they frequently indicated that what brought them to the work related to what keeps them well in the work. Responses provided by participants yielded 45 codes, which were grouped into six themes using Braun and Clarke's (2006) method of thematic analysis. A detailed description of the method

and the trustworthiness of the analysis is provided in Chapter 3. These six themes were later grouped into three major themes. Table 2 outlines the themes and subthemes with the participation rates and frequency of codes.

Table 2

Themes Related to What Brought you to the Work

Main Themes and Subthemes	Participation Rate (%)	Frequency (#)
Meaningful Work	81	23
Offering Support to People in Need	75	21
Personal Growth	13	2
Personal Experience with the Population being Supported	69	13
Worker Experience with Similar Challenges	38	7
Worker's Family Experience with Similar Challenges	25	4
Worker's Family Member in a Similar Field	13	2
Natural Aptitude for the Work	38	9

Meaningful Work. This was the largest main theme, with a participation rate of 81% (N=13) and including 23 codes. Two subthemes were identified: (a) offering support to people in need, and (b) personal growth. Sample quotes providing more detail are presented below.

The largest subtheme was the opportunity to offer support to people in need (75% participation rate, N=12, 21 codes). Participants within this theme uniformly identified that they are "Just wanting to help people, basically. I am lucky enough to have had a pretty privileged upbringing in life and am wanting to take advantage of that to help other people that haven't been so lucky" (Participant 2). Participants highlighted feeling that they need to do something for people in genuine need. For example, "I can't help but be passionate because I know if I sit back there are people who'll die every day. Sitting back and doing nothing doesn't sit well with me,

doesn't sit well with my conscience" (Participant 9) and "I think being able to end your day confident that you've done whatever is in your power to respond to suffering, injustice is what brought me here" (Participant 10). These acts of helping people were identified as meaningful to these participants:

> What is rewarding is that your work can make a meaningful difference in somebody's life. You are directly contributing to reducing real problems. That's a whole lot more satisfying than improving the ability of a large company to process orders for their equipment . . . you are having a direct impact on people. (Participant 14)

The second largest subtheme within Meaningful Work was the opportunity for personal growth (13% participation rate, N=2, 2 codes). The participants within this subtheme identified that the personal growth caused by the work was desirable. For example:

> The slow process of realizing that when I helped somebody who was experiencing similar things to what really almost wrecked my own life, that I would start to grow and feel accomplishment and feel like there's corollary there. You end up helped by them. (Participant 7)

Personal Experience with the Population being Supported. The second major theme answering, "What brought you to this type of work?" was personal experience with the population being supported, with a participation rate of 69% (N=11) and included 13 codes. The following three subthemes were identified: (a) worker experience with similar challenges, (b) worker's family experience with similar challenges, and (c) worker's family member working in a similar field. Illustrative sample quotes providing more detail are presented below.

The largest subtheme was worker has experienced similar challenges (38% participation rate, N=6, 7 codes). In each of these codes, the worker had experienced similar challenges to the people they are now offering support to. For example:

> My 20 years of substance use, addiction, living on the streets, about a decade of homelessness. It was really just a natural progression of making changes in my life and allowing myself to have stability that I came believe that I would be able to assist others with that as well. (Participant 15)

Similarly, "I've been on the other side of the desk and I come from a really shitty adverse childhood experience score. When I'm working, I'm well aware that I'm in a community of workers with similar experience to mine" (Participant 7). In many cases, the participants highlighted that their personal experience with similar challenges caused them to reject the stigma commonly directed at people experiencing substance use challenges: "I am a person despite whatever stigma may have been against me when I was young. So always having that human piece to the people that I worked with and recognizing that they're really wonderful, fantastic people despite their difficulties" (Participant 4).

The second largest subtheme within Personal Experience with the Population being Supported was the Worker's Family has Experienced Similar Challenges (25%, N=4, participation rate, 4 codes). The participants within this subtheme identified that family members experiencing similar challenges had sensitized them to helping work of this kind and reduced the stigma associated with people that use substances. For example:

> What made me want to do it was growing up with both of my parents' struggle with substances. It unfortunately was the reason for my mother's passing when I was young, so I think I always had that connection, as many people in this field do, as well as my

> own experiences with substances when I was young. I think just seeing that my parents were people, despite all the stigma against them. (Participant 4)

Similarly:

> I have people in my family that remind me of people in the downtown East side. There's a lot of drug and alcohol issues within my family. Borderline poverty issues, that kind of thing. My family also was very helpful to people. They help people. That was a part of my view on the world and humans. (Participant 6)

The third largest subtheme within Personal Experiences with the Population being Supported was 'Worker's Family Member Works in a Similar Field' (13% participation rate, N=2, 2 codes). Participants that spoke on this theme had a family member that set an example for the participant in working in the helping professions. For example, "My dad's a therapist and I grew up doing a lot of talking. I like that way of interacting with people and it's quite a privilege and vulnerable people and marginalized people don't get those opportunities to just talk openly" (Participant 5).

Similarly:

> My uncle was a social worker. He said that there's should be no shame in somebody who makes money, but if you have a chance to make a difference, it's just as important, and you should never feel ashamed for doing something for less money, but that makes a difference. That always stuck with me, and that's why I started in the helping fields. (Participant 12)

Natural aptitude for the work. The third major theme for "What brought you to this type of work?" was Natural Skill/Aptitude for the Work, with a participation rate of 38% (N=6) and including 9 codes. Participants who spoke on this theme talked about finding they had

naturally gained the skills and aptitudes necessary to do this work. For example, “When I was young, I was encouraged to become a counsellor because, ‘You do it anyways, you might as well go to school and get paid for it,’ so it just felt natural” (Participant 4), and “I feel like I’m a fairly emotionally attuned, naturally sort of empathetic person. Most of my support work/counseling/cheerleaders/life coach skills are just an accumulation of the things I've learned and experienced” (Participant 15).

What does Personal Wellness Mean to You?

During the contextual section of the interviews, participants were asked “What does personal wellness mean to you?” Self-identifying as being successful in maintaining their wellness was an inclusion criterion for this study, and so it is important to understand as fully as possible what personal wellness means to these participants. Using thematic analysis, participant responses were summarized into five themes (78 codes). Table 3 outlines the themes with the participation rates and frequency of codes.

Table 3

Themes Related to What Does Personal Wellness Mean to You

Main Themes	Participation Rate (%)	Frequency (#)
Balance	69	17
Awareness and Acceptance	63	23
Connection	63	12
Motivation/Agency	50	15
Physical Health	31	6

Balance. The largest theme was Balance, with a participation rate of 69% (N=11) and including 17 codes. Participants within this theme spoke on wellness being a balance between

the various roles and aspects of themselves. One participant stated, “So more generally when thinking about wellness I think about balance especially because I tend to occupy several roles in life and I know in times when I felt unwell, I have felt unbalanced in those roles” (Participant 4). Another stated, “Personal wellness really comes down to physical health and mental health, I would say, and having a balance of both of those and being fulfilled in both of those and satisfied with that” (Participant 2). Applying the Indigenous Medicine Wheel to the concept of balance, one participant stated, “For me, wellness is defined by the medicine wheel. Wellness is having balance. Having my spiritual, my physical, all those things in balance. As long as I can have it relatively securely together, that’s what I look for” (Participant 12).

Awareness and Acceptance. The second largest theme was Awareness and Acceptance with a participation rate of 63% (N=10) and including 23 codes. Participants within this theme talked about a sense of being mindfully aware of the present moment and being able to accept and work with whatever is present within themselves and their environment. For example:

> I think the degree to which I'm able to rest into myself in the present. The degree to which I’m able to allow myself to be where I am. The degree to which I’m able to recognize that I'm not escaping or recognize that I am. A level of fluidity and a wanting to be present in my body, in my reality. Am I accepting my reality right now, regardless of what it looks like? What degree am I accepting it? I think that, to me, has a lot to do with it. (Participant 8)

Similarly, “I’m not wishing I was somewhere else or thinking about something else and that to me, I think, is always a sign that I’m like physically and mentally and emotionally doing okay or doing well.” (Participant 4). Participants within this theme also noted a recognition that wellness is dynamic and imperfect, for example, “I’d like to say it shouldn’t be perfect. Any

expectations around perfection with that, I think would be unhelpful. Of course, it's very personal and subjective and fluid" (Participant 7).

Connection. The third largest theme was Connection with a participation rate of 63% (N=10) and represented by 12 codes. In many cases, this meant feeling present specifically in their connections with their families. One participant stated. "In the context to the work that I do, wellness in many ways means that when I leave work, I'm able to engage, interact and participate in my family structure" (Participant 16).

While for others connected wellness had to do with feeling connected to both others and to something bigger and meaningful in their lives, "Feeling connected to something. It could be people, it could be the bigger universe, it could be feeling a sense of connection because I really feel that disconnection is the opposite of wellness" (Participant 6), and "Wellness for me is also about connection, connection to self, to others and to that greater thing in life, whatever that is for you" (Participant 4).

Motivation/Agency. The fourth largest theme was Motivation/Agency, with a participation rate of 50% (N=8) and including 15 codes. Participant responses fitting into this theme stated that wellness is connected to feeling motivated and having agency in their lives. For some, this motivation had to do with the energy to engage in the things that keep a worker well, for example, "If my energy goes up and down, when I'm not doing so well, less energy and less motivation to do the things that keep me well." (Participant 5). This may include a sense of agency in self-care or in accessing the resources they need, as in "I find when I'm feeling really well, I feel like I can handle things, or I know like where to go if things do feel difficult." (Participant 4).

This sense of motivation also had connection to meaning in some participants lives, as in "Wellness involves not being passive as far as the suffering, and injustice, and stuff like that. I feel motivated and that I can do something about those things" (Participant 10) and "Yes, I think in the context of work, in the opioid crisis, wellness to me definitely is feeling like I'm not powerless in a very kind of powerless situation" (Participant 4).

Physical Health. The fifth largest theme was Physical Health, with a participation rate of 31% (N=5) and including 6 codes. Participant responses fitting into this theme focused on physical health as indicators of personal wellness. Summing up what participants within this theme identified, one participant stated that wellness, "On the physical side, is just reasonable physical health, it doesn't have to be perfect" (Participant 14).

Critical Incident and Wish List Categories

The critical incident part of the interview was intended to gather data relating to the central research question of the current study, namely *How do CMHWs maintain wellness while responding to the fentanyl overdose crisis?* The first interviews yielded a total of 429 incidents with 205 (48%) helping critical incidents, 151 (35%) hindering critical incidents, and 73 (17%) wish list items. In the second interview, participants were provided an opportunity to review and reflect upon the results of their first interviews, yielding a total of 1 additional critical incident and bringing the total to 430 incidents. In addition, 8 critical incidents had contextual and/or impact information added to them as a result of the second interviews.

The final collection of incidents were subdivided as follows: 205 (48%) helping critical incidents; 152 (35%) hindering critical incidents; and 73 (17%) wish list items. These items were placed into categories created based upon themes between the incidents. A total of 5 categories

with 13 subcategories emerged. Participation rates were calculated by dividing the number of participants who communicated incidents fitting into a particular category by the total number of participants (N = 16). Table 4 summarizes the categories, the total number of items in each category, and the participation rates in percentages.

Table 4

Categories of Critical Incidents (Helping and Hindering) and Wish List Items

Categories	Helping			Hindering			Wishlist		
	P#	P%	I#	P#	P%	I#	P	P%	I#
Collective Ethics	16	100%	52	15	94%	39	10	63%	18
Purpose to the Work	13	81%	21	0	00%	0	0	00%	0
Client Interactions	11	69%	14	8	50%	12	0	00%	0
Being Realistic about the Crisis	6	38%	12	1	06%	1	0	00%	0
Societal Recognition	2	14%	4	4	25%	5	6	38%	8
Crisis Intervention Policy and Practice	1	06%	1	10	63%	22	4	25%	5
Social Support	16	100%	52	13	81%	47	10	63%	18
Social Support from Non-colleagues	13	81%	20	7	44%	13	0	00%	0
Social Support from Colleagues	10	63%	20	10	63%	16	4	25%	4
Management	6	38%	7	11	69%	18	4	25%	4
Professional Support Services	5	31%	5	0	00%	0	5	31%	10
Individual Strategies to Maintain Wellness	16	100%	55	13	81%	22	5	31%	8
Mindfulness, Grounding, Processing	12	75%	26	3	19%	4	3	19%	4
Physical Activity and Diet	11	69%	16	5	31%	7	2	14%	2
Creative Expression	6	38%	7	0	00%	0	2	14%	2
Substance Use	6	38%	6	10	63%	11	0	00%	0
Work/Life Balance	13	81%	41	11	69%	20	6	38%	6
Structural Supports	4	25%	5	11	69%	27	10	63%	23

Note. P# = Number of Participants; P% = Percentage of Participants; I# = Number of Incidents

According to Borgen and Amundson (1984), a minimum of 25% participation rate is required for category viability. Each of the 6 categories and 13 subcategories that emerged in this study met the 25% participation rate test under one or more of the helping, hindering, or wish list

headings. The results pertaining to each category and subcategory are discussed in detail below. Category definitions, the total number of incidents reported in each category, participation rates, and representative participant quotes for the helping factors, then the hindering factors, and finally the wish list items are provided. It is important to note that the critical incidents pertain to only the helping and hindering factors. While the wish list items are included in the same table, they are different from the critical incidents in that they reflect what the participants wish would have happened or are hoping to happen in the future rather than past events.

Category 1: Collective Ethics

This category pertains to participants' beliefs about why the work is important, what motivates them to act, how they believe society should regard and behave towards their clients, and the interaction between these beliefs and their work lives. Participants described very similar beliefs, motivations, and purpose throughout the current study. The title *collective ethics* was chosen to highlight and honor the importance of the shared nature of these beliefs. Reynolds (2011, p. 30) defines *collective ethics* as:

> Those important points of connection that weave us together as therapists and community workers. In most of our work these collective ethics go unnamed, but they are the basis for the solidarity that brought us together and can hold us together.

The following subcategories compromise the *collective ethics* category: (a) Purpose to the Work; (b) Client Interactions; (c) Being Realistic about the Crisis; (d) Societal Recognition; and (e) Crisis Intervention Policy and Practice. Taking these subcategories together, participant participation rates were 100% (52 Incidents) for Helping, 94% (36 Incidents) for Hindering, and 56% (12 Incidents) for Wishlist. The results from these subcategories will be reported below in detail.

Category 1 (A): Purpose to the Work. This subcategory pertains to participants finding meaning, purpose, and value in the work. This category contained only helping incidents.

Helping (81% participation rate; 21 incidents). Helping incidents in this subcategory focused on participants' values and beliefs guiding and fueling their work that have a positive impact on their wellness. Themes regarding the desire to act in accordance with values, responding to suffering and injustice, the work as a calling, and helping people with less privilege are illustrated below with quotes.

Acting in Accordance with Values. Participants described incidents in which their values providing a grounded base in guiding decisions and in fulfilling their need to help others. One participant stated:

> My values are my foundation, how I make decisions and how I see the world. They are my guiding team when I'm struggling with something. Having them as a base and being able to access them consciously is what makes it helpful to my overall wellness. It speaks to our need as helpers I believe. We need to be doing something we believe in, and we might all believe in something slightly different, but it has to resonate with our inner self, our inner beliefs and values and our intentions about how we want to help and connect with others. (Participant 5)

Responding to Suffering and Injustice. Participants specifically named needing to respond to suffering and injustice as important to their wellness. One participant stated:

> Being able to end your day confident that you've done whatever is in your power to respond to suffering, injustice. That's a part of wellness. My conscience is easy. I haven't neglected anything that's in front of me. I've exhausted every capacity I have, and I can say I've done my best today without hesitation. (Participant 10)

Speaking on an incident in which he drew motivation from the need to respond to suffering, another participant stated:

> I can't help but be passionate because I know if I sit back there are people who'll die every day. Sitting back and doing nothing doesn't sit well with my conscience. It helps in the sense that it makes me more relentless. It makes me think about what I could do next to make things better. (Participant 9).

Illustrating the effect of responding to suffering and injustice on their wellness, one participant stated:

> What is rewarding is you can make a difference in somebody's life. You are directly contributing to reducing real problems. That's a whole lot more satisfying than improving the ability of a large company to process orders. I am a whole lot happier doing this work than I had been before. It's harder work than before, but much more rewarding. (Participant 14)

This Work as a Calling. Participants identified incidents involving this work as a calling and that the fulfillment of this calling as helpful to their wellness. One participant stated:

> In moments of crisis, if I feel like I've really stepped up in a good way or have been helpful or have intervened in a way that is a net gain it even gives me sort of a renewed faith or confidence in my calling or my abilities. (Participant 15)

Expanding on the impact of this calling, another participant stated:

> I'm pretty free with the terms like sacredness or calling to it. That had been elusive all my life. In my adult life, I was always trying to be some kind of good man, to do some kind of significant thing. I am able to realize that desire in this work. It's meaningful, it blows my mind that I get to do this. (Participant 10)

Helping People with Less Privilege. Participants spoke about helping incidents involving the desire to help people with less privilege. One participant stated:

> Wanting to help people. I'm lucky enough to have a pretty privileged upbringing in life and just wanting to take advantage of that to help other people that haven't been so lucky. I feel a sense of responsibility to use the privilege I have to help people in a meaningful way. (Participant 2).

Speaking on what informed her desire to work with people with less privilege, another participant stated:

> It's a matter of meaningful work, and also of my family history. I have people in my family that remind me of people in the downtown East side. There's a lot of drug and alcohol issues within my family. Borderline poverty issues. My family also was very helpful to people. That is a part of my view on the world and humans and the privilege I have. (Participant 6)

Category 1 (B): Client Interactions. This subcategory pertains to interactions with clients, including both positive and negative interactions, including overdose deaths. This category contained helping and hindering incidents.

Helping (69% participation rate; 15 incidents). Helping incidents in this subcategory focused on interactions with clients that produced a positive effect on their wellness. Themes regarding connection and bonding, successful helping interactions, and seeing clients doing well are illustrated with quotes below.

Connection and Bonding. Participants spoke about a sense of connection and bonding with their client as beneficial to maintaining wellness. One participant stated:

> We’re some of the few people who actually get to see who they really are and there's so much more than what most people see. Those were the moments where I felt the most joy and wellness. It feels special. It feels rare. I feel honored and privileged to be able to experience that with my clients. I really like being able to be that for them. I'm their worker but I’m also their friend and someone who can support them. I’m there with them on their worst days but I also get to be there with them on their best days because I’m the first person they call regardless. (Participant 4)

Speaking on an incident involving closeness with clients, another participant stated, “I’ve been there for eight years and they are family now. I feel filled with love sometimes coming in and just feeling I can be there in whatever way that looks like for them” (Participant 8). Speaking on the effect of connecting, another participant stated, “Connecting with people rather than working with people, moving at their pace fosters more successes with that person. That helps with wellness because you come away feeling great about your day” (Participant 12).

Successful Helping Interactions. Participants spoke about successful helping interactions as being beneficial to their wellness. One participant stated, “Any time I have a chance to feel like I’m helping my residents and doing a good job I think I have a positive dopamine reaction” (Participant 7). Another stated, “Being able to help someone get on income assistance or serving a meal and just being in process with them, its huge for my wellness. I feel effective” (participant 8).

Seeing Clients Doing Well. Participants spoke about incidents involving clients doing well as beneficial to their wellness. One participant stated:

> It goes back to having hope for them. They’re not just this person who struggles with addiction and mental health. They’re a mom and they’re a sister, and they have all these

> other sides to them that have been shut off and dormant. I like to think of them in hibernation sometimes when they're caught up in addiction. Then there are these pockets of them coming up and waking up. It's exciting to see that. That's quite encouraging and motivating for them and for me to see. I feel like then I have a purpose. (Participant 5)

Hindering (50% participation rate; 12 incidents). Hindering incidents in this subcategory focused on interactions with clients that produced a negative effect on their wellness. Themes regarding client overdose experiences and conflict with clients are illustrated with quotes below.

Client Overdose. Participants spoke about the negative effect of responding to client overdoses. One participant stated, "Witnessing a lot of death, responding to a lot of overdosing community members doesn't help. Incrementally, each one has a negative impact on me" (Participant 16). Similarly, another participant stated, "It destroys the illusion of safety. It's stressful and it's heavy and dark" (Participant 8). Echoing this, another participant stated, "I was heartbroken. I was just in shock. I couldn't function" (Participant 1). Speaking on a sense of dread about future overdoses, one participant stated, "We know that someone is going to overdose. It's just an awful feeling watching and waiting for someone to go down" (Participant 9).

Conflict with Clients. Participants also spoke about the negative effect of conflict with clients. One participant stated:

> When you've been at the receiving end of a lot of negativity. Throwing things at you, yelling at you, calling you every word in the book, and having a lot of negative energy thrown at you, you absorb that. You internalize it, so it impacts your relationship with

> yourself, but then it also impacts your ability to have relationships with other people. You get to this place of feeling angry and guilty and bad about yourself. (Participant 6)

Another participant compared ongoing conflict with participants to water erosion. They stated, “Ongoing exposure to people who aren’t doing well is like the water that keeps rubbing the rock and eventually erodes it. I think that the exposure without proper self-care erodes one’s wellness. One’s view of the world” (Participant 5).

Category 1 (C): Being Realistic about the Crisis. This subcategory pertains to accepting the extent of the crisis, the limited power of the worker to intervene, and avoiding taking responsibility for more than the worker is able to do in response. This category contained helping and hindering incidents.

Helping (38% participation rate; 12 incidents). Helping incidents in this sub-category focused on letting go of responsibility for what the participants can’t control and focusing on the help that they can provide. Themes that describe accepting the crisis and releasing responsibility are illustrated with quotes below.

Accepting the Crisis. Participants spoke about the need to accept their limited power to intervene. One participant stated

> The fact is this crisis is happening, and I can only do what I can do. That has been a really big piece for me around separating myself a little bit from this. Taking some weight off of a situation that feels hopeless, because there is a lot of things that happen in life that feel hopeless. There is also a lot of beautiful things. There is a lot of everything. (Participant 8)

Releasing Responsibility. Speaking on an incident involving releasing responsibility for stopping the crisis, one participant stated:

> I don’t have to carry the weight of the world or the weight of this community. I need to carry the weight of what I'm responsible for. When I’m able to recognise that on a daily basis I can get rid of the idea that I’m going to fix everything which eventually leads to disappointment and then more of those guilt feelings. Sometimes shit happens, and you can't always fix it because there’s more influences on the situation than just me. That’s that humility that eventually teaches me some wellness. (Participant 12).
>
> Echoing this, another participant stated:
>
> You tend to worry, you go home, you think about it, what's going to happen to this person? Should I have done this before I left? Then that sits with you for the rest of the night. You come back to work the next day, you feel stressed because you didn’t get a good night sleep because you're worrying about this client, and all that just builds up. Accepting that I can’t save everyone in this crisis helps with this. (Participant 9)

Hindering (6% participation rate; 1 incident). A single participant spoke about a hindering incident regarding difficulty in being realistic about the crisis. They stated:

> Feeling like I should be able to fix everything despite the crisis and not understanding why I’m not enough. It causes me to have a sense of unwellness and a jaded view of my client population. Cynicism comes into it and I’m no longer having unconditional positive regard. I’m not doing great work and it becomes this huge spiralling mess. (Participant 12)

Category 1 (D): Societal Recognition. This subcategory pertains to workers feeling their suggestions for maintaining wellness and addressing the crisis are heard and responded to as well as society at large recognizing the crisis and the role the workers are playing in addressing it. This category contained helping, hindering, and wish list incidents.

Helping (14% participation rate; 3 incidents). Helping incidents in this subcategory focused on hearing about similar work being done in the media, using social media to tell their story, and being recognized for the work. Participants described feelings of empowerment, excitement, and motivation in response to these incidents.

Hindering (25% participation rate; 3 incidents). Hindering incidents in this subcategory focused on the effect of a lack of societal recognition of the work. One participant stated:

> First responders in the newspapers, in TV, in everything does not include the work of support workers. We are actually first to respond but we're not defined as "first responders". We aren't recognized and so we don't have the amount of support that others do. Wellness suffers because of that lack of recognition and support. (Participant 8)

Speaking on the impact of not being recognized for the work, one participant stated:

> You feel like nobody cares. It almost feels like your effort is useless. It puts you in a very hopeless situation because you feel like you're not being seen and heard no matter what you do. It's not going to make a difference. It takes any sort of control away from you, and when that's gone, then what's left? (Participant 9)

Wishlist (37% participation rate; 7 incidents). Wish list factors associated with this category related to what participants wished in terms of societal recognition of the work. Themes regarding having their occupation recognized and positive media attention are illustrated with quotes below.

Occupational Recognition. Participants within this category spoke on the desire to have their occupation recognized by society. One participant stated, "I know that most people that are outside of this work have no clue and the newspaper is not shedding light on what's actually

happening and what we do" (Participant 8). Similarly, another participant stated, "Taking it out of obscurity. I think what would help. Acknowledging and naming it. This is a job. This is a defined title" (Participant 10).

Positive Media. Participants spoke on the desire for more positive media attention. One participant stated, "I want to feel proud about where I work because I have to put so much time into it. It would be sweet if there were more things to promote the organization and the identity of the organization" (Participant 13). Another stated, "If people outside of this community wouldn't be so fearful, if media didn't perpetuate the fear mongering that happens around people in poverty and substance users and those that are trying to help" (Participant 16). Speaking on the potential impact of increased recognition, one participant stated, "Sometimes, it's just a verbal recognition that would speak volumes. A sense of, 'We see the work that you're doing,' is nice to have" (Participant 5).

Category 1 (E): Crisis Intervention Policy and Practice. This subcategory pertains the effect of crisis intervention policy and practice on the participant's wellness. This category contained helping, hindering, and wish list incidents.

Helping (6% participation rate; 1 incidents). One participant incident involved crisis intervention policy and practice as being positive for their wellness. They stated, "I really like harm reduction and no judgement approaches. Feels much better than less accepting interventions. You're there to support and to help them get back up and it feels good to be with them no matter what they're doing." (Participant 13).

Hindering (63% participation rate; 20 incidents). Hindering incidents in this subcategory focused on the negative effects that crisis intervention policy and practice have on

participant wellness. Themes include the disappointment with the system, inability to intervene in ways that align with their values, and not being able to change policy and practice.

Disappointment with the System. Participants spoke on the negative effects of incidents involving disappointment with the system. One participant stated:

> It's not the clients that burn us out, it's the system that burns us out. It's not the fentanyl, it's not the drugs, it's not the addiction. It's poor housing and stigma and the way our clients are treated when they access medical services. We are working in a broken system. I would think about the system and all this that I was caught up in and I was really starting to experience symptoms of burnout as a result. (Participant 4)

Relaying a story in which they felt let down by the system, another participant stated:

> A big guy went down, and I had to get on him and breath for him. What felt like forever but was probably 10 to 15 minutes, paramedics arrived. He went to the hospital and they discharged him right back down here. I did my part and the system failed in response and that really makes me question how to keep doing this. (Participant 11)

Inability to Intervene in line with Values. Participants frequently spoke on the negative effects of not being able to intervene in ways that aligned with their values. One participant stated, "I was told I can't attend street overdoses. I am not choosing life or death for a person because they're just outside the building door. That was awful" (Participant 10). Another participant stated:

> It wasn't the opioid crisis that was contributing to my lack of wellness, but not being able to be genuine in the face of it and not being able to offer what I really did feel like I could offer. I felt pressured by that system to do what they thought was best but knowing in my heart that it wasn't what would actually help. It was horrible. It impacted my mental

> health, my drive at work, and my desire to do my job, my relationships with my colleagues, I began to feel resentful. When I went home, I remember just feeling guilty. I keep using the word dirty. A sense of shame. (Participant 4)

Not being able to Change Policy and Practice. Participants spoke on the negative effect of incidents involving being unable to change policy and practice. One participant stated, “We see this huge flaw, but there's nothing we can do about it. Powerless. I wasn’t allowed to speak about things like safe supply or how I felt this system could be hurting people and not helping them.” (Participant 4). Similarly, another participant stated:

> In the first two years of the fentanyl crisis, there was not a response from the health authority. People were dying, the intensity of work was increasing, and my coworkers were tapping out. It was pretty significant, because I felt like we had the capacity to respond but no one cared to hear it. (Participant 10)

Speaking very clearly on how crisis intervention policy and practice negatively affects his wellness, one participant stated:

> Not having a safe drug supply and people's callous interaction with the overdose crisis harms my wellness. The desire to cut funds to systems that save people’s lives when we lose minimum one person a day in this community harms my wellness. It just doesn't make any sense. You hear how this community is full of people that are wolves and its sheep all around the outside, and it's just bullshit. People actually just want the property down here, want the space, for development. This is the community that has the healthiest, not physically healthiest, but healthiest community membership due to reciprocity and resilience and activism. People here already know what their neighbours have to share. People here know if their neighbour is alive or dead. Outside this

> community, people are afraid to ask their neighbor for a cup of sugar and don't know if they're alive or dead. They're scared of human beings. Down here is an actual community. It's has all the points that a healthy, strong, vibrant community needs. If you don't think that losing 365 people minimum annually from your community due to accidental overdose because we can't provide safe substances for them to use as a coping mechanism for all the horrors that happened to them prior to this very moment is injustice, then we are failing as a society. People that disagree can take their moralistic belief systems full of fallacies and just stuff it. (Participant 16)

Wish list (25% participation rate; 5 incidents). Wish list factors associated with this category related to what participants believe would help in terms of crisis policy and practice. Themes regarding reduction of stigma, increased services, better coordination of crisis response, and client/worker informed policy are illustrated with quotes below.

Stigma Reduction. Participants spoke on reducing stigma and increasing services for their clients. One participant stated, "You have to accept the truth, you can't hide drugs and there are people who are going to do them. You just put them at risk. Why not just accept it and help keep them safe?" (Participant 1). Similarly, another participant stated, "Changes in drug policy, changes in the stigma around drug use. Losing the stigma would help" (Participant 10). Another participant stated, "The notion that this community is less worthy. If we had a little bit more money for the people, the struggles would shift and create ease in our community. Whatever eases the distress of the community, eases my work" (Participant 16).

Increased Services. One participant stated, "It is hard when people are ready and there's no detox space. If services were increased then you'd feel like you're not alone, it's not just staff that are trying to fight. It would feel like you're holding less." (Participant 5).

Better Coordination. Participants spoke about the desire for better coordination of services. One participant stated, “Coordinated response would help. Why aren’t we working with the other housing providers? Are we in some silo? If we’re collaborating, we could possibly affect some change for all of the staff that’s doing this work” (Participant 7). Similarly, another participant stated, “Knowing and being able to connect with other services is really encouraging. It brings a sense of togetherness and more of it would help. It creates a sense of we aren’t alone in this” (Participant 5).

Client/Worker Informed Interventions. Participants spoke about the desire for policy to be better informed by client and worker knowledge. One participant stated:

> Everything I have learned about the opioid crisis has been learned on the backs of people who are doing it for free and not getting paid and watching their friends die. I think listening more to them would help. When you're dealing with people’s lives and well-being it’s unethical to trial and error what’s going to work. By listening it would help us I would feel okay supporting this person in this way because I know from other people that it works, and it helps. (Participant 4).

Category 2: Social Support

This category brings together subcategories regarding social support. The following subcategories compromise the Social Support category: (a) Social Support from Non-colleagues; (b) Social Support from Colleagues; and (c) Professional Support Services. Taking these subcategories together, participant participation rates were 100% (45 Incidents) for helping, 75% (28 Incidents) for hindering, and 56% (14 Incidents) for Wishlist. The results from these subcategories will be reported below in detail.

Category 2 (A): Social Support from Non-Colleagues. This subcategory pertains to social support from non-colleagues. This subcategory contained helping and hindering incidents.

Helping (81% participation rate; 20 incidents). Helping incidents in this subcategory focused on social support from colleagues that produced a positive effect on participant wellness. Themes regarding support from family, from partners, from friends, from community, and from pets are illustrated with quotes below.

Family Support. Participants spoke on the helping impact of their families. One participant stated, “My family is better than any anti-depressant, any bottle of booze, or any pill or needle I could take because in the end it's not just about me anymore. My wellness is connected intrinsically to my family’s wellness” (Participant 12). Describing the impact of his children, one participant stated, “Seeing my little kids running towards me just to give me a hug. Having so much excitement for me, that’s just priceless and that takes my mind off things immediately. I’m feeling loved, feeling cared for” (Participant 9). Participants also spoke on the positive impact of visiting extended family. One participant stated, “I visit my mom and family, I cry a lot. They witness this broken part of me as I recover. Then I come back, and I’m together, and strong, and resilient. I’m glad to have that loving, supportive family” (Participant 10).

Partners. Participants identified helping experiences with their partners. One participant stated, “She talks about actually loving the people that we work with, and without that connection, that model of love, it can be impossible to believe. She models this through acts of understanding and love towards me” (Participant 16). One participant described acceptance from their partner as helping, “It always helps because he accepts me the way that I am. He doesn’t expect me to always be able to surmount all the difficult stuff. He’s patient and he is there for me” (Participant 7). Speaking on his wife helping with motivation, another participant stated,

"My wife is able to say, 'Hey, it sucks, but you've got a job to do, and you need to get back in the saddle.' She can step in and gets me moving when I'm down" (Participant 12).

Friends. Participants spoke about their friends as helping their wellness. One participant spoke about investing in friends and feeling lucky to have their support, "I've put a lot into my friend group, and I get a lot out. They'll lift you up and inspire you. If something crazy happens I can easily call, and they'll be there for me" (Participant 15). Another participant discussed having easy access to their friends through a group chat and receiving validation from the group. They stated, "We have a group chat in which we always talk every day. You just can send a text that you feel certain way. It's validating. Other people know how I feel and care. The validation is big" (Participant 13). Another participant stated, "Having people just say they're there for you. A lot of times I'll just be feeling down on myself and talking down on myself and having people just kind of like positive affirmation stuff, it's nice to hear" (Participant 2).

Community. Participants highlighted the community aspects of their friend groups as helpful. One participant identified feeling safe and understood within their community as helping their wellness, "A community of like-minded people. We work in different areas but are able to have therapeutic conversations. Checking with each other and we're just more thoughtful. That prevents burnout because all of our conversations have the potential to be therapeutic." (Participant 4). Speaking on his faith community, one participant identified a sense of purpose and of support as helpful. "They give me a purpose outside of work. A sense of mission, but also a sense of support that I don't have to tell them the details. I just have to tell them I'm struggling with something at work" (Participant 12).

Hindering (44% participation rate; 13 incidents). Hindering incidents in this subcategory focused on experiences related to social support from non-colleagues that did not

help participant wellness. Themes regarding isolating from others, hiding experiences and feelings from others, challenging relationships with non-colleagues, and non-colleagues who do not understand the work are illustrated with quotes below.

Isolation. Participants spoke about the negative effects of isolating themselves from others. One participant spoke about difficulties in managing energy levels and the need for social contact/outside activities. They stated, "Work can make me feel tired all the time and if I allow myself to stay inside and not do anything, it makes it worse. I don't spend time with anyone outside of work and I'm not as relaxed" (Participant 3). Expanding on the difficulty in connecting with others when not feeling well, another participant stated:

> It is really hard, because when you are processing loss, or you are depressed, or you're burned out, it is hard to connect with people, even though you really want to. Without finding a way to connect things get worse. I start to ruminate a lot. It's not very helpful, it goes to stupid, shitty places and I start to relive things, I start to get upset. (Participant 6)

Hiding Emotions. Similar to isolating themselves from others, one participant spoke on the negative effects of hiding their emotions from others. They stated:

> Pretending that nothing's wrong doesn't help. Thinking that I was powerful enough to deal with it on my own and realizing that nobody is. This stuff can only really be dealt with a community to help you. You can't do it on your own. Whether it's a family or a full-on community, without those things, you're left holding too much. Your backpack can't hold all of that comfortably, and that's when you start getting into the negative ways of dealing with it. (Participant 12)

Challenging Relationships. Participants spoke about the negative effects of a variety of challenging relationships with partners, family, roommates, and friends outside of work.

Speaking about the difficulty in caretaking their family while doing this work, one participant stated, “In my personal life, there's family illness and I was keeping the family together. That was very stressful. There was nothing that I was doing that was productive other than just throwing myself into work and my family” (Participant 11). Similarly, another participant spoke on the difficulty in managing energy levels while supporting a partner with mental health challenges, “Having to be someone’s everything, and always be super worried about whether or not they're doing okay. Sometimes I’d have days where I really don't know if I’ve got the gas for this’” (Participant 15). Speaking on challenging relationships outside of work in general, one participant stated, “What doesn’t help is if you have other relationships in your life that are negative. It’s just there’s too much emotional labor at work to also have negative, toxic personal relationships” (Participant 11).

Non-colleagues Who do not Understand. Participants spoke about incidents involving non-colleagues that do not understand the work as detrimental to their wellness. One participant stated, “When you try to open up to people about the work and they are not receptive. They don’t understand. You feel like they don't want to hear about work anymore or can't empathize. It can really push you away” (Participant 13). Echoing this difficulty, another participant stated, “I have a partner who sort of gets it, but doesn't at the same time, and he's a sensitive little muffin. It is not that he is unsupportive, but his lack of being able to understand fully can be frustrating” (Participant 6).

Category 2 (C): Social Support from Colleagues. This subcategory pertains to social support from colleagues. This subcategory contained helping, hindering, and wish list incidents.

Helping (63% participation rate; 20 incidents). Helping incidents in this subcategory focused on social support from coworkers that produced a positive effect on participant wellness.

Themes regarding debriefing with coworkers, collective memorials, supportive team environments, being able to rely on coworkers, learning from and teaching each other, and spending time together outside of work are illustrated with quotes below.

Debriefing. Participants within this sub-category spoke about the importance of connecting with and debriefing with understanding coworkers. One participant stated:

> When you're dealing with a crisis you switch into another mode. It's like another part of my personality kicks in and the vulnerable part of me becomes separated. It's like you're almost outside of yourself but it's good that another part of you is taking over. Everything disappears around you, and you're just hyper-focused on what you need to do. When you come out of an incident, and you're switching back into the vulnerable part of you that's when the reality of what happened kicks in. You're like, 'Oh, I'm not just mechanically doing the things I need to do to save someone's life, and actually I'm covered in someone's blood'. The real fear starts, but when you're able to talk to somebody who can really understand afterwards, you don't feel so alone, and it helps you share the weight of your experience. You can take a breath. There's something very powerful about someone being able to understand. You feel like things are going to be okay. (Participant 6)

Another participant described the debriefing process as preventing trauma. They stated:

> People who have been traumatized, those people isolate themselves and so many of the workers who work with them, their self-care is to isolate, but you're just mimicking the behavior that your clients are doing. So, I think it's so important to have that de-briefing because I need that processing with my coworkers to prevent trauma. (Participant 5)

Collective Memorials. One participant spoke about coworkers gathering together and supporting each other in honoring the people being lost as helpful. He stated,

> I host an annual collective memorial at my house. I think collecting the community is important. Culturally, we don't have a lot of mechanisms to deal with this much grief and trauma. We're really disconnected. I think that whole together thing. Front line workers, they're invisible and when we connect and support and honor our people and each other it's a good thing. (Participant 10)

Supportive Team. Participants spoke about the importance of being a part of a supportive team. One participant spoke about a number of benefits of a supportive team environment. She stated:

> We do a weekly debrief with our team. That practice I found, it's really helpful and it's just so normalized. We're encouraged to talk about ways in which we're struggling as people in the work that we do. I know that it's okay for me to leave a client and be really worried about them and I can talk about that with my team. It helps empower me to feel more comfortable. We are also asked what we need from the group before anyone responds, so we can say just to listen or for advice or whatever and that helps too. It is encouraging and validating and supportive. I think one more piece of our team debriefs is-- and I think this is common anywhere where you have a sense of openness, is that I can learn from others. I don't have to experience this difficult thing to learn from it, because it's shared openly. (Participant 4)

Reliance on Coworkers. Participants spoke on the importance of being able to rely on coworkers. One participant stated, "You feel supported, and you can rest with that. Not only the emotional support but support in terms of physical help. We share responsibility and it helps" (Participant 8). Similarly, another participant stated, "In this instance I could have been harmed

and my coworker helped me safely exit. It is very good for my wellness to know that I'm not on my own, my coworker has my back" (Participant 14).

Learning From and Teaching Each Other. One participant spoke about the benefit of working with more experienced coworkers:

> Any time there is a gap for me where I'm not responding regularly, I feel like I benefit from being with a more experienced coworker who I can watch intently with what they are doing, to get really re-acquainted with that type of a situation. In this situation I was feeling more relaxed because I was with someone that I knew was very experienced (Participant 8).

Another participant spoke on advising younger workers:

> I'm the old guy at work. People who are new come to me and are like, how did you even last this long? I just tell them, you got to just take care of you. You're not going to be any good to anybody else if you don't. You need to feed your sense of self. You need to take time to unplug from what we do too. I like being able to advice the younger workers in this way, makes me feel good. (Participant 12)

Time Together Outside of Work. One participant talked about the benefit of spending time with colleagues outside of work. They stated:

> It's nice to be able to be around people who know how fragile you could possibly be that day. You don't even have to talk about your day, they already know what kind of day you had. It's just nice to enjoy something, be happy, and be doing something with people from work that has nothing to do with work. (Participant 11)

Hindering (63% participation rate; 15 incidents). Hindering incidents in this subcategory focused on social support interactions with coworkers that produced a negative

effect on worker wellness. Themes regarding feeling unsupported by coworkers, burned out coworkers, and a culture of drinking with coworkers are illustrated with quotes below.

Feeling Unsupported. Participants spoke about the negative effect of feeling unsupported by coworkers. One participant stated:

> I had a colleague that after an incident say to me, "Oh, I saw you get punched. It was just a small punch. It wasn't much. Don't tell me you're going to call in sick tomorrow." For me, someone who never calls in sick, when I got home, I wasn't even thinking about the punch or the incident. I was more focused on what that colleague said. It was more painful than the incident itself. Situations like that, it crushes a person. (Participant 9)

Similarly, another participant stated:

> I called the building across the street and asked them if they would help me out. The person I spoke with wouldn't help me. I was livid, this was a life and death situation, and he was endangering me by not helping me, endangering this person's life and making my life a lot more stressful than it needed to be. (Participant 6)

Participants spoke about the negative effects of difficulty in communicating and feeling accepted by coworkers. One participant stated, "Sometimes I feel insecure, really expressing if I'm having a hard time with some coworkers. Like it's a sign of weakness somehow, it did not feel like a safe conversation at all. It feels a bit gross" (Participant 13). Another participant stated, "We got one person who doesn't listen to the rest of the team. Trying to get this person to understand, respect other people's opinions. We are all are affected by it. It's terrible" (Participant 14).

One participant identified non-constructive debriefing as detrimental to their wellness. They stated, "Not that you can't have moments where you're upset with the system, your job, but

I think when you're a big group of people going around telling horror stories. That gets me just overwhelmed. Why bother?" (Participant 5).

Burned out Coworkers. Participants spoke about working with burned out coworkers as detrimental to their wellness. One participant stated, "Occasionally I encounter coworkers that aren't helpful. You can tell that this person is dealing with their own burn out and it is spilling over into the job. It's not easy but it is so frustrating to work with that" (Participant 6). Speaking on feeling drained by burned out coworkers, another participant stated, "Anytime I'm working a shift where I have to put as much emotional labor into my coworkers as I do the people we're working for it's just taxing. There's only so much gas in the tank" (Participant 5). Speaking on trying to adjust to a burned-out coworker, another participant stated, "I would find that I was leaving the office to keep busy, just avoiding them, and that's also not fair to the residents and the clients. Just my stress is a lot higher" (Participant 11).

One participant spoke specifically on concern that work is not being followed up on by burned out coworkers. They stated, "It leads me towards becoming apathetic. If no one cares about this, then why should I care about it? I feel resentment and if I catch my attitude shifting that negative place, then I know my wellness is affected" (Participant 15).

Culture of Drinking. Participants identified a culture of drinking with coworkers as having a negative effect on wellness. One participant stated, "It's one of the reasons why I'm not feeling better in my wellness. The drinking culture. I wish that we could hang out and I'm frustrated about that. I want to see them. We survived a week" (Participant 7). Another stated, "Drinking is a big part of our workforce. It's always out for a drink after work. I don't do it as often and I don't have a strong social connection compared to other people that are going out drinking" (Participant 13). A third stated:

> My first boss said there's two things that will happen here. You'll burn out in 18 months or you'll follow my method: four pints before work, four pints after work. I was like, literally, you're telling me to get drunk before I come to work? He was like, well, you got a better way to deal with it? I was one of those workers where every weekend, we got together and got stupid drunk. That just doesn't work anymore. I can't do it. (Participant 12)

***Wish List (26% participation rate; 4 incidents*).** Wish list factors associated with this category related to what participants wished in terms of social support. Participants spoke on wanting more non-judgmental support, more team building, and the opportunity to share with each other what they have learned about maintaining wellness.

Non-judgemental Support. Regarding the desire for non-judgemental support, one participant stated:

> Being encouraged to talk about our good days and our bad days. It helps me to process and decreases shame, because you can know that other people are feeling it too, instead of me burning myself out trying to find ways to work through it. I wish we could have more support like this. (Participant 4)

Team Building. Regarding the desire for more team building, one participant stated:

> More team building things would help. Having moments together that have nothing to do with work can be really nourishing and supportive for the team. You can be really connected with a coworker because you've gone through something really traumatic. You can also have those connections outside those traumatic events that have nothing to do with your work that then support you in your role together. Stronger connection means stronger team, better work environment. It also means that when something happens that

needs debriefing, we have connections to tap into more easily, more naturally. (Participant 5)

Sharing Wellness Information. Regarding wanting the opportunity to share with each other what they have learned about maintaining wellness, one participant stated, "I'd like to be supporting that wellness and sustainability for front line workers because I know what it looks like. I've experienced it, witnessed it, endured it. I would like to be in that role" (Participant 10). Another participant stated, "I wish we could be able to provide more education and presence with each other. We should be meeting and teaching each other and able to provide more education and being more around the neighborhood with each other" (Participant 13).

Category 2 (C): Management. This subcategory pertains to positive and negative support, communication, and direction from management. This category contained helping, hindering, and wish list incidents.

Helping (44% participation rate; 8 incidents). Helping incidents in this subcategory focused on incidents with managers that produced a positive effect on their wellness. Themes regarding feeling supported by management and being inspired by management are illustrated with quotes below.

Support. Participants spoke about feeling supported by management as helpful in their wellness. One participant spoke about improving wellness by moving to a worksite with a manager known to be supportive of staff. They stated:

I chose to do a fulltime line at this site because people that work here actually give a shit, and so does the manager. The manager shows up and actually checks in on you and goes, "Hey, I noticed what you did there. Good job," and is supportive of staff. Having and

> knowing that you have a manager that has your back, that understands you, that is actually really helpful to the gig. (Participant 6)

One participant relayed the helpfulness of acknowledging their burnout to their management, feeling supported in response, and working through recovery together. They stated, "I acknowledged that I was burnt out to my manager and we came up with an initial plan to manage that. I was worried about the impact of taking time off, but it really helped. I wouldn't have done that if management hadn't been so supportive" (Participant 8).

Participants spoke about feeling heard by management in general as helpful. Speaking about approaching management with a list of requests for support and receiving a positive response, one participant stated:

> Sometimes you need to take a sick day because you need a mental break, stop asking me why. Just let me take a day without having to give you too much reasoning as to why. We can't work alone anymore, that sort of thing. That was a tipping point for management. People were on the fence about leaving, just they were done. It was too much. Management took our requests, and they ran with it, they responded to it. They did their best to meet everything that was on that. That was a big shift in the organization starting to catch up to a drastic change with this crisis and the demands that it holds with it. (Participant 8)

Inspired. Participants spoke about being inspired by management as helpful to their wellness. One participant stated:

> We're led by this fearless badass woman, and we're encouraged to stay angry, be angry, and that's good. If you're not angry, then you're probably not being yourself in some way or you're dissociating. She did our job for a really long time, which is why I think she's

> so amazing. When I think about how women are traditionally or historically expected to be, I feel like we don't have to be that way in our job. We speak out. (Participant 4)

Echoing being inspired by management having front-line experience, another participant stated:

> This is the only non-profit run by people who have physically, tangibly personally responded to this crisis. All of the other non-profits are run by people who haven't been in the dark, in the rain, turning over a person's body, not knowing if they're alive or dead or if they'll survive that moment. When you have done that many times a day over years, you treat the front-line worker very differently. Like you care about their experience. I feel that from this organization. (Participant 10)

Hindering (69% participation rate; 18 incidents). Hindering incidents in this subcategory focused on incidents with management that produced a negative effect on participant wellness. Themes regarding unhelpful debriefing, a sense of unavailability from management, unhelpful wellness directives, and not feeling heard are illustrated with quotes below.

Unhelpful Debriefing. Participants spoke about unhelpful debriefing with management as having a negative effect on their wellness. One participant spoke on receiving feedback after an overdose. She stated:

> I'm dealing with an overdose by myself and I'm trying to phone for help and Narcan him at the same time. Afterwards, while I was taking my break, management came up and provided feedback on how I could have communicated better. They interrupted me trying to decompress. I am trying to calm down from this horrible overdose and she interrupted me to tell me what I had done wrong. I was annoyed for a week. None of the

> management would ever work frontline in a place like this. It's frustrating when they try to criticize me. (Participant 3)

Echoing this frustration, another participant spoke on feeling that management puts too much blame on staff for challenging situations. This participant stated,

> They never talk about the staffing situation. They always talk about what you could have done differently. You should have been able to do more. You should blame yourself for this problem. It makes you feel even though you know you're doing so much you should be doing a lot more. That invalidation is so painful. (Participant 9)

Another participant spoke about this sense of it not being safe to tell management when they're not feeling well in the work. They stated, "People don't feel comfortable coming forward. As soon as you say you're not okay, your employer's like, 'Well, you're letting everyone down' They expect us to give so much but the minute you're not okay they're not supportive" (Participant 11).

Unavailability. Participants described the belief that management is unavailability as unhelpful. Speaking on feeling demotivated by a lack management attention, one participant stated, "An incident like that happens and you don't even get a call from your supervisor to see how you're doing. When you feel like you're not being seen, heard, acknowledged, you don't feel relevant or useful." (Participant 9). Another participant spoke on the perception that management is too busy and shouldn't be approached. They stated:

> If I reach out, my perception is, my managers are so busy, have so many things to do all the time that I don't want to be another thing for them to deal with. I just really don't look for the support from management. A lack of support from the workplace can undermine

> your belief in longevity of the work. I think I always had an idea that there was maybe an expiration date on this work for me and the lack of support is involved. (Participant 15)

Unhelpful Wellness Directives. Participants spoke about unhelpful wellness directives from management as hindering their wellness. One participant stated, “They’re like hey, what are some good wellness ideas? Well, hire more staff, give us a wage that's like a living wage. They’re like, no, we didn't mean it that. We meant yoga. It’s ridiculous” (Participant 11). Another participant spoke about frustration regarding being told that they are not doing enough self-care by her employer. They stated:

> I’ve experienced being told that I'm not doing my self-care to the standards of the employer, which I reject. The expectation like this idea of self-care, this model that has been imposed on us from outside of our actual experiences. Making people feel like they’re not doing enough for their self-care. We are doing the best we can and I'm not killing myself so that my employer is happy. (Participant 7)

Not Feeling Heard. Participants identified incidents in which they did not feel heard and supported by management as unhelpful to their wellness. One participant spoke on feeling management is unwilling to listen to workers. He stated:

> I know that senior management went through the China White crisis and the AIDS crisis. I respect that. I want them to respect that the opioid crisis is not the China White crisis and it’s not the AIDS crisis. It's another new crisis that they could be a bit more loving about. They need to be transparent with us, they need to communicate with us. They need to say, tell me about the opioid crisis. What’s it like for you to reverse multiple overdoses a day? But they’re not, they’re going, we did all this. We know. Completely decided that we're bullshit and they’re the only ones that know what’s going on. In return, staff are

> quickly shutting down, eroding confidence and feeling disrespected in a situation where our responsibilities are shifting. (Participant 7)

One participant spoke on feeling abandoned by management. He stated, “There was a time I could go to work knowing that they were fighting and supporting. Then that was gone, and it felt like an avoidance by the decision-makers to actually do something that would support our day-to-day experience” (Participant 10). Another participant spoke about incidents in which he felt that he is working for a mental health organization that does not consider staff mental health as much as it should. He stated:

> The unspoken expectation in support work is that the staff are invincible. There’s a hero-like expectation that we go through what we go through, we do what we do in a day and that when something tragic happens we're meant to like [whistles] show up to work the next day raring to go. The hypocrisy of working for a mental health organization and feeling like employee’s mental health is not considered as much as it should be. You can’t survive in this type of work feeling resentful of the toxic organization that you’re working for in the midst of some really intense things that are happening already. That’s a recipe for failure. (Participant 8)

***Wish List (25% participation rate; 4 incidents*).** Wish list factors associated with this category related to what participants wished in terms of management support. Incidents within this category focused on increased acknowledgment from management, and on management being more responsive to worker’s wellness wishes.

Acknowledgement. Participants spoke on the desire for increased acknowledgement from management. One participant stated, “Having more acknowledgment and actual human resource management would be so helpful. Having and knowing that your manager has your back, that

understands you and is also willing to acknowledge you is really helpful" (Participant 7). Another participant echoed this and suggested that increased check-ins and performance reviews would be helpful.

Responsive to Wellness Wishes. Participants spoke about the desire for management to be more responsive to worker's wellness wishes. One participant stated, "Show that they're willing to listen as though it's a new experience even if they don't feel like it is. People would feel like they had somewhere to take their distress. Offering support without putting a burden on people." (Participant 7). Similarly, another participant suggested that asking what structural supports would help worker wellness and respecting the suggestions would be helpful.

Category 2 (D): Professional Support Services. This subcategory pertains to counselling, crisis debriefing, workshops, and primary and alternate health care services. This category contained helping and wish list incidents.

Helping (31% participation rate; 5 incidents). Helping incidents in this subcategory focused on interactions with professional support services that helped participant wellness. Participants identified counselling services and body focused services as helping their wellness.

Professional Counselling Services. Participants described professional counselling services as beneficial to their wellness. Describing the effect of counselling services, one participant stated, "It's contributed to my overall and improved mental health. I look forward to discussing how I'm feeling with a professional. Valuing their feedback on it. Having suggestions for relieving work issues is a big help" (Participant 2).

Body Focused Services. Participants also described counselling coupled with body focused services as helping their wellness. One participant stated, "I have a therapist helps create a different more robust understandings of my experience. Coupling that with intense massage

work allows me to be in my body, the space to be healthy and let go of all the negative" (Participant 16).

***Wish List (31% participation rate; 10 incidents*).** Wish list factors associated with this category related to what participants wished in terms of professional support services. Themes regarding access to counselling services, professionally led debriefing groups, and more community supports for staff are illustrated with quotes below.

Counselling Services. Participants spoke about the desire for increased access to counselling services. One participant stated, "Having some real mental health supports, a chance of getting long-term therapy to deal with what we're going through. If we're able to deal with these things without prescription medications or substance use, it makes us healthier." (Participant 12). Another participant stated, "Increased actual access to counseling would be great because then you don't have to feel guilty like you're off-loading emotionally on friends or family" (Participant 15).

Debriefing. Participants spoke on the desire for professionally facilitated debriefing services. One participant stated:

> Having a debrief counselor and being able to come together as a group would help. I think I would have processed my stress a lot quicker about the incident. I was in crisis mode and trying to help keep someone alive. It took me a while to discern how do I feel about this. Doing it with another person that is a counselor would have helped me process that and then understand what I need. (Participant 6)

Increased Community Supports. Participants spoke about the desire for increased community supports for staff. One participant stated, "Whether it be yoga or fitness memberships, there should be community supports available free. That would help us who can't

afford to go to yoga. Also, availability at varying times so that people who work shift work" (Participant 12). Another participant identified low-cost daycare services as being potentially helpful. They stated, "Something to help alleviate stress because I have coworkers who are coming off of a nightshift and going to go pick up their kids. I'm like holy shit you're making little money and you just came off a nightshift" (Participant 11).

Category 3: Individual Strategies to Maintain Wellness

This category pertaining to participant's individual strategies to maintain wellness. The following subcategories compromise the Individual Strategies to Maintain Wellness category: (a) Mindfulness, Grounding, Emotional Processing, and Spiritual Practices; (b) Physical Activity and Diet; (c) Creative Expression; and (d) Substance Use. Taking these subcategories together, participant participation rates were 100% (55 Incidents) for helping, 81% (22 Incidents) for hindering, and 31% (8 Incidents) for Wishlist. The results from these subcategories will be reported below in detail.

Category 3 (A): Mindfulness and Spiritual Practices. This subcategory pertains to mindfulness and spiritual practices used to help workers mitigate stress or maintain positive wellness. This category contained helping, hindering, and wish list incidents.

Helping (75% participation rate; 26 incidents). Helping incidents in this subcategory focused on the positive effects of various mindfulness and grounding techniques, processing emotions, and spiritual practices. These themes are illustrated below with participant quotes.

Mindfulness and Grounding. Participants spoke about the importance of mindful awareness in helping their wellness. Illustrating this process, one participant stated:

> I need to start being curious with whatever is going on with me internally. Watching and witnessing my internal dialogue and reactions constantly from a detached state of

> curiosity. Whether it appears as positive or it appears as negative, really in that level of creating some degree in separation to see and study myself helps. (Participant 8)

Numerous participants described incidents involving using breathing techniques to ground, be present, and be mindful. One participant stated, “It’s another tool to bring me back to the present and myself. Certain clients where they're super intense and angry and shouting. When they're shouting at me or whatever, I try to breathe through it” (Participant 8). Another participant stated, “It’s easy to get caught up in a narrative and negative feelings. Let’s just focus on the breath for a minute. That ability to separate and disengage from that for a bit helps me to calm down.” (Participant 6).

Participants spoke about the importance of involving their bodies in their mindfulness practices. One participant stated:

> The fact that I’m not burning out has 100% to do with the bodywork. It’s in the peace of being present in my body and coming back to my body and getting out of my head. What about it is helpful is resting into your physical, being present, and how that presence allows you not to be influenced or allows you to be with what is. It’s the reminder as well that there's more life than this and life goes on. Because I think when you're lost in a situation like that or in any kind of emotional response or reaction, that’s the only thing that is in those moments. You’re wearing sunglasses of that, and you’re back there on some level. This is one thing that kind of starts that process of maybe shifting. Even if it's moments or glimpses of feeling that there's something more happening, that I’m not just this. This isn’t all that's happening. There’s a shift” (Participant 8).

Accepting and Processing Emotions. Participants spoke about helping incidents involving accepting and processing their emotions in a conscious, mindful way. Speaking on

letting themselves feel sadness regarding the work, one participant stated, “Acknowledging the depth of grief in myself. I always make sure at the end of the day we’re not avoiding sadness. Not letting things stick to us. It’s okay to cry. It’s healthy to be deeply sad” (Participant 10). Speaking on the effects of letting herself cry another participant stated:

> Even as a little girl, if I get upset, until I cry, it was never over for me, so it’s not a bad thing, it’s your body processing it. I feel like the tears help just to unload. I feel relaxed. You’re just loose like I’m okay, where before it’s like you're holding something and then your body, like your muscle's all relaxed. (Participant 5)

Participants spoke about the importance of humor and laughter in processing tragic events. One participant stated, “Being able to laugh and crack jokes about the most tragic things. Finding a lightness or a lack of seriousness. Remembering that life isn’t serious even if it appears to be really helps” (Participant 8). Speaking on the effects of letting herself laugh, another participant stated, “When you’re in the moment I think the adrenaline you just let it out somehow. It’s a relief. It’s like the calming down part. I think the laughing it gets you back down” (Participant 5).

Participants spoke on accepting their feelings as important to their wellness. One participant stated:

> When I wake up in the early hours and I’m feeling scared of what’s going to be happening the next day I do the aware of the feeling thing. It’s perfectly reasonable to be scared sometimes with stuff that might come up. I just say, ‘Yes, this is okay. It’s reasonable to feel this way.’ Just be present to that feeling and do nothing with it and often I go back to sleep. If I fight it, it's exactly the opposite. It’s the same with the anger or depression or whatever. If I’m trying to tamp it down, it will strengthen. If I make

> myself aware of it, observe how it feels, and do nothing, the internal energy that's driving it just-- your body will only keep doing that for so long, and then it stops. (Participant 12)

Spiritual Practices. Participants within this subcategory described helpful incidents involving using spiritual related practices in ways matching mindfulness and grounding. One participant stated:

> I used to try and self-medicate and not feel the feels, that just allowed things to build up in a trash bag of feelings that eventually just overflowed into this stinking mess. For me, being able to feel things as they're happening and to process them and to pray through them and give them up to somebody that I view is greater than myself takes away that sense of responsibility and that guilt or that shame for not fixing it. (Participant 12)

Speaking on the effect of smudging, one participant stated "I found it to be incredibly healing, incredibly powerful. It just was really beautiful, healing, and honoring. Spiritual experiences I think are hard to verbalize but it helped me let go of things" (Participant 4).

Bringing elements of each theme within this subcategory together one participant stated:

> I get into the ocean and I just leave all the heaviness there. It's no longer mine. Just an engagement with my physical body and the reality of the capacity of the ocean to hold all the anxiety and the stress and all the other people's stories. I don't need to carry all of them. I'm firmly back to the present. It's a big enough vessel to hold all the weird shit this work requires. (Participant 16)

Hindering (19% participation rate; 4 incidents). Hindering incidents in this subcategory focused on the negative effects of being stuck in specific states, or avoiding thinking, feeling, and processing. Themes regarding feeling stuck in difficult emotions or events, and avoiding thoughts and feelings are illustrated with quotes below.

Participants spoke about the difficulty involved with specific challenging emotion states. Speaking on anger, one participant stated, “There’s a lot to be angry about, but if you sit there in that anger for too long it can consume you. Allowing that anger to take over, it’s not useful, is not helping anybody” (Participant 12).

Participants spoke about the negative effects of being both being lost in an emotional response, and also of trying to avoid responses altogether. One stated, “My brain is stuck in a story or event. I think when you're lost in any kind of emotional response or reaction, that’s the only thing that is in those moments and it doesn’t help” (Participant 8). Another said, “When that TV goes off, you’re left alone with your thoughts, now you got to deal. It’s a good sign if I'm watching a ton of TV that I'm trying to avoid something. It doesn’t help at all” (Participant 12).

Wishlist (19% participation rate; 4 incidents). Wish list factors associated with this subcategory related to what participants thought would help in terms of Mindfulness, Grounding, Emotional Processing, and Spiritual Practices. Participants outlined the desire to spend more time meditating or engaging in Indigenous healing practices.

> One participant spoke clearly on the desire for more self-compassion. They stated:
>
> We want to do our best and be there but sometimes, because we’re human, we can’t always be that way, so we feel bad about ourselves. We’re hard on ourselves if we're not doing enough. We're not changing the system. The over identification with the job and really being dedicated to it. I’m not enough. I’m not doing enough. I’m not right. Is there something wrong with me? How can we frame it so that you can just sit with yourself and sit with your suffering and give yourself what you need? Give you the worth, the care, the love and the kindness that you need in that suffering right now. The self-compassion work might be helpful to help process and reconcile these feelings” (Participant 6).

Category 3 (B): Physical Activity and Diet. This subcategory pertains to exercise, use of physical activities to maintain wellness, eating habits and diet. This category contains helping, hindering, and wish-list incidents.

Helping (63% participation rate; 16 incidents). Helping incidents in this subcategory focus on the positive effects of physical activity and diet on their wellness. Themes regarding exercise, diet, and care for their bodies are illustrated with quotes below.

Exercise. Participants within this subcategory identified helping incidents involving exercise. Speaking on the helpfulness of exercise during the workday, one participant stated, "I go in the middle of my day. Even if I'm having the shittiest day, the minute that I get halfway through working out all of that is gone" (Participant 16). Speaking on the power of exercise to take his mind off of work, another participant stated, "I knew at that point that even though I had things to do I had to put everything aside. When I came back, I felt tired and good. My mind wasn't constantly on work. That helps me" (Participant 9).

One participant spoke specifically on the power exercise has to help in letting go of vicarious trauma, they stated:

> If you're exposed to somebody's trauma, physically moving allows that trauma to move too. Here I am at the gym and having a moment with my body. I'm really strong. It's just a moment of tapping into me. When you're exposed to people over and over who are not doing well, I wish I could change it for them and that's kind of out of my control but what's in my control is I can take care of this body. This body is the body that's going to keep helping them. (Participant 5)

Diet. Participants spoke on the positive effect of maintaining a healthy diet. One participant stated, "When I make my own food and bring it to work, I feel more grounded. It

gives me a sense of purpose as well. All around I feel better when I do it" (Participant 2). Another stated, "Eating healthy helps because then I have energy and I feel good about myself. I have control. I feel some agency to take care of myself" (Participant 13).

Hindering (19% participation rate; 7 incidents). Hindering incidents in this subcategory the negative effects of poor diet and physical care. Themes regarding not eating at work, diet as a negative coping strategy, and not getting enough sleep/exercise are illustrated with quotes below.

Not Eating While Working. Participants spoke about the negative effects of not eating while working. One participant spoke on the increased difficulty in supporting clients when hungry, stating, "If I have a challenging client in my office and they're just going and going, and I haven't eaten anything and I'm at my breaking point I'm already irritated it just really is not good" (Participant 3).

Diet as Negative Coping. Participants also spoke about using food as a negative coping strategy. One participant stated, "Eating was one of my coping mechanisms. I was unwell, I would stop at a shop, grab three donuts, three or four days a week. It turns out that that many donuts really put you in a bad place" (Participant 16).

Lack of Sleep/Exercise. One participant spoke about a negative cycle involving not caring for their physical health. They stated, "Not sleeping properly, not getting enough exercise. They're interconnected. Work can become an excuse. I'm too tired to eat well or exercise but then I don't sleep well either and it cycles" (Participant 7).

Wish List (14% participation rate; 2 incidents). Wish List factors associated with this category related to what participants wished in terms of physical activity and diet. Participants spoke on the desire to exercise more and heal from physical injury.

Category 3 (D): Creative Expression. This subcategory pertains to the use of creative expression to help workers mitigate stress and maintain positive wellness. This category contained helping and wish list incidents.

Helping (38% participation rate; 7 incidents). Helping incidents in this subcategory focused on the positive effects of making and engaging with creative pursuits. Themes regarding making art, connecting with others through art, and engaging with art as self-care are illustrated with quotes below.

Art. Participants spoke on creating a variety of types of art, including writing and performing plays, making music, writing in general, various forms of visual art, and in one case, gardening. One participant stated:

> I'd be in the moment where I'm creating something, and that's just nice on its own. There's something rewarding about it in that sometimes you have unsuccessful things at work happen and just all these blocks and barriers, but then on the inside you can also do this creative thing and this taps into another part of me and that gives me energy which then translates into energy going back to work and dealing with the uncomfortable or the harder thing. It's nourishing. The creations build a form of resiliency that I can bring, indirectly, into my work afterwards" (Participant 5).

Connecting with Others Through Art. Participants spoke on connecting with others through making art together or engaging with a community of artists as helpful. One participant stated, "It gives me a sense of purpose. I'm engaging in something that I'm passionate about. As a bonus when there's a lot of other people playing music together, it's cool to be part of that, a sense of community" (Participant 2).

Wish List (14% participation rate; 2 incidents). Wish list factors associated with this category related to what participants wished in terms of creative expression. Participants specifically spoke on the desire for more time and space to be creative.

Category 3 (D): Substance Use. This subcategory pertains to substance use and its effects on worker wellness. This subcategory contained helping and hindering incidents.

Helping (38% participation rate; 6 incidents). Helping incidents in this subcategory focused on the positive effects of substance abstinence or use on worker wellness. Themes regarding substance abstinence and cannabis use are illustrated with quotes below.

Abstinence. Participants within this subcategory spoke on the positive effects of abstinence. One participant stated:

> They acted as barriers between not only myself and my feelings, but myself and my clients that I was engaging with. When I switched from trying to medicate to finding more healthy ways to give up the feelings of worthlessness or incompetence or any of those things that come with this work things improved. (Participant 12)

Cannabis. Participants spoke on the positive effects of cannabis use. Speaking on cannabis helping them let go of anxiety, one participant stated, “I’ve found that cannabis products assist with my anxiety. They do help. I’m able to relax and let go of my worry” (Participant 16). Another participant spoke on cannabis helping him disengage from work, stating, “I find that helpful to me, because it can help me disengage from work and engage in something else. I get really interested in something and I engage with it really easily.” (Participant 6).

Hindering (63% participation rate; 11 incidents). Hindering incidents in this subcategory focused on the negative effects of substance use on their wellness. Themes regarding alcohol use and cannabis use are illustrated with quotes below.

Alcohol. Participants spoke on the negative effects of alcohol use. One participant stated:

> You're drinking, then you're hungover, and then you want to eat all the crap. It's just a terrible cycle. It's not a good coping mechanism but like when you've just had a crap day, you go home and have a bottle of wine, and then that is the norm, then it's two bottles of wine, and then you're like, okay, this is bad. (Participant 11)

Speaking on social pressure and the effects of drinking on the work, one participant stated:

> It's a very common thing to go and drink about work with your coworkers. That's the traditional thing that a lot of people do. You all get drunk about it. Really hungover at work the next day and having it contribute to feeling unwell. You don't have the same kind of empathy levels that you maybe normally would. (Participant 2)

Participants within this subcategory also spoke on the negative effects of cannabis use. One participant stated, "Weed is a band-aid. It'll be helpful in that it can turn my mind off and give me instant relief to mental anguish, but it takes away my ability to be productive at all in my personal life" (Participant 2).

Category 4: Work/Life Balance

This category pertains to participant efforts to maintain separation between their work and personal lives, as well as difficulties experienced in accomplishing this. This category contained helping, hindering, and wish list incidents.

Helping (81% participation rate; 41 incidents). Helping incidents in this subcategory focused on efforts to maintain separation between their work and personal lives that are helpful to participant's wellness. Themes regarding boundaries, second jobs, taking time off, taking vacations, getting outside, and family are illustrated with quotes below.

Boundaries. Participants spoke about helping incidents involving maintaining boundaries regarding what they engage with in their personal lives. One participant stated, "I'm able to make boundaries around client stories so I'm not still focused on it when I'm at home. I just think it's very adaptable to leave those stories at work" (Participant 11). Speaking on the impact and function of boundaries of this kind, one participant stated:

They promote work-life balance especially. I'll come home and say to my partner, "'If we're going to watch a movie, it has to be a funny movie. I don't want to watch some dark movie about addiction.' I see a lot of trauma all day, and I need to step away from it at night. Even something as seemingly small as a movie, it all lands. Especially in BC where we're considered ground zero for the opioid crisis. You can't open a paper or turn on CBC radio or watch the news without something. I'm careful to limit my exposure to media portrayals and representations of what's happening, because I can't work all day and then go home and see something there too. (Participant 4)

Describing boundaries regarding work talk, another participant stated:

> Having a container for work stuff helps. I went out last night after work and we said, "Okay, we'll have 10 minutes of it, and then we're going to put it aside" A short vent/debrief session and then boundaries around work talk. There are some other great things that are happening in the world and for yourself that you need to pay attention to.

> Funny stories and successes are okay. Nothing that ends with another task on the list. Nothing that takes us away from being away from work. (Participant 5)

Speaking on the impact of having boundaries around work talk, another participant stated:

> Going out with my friend and talking about things that have nothing to do with work was really helpful because you realize that there's things in the world other than the issues and the challenges that the community members that we work with are facing every day. It recharges you and gives you a sense of that hopeful life-affirming quality. Being able to laugh and have some brevity, some lightness. It brings me out of myself and that is very helpful. (Participant 6)

Participants identified intentionally engaging in non-work activities as helpful in maintaining these boundaries, one participant stated:

> I participate in a book club that helps. Then there's no work talk so another part of me is coming up. Not that I want to forget about what's happening, but it can just be so taxing when that's all you're thinking about. I feel like there needs to be sometimes these breaks where my other non-helper parts are being accessed. I think that nourishing new ideas, new ways of thinking about things, balance. (Participant 5)

The boundary supporting activities that participants described were not always social. One participant stated, "When I get home, I try and just turn my mind off of work usually by watching something funny. It lets me turn off from feeling stress that comes with thinking about a lot of the aspects of work" (Participant 2). Another participant stated, "Reading for pleasure helps a lot. It's a nice escape. That's the only thing I'm thinking about. It's just you and your book" (Participant 11).

One participant spoke on being intentional in creating rituals that help her leave work at work. She stated:

> I have end of the day rituals where I transition out of work. I'm conscious during my walk home as I leave the neighborhood. With that moment of just reflecting on the day, and then letting it go. Now I get to have my evening doing something else. I'm refueling with stuff outside of work so that tomorrow I have the energy to do it again and be there. (Participant 5)

Second Job. Participants spoke about maintaining a second job in a less stressful environment as beneficial to their wellness. One participant stated:

> I have a second job in a place where I am not having my fight or flight triggered. I don't need to be on some internal level reacting to every noise as if I'm going to have to respond to it. I think one thing about this work is you're managing people's survival. This second job is somewhere where I'm surrounded just by beautiful objects. It's just another reminder that there's more than just the survival and limitations at work. (Participant 8)

Similarly, another participant stated, "I have a second job because I think having purposeful engagement aside from my main work is healthy. When I'm just doing this job it becomes my life and my other job balances that" (Participant 13).

Similar to maintaining a second job, participants spoke about seeking out experiences to balance out stress at work. One participant stated,

> I work with all these women who get abused and assaulted by males and then I'm like, "Oh my god men are terrible." But no, men are not terrible. There are good men in the world. So, I seek out positive experiences with men in my personal life to create some separation from that. I selected a male physio so that I can have a positive relationship

with a male for instance. I think it gives me hope to seek out positive experiences outside of work. (Participant 5)

Time Off. Participants spoke about the beneficial effects of taking time off of work. One participant stated, "Because our work is so specific in assisting others, you're not taking time to think about yourself. Taking time off and focusing on your life helps. Applying the same tactics that you do for other people on yourself" (Participant 2). Speaking on taking mental health days away from work, another participant stated, "The next morning I'm so ready to be 100% there, present. A mental health day is what I call it, just time for you. They are so important and so restorative" (Participant 5). One participant talked about the renewing effect of taking an extended break from work. They stated:

> I took a month off and I was worried about how that might impact my survival because I was making half wage on sick time, but after a few days the ability to reset by starting to do things for myself, going for walks, doing yoga and just being away really refreshed my perspective. There's a renewing quality to it. (Participant 8)

Vacations. Participants spoke on taking vacations as benefiting their wellness. One participant stated, "To unplug from what you do, and not use your vacation just to sit time through. Realize that there's more to life than what I do, and there's more to me than what I do during vacation" (Participant 12). Another participant echoed this in talking about getting out of the city. They stated, "It takes me away from the environment I work in too. It's nice not to see so much crisis everywhere, and to not see my clients, to have my own life" (Participant 3). One participant stated, "It has a very boosting, energizing effect on my wellness. I come back to myself outside of work" (Participant 15).

Outdoors. Participants talked about being outside and in nature as helping them separate from work in a positive way. One participant stated, “There’s something different because I spend a lot of time in this neighborhood. I don’t get much separation from it. Getting a little separation from that and getting out into nature helps” (Participant 10). Echoing the benefit of this separation from work through being in nature, another participant stated, “When I’m out in nature I feel like I’m being purified because the air is so clean and it’s shaded. It is so peaceful and beautiful, and I always feel better when I’m in there. It’s removed from the work” (Participant 13).

Family. Connecting to the *Social Support* category, participants spoke about their family as a part of maintaining work/life balance. One participant stated, “Having the structure to be a dad, to be responsible for someone else, not spend my days off in bed watching TV, drinking too much, or decompensating because I’m just thinking about work. I keep good boundaries for them” (Participant 10). Echoing this, another participant stated, “I do have a family to be respectful for. My wife, she’s really good at asking me to stop work. Let it go, sit with me to have a conversation, walk the dog, watch TV” (Participant 14). Speaking specifically on his kids as helping him separate his own time from his work time, one participant stated, “Coming back to my family, playing with the kids, run around the house until tired. That for me is so therapeutic. Those little things that help me step back and say, this is my own time” (Participant 9).

Hindering (63% participation rate; 20 incidents). Hindering incidents in this subcategory focused on challenges to work/life balance that produced a negative effect on their wellness. Themes regarding not taking breaks while working, working too much, thinking about work all the time, and over-identifying with the job are illustrated with quotes below.

Not Taking Breaks. Participants spoke on the negative effects of not taking breaks while working. Speaking on the effect of not being able to take a break after an overdose, one participant stated,

> An incident like that happens you can't just say, "I need a break. I need to go home" because it's almost like you're expected to understand that this is what you signed up for. You just have to deal with it because there is more to come. After a while it almost seems like you get desensitized to it, you almost stop to see the human in these people. You become very robotic, you just go in there and do what you have to do and leave. You almost stop being able to break out of work mode at all. (Participant 9)

Speaking on feeling that she is unable take a real break, one participant stated, "I feel choice-less, not being able to step away for a breath. I could not go on my lunch break, for example. In fact, I didn't really know where there would be lunch on any given day" (Participant 8). Speaking on needing time to herself to recharge, another participant stated, "My position is so emotionally draining. I need even half an hour to just be by myself because sometimes it is from 8:30am to 6:00pm that I'm just seeing people in crisis. It's too much but it happens" (Participant 3).

Working too much. Participants described incidents regarding working too much as detrimental to their wellness. One participant stated:

> You can't attend to the job in the same way when you're overworked, when you've been spending too much time at work, because you don't want to engage. It is a very challenging job to be in if you don't always want to be there. The whole purpose of the job is to have relationships with people and if you are in a shitty mood it will come right back at you. Resentment builds and the work gets harder. (Participant 6)

Thinking About Work all the Time. Participants spoke about the negative effects of thinking about work all the time. One participant stated:

> On the weekends when I'm reading about work stuff and seeing it on the news, it's like I never leave and so I'm always kind of in that less refreshed place. It really makes me feel it is the whole world, that's all there is, just overdose epidemic and photos of needles all the time and all this stuff. No break, no reset. You could be out for lunch somewhere but still talking about these things. Seeing them in your head all the time. (Participant 13)

Speaking on the effects of taking work concerns home, another participant stated:

> There are instances where a client is clearly vulnerable at the end of your shift, and you worry about their safety. You go home, you think about it, what's going to happen to this person? That sits with you for the rest of the night. You come back to work the next day, you feel stressed because you didn't get a good night sleep because you're worrying about this client, and all that just builds up. (Participant 9)

Participants identified being on call as similarly detrimental to their wellness. One participant stated, "Over the last year so many people dying, I was waiting to get the phone call all the time because I'm on call. I feel like my whole life is being sucked up. That made me feel actually crazy" (Participant 13).

Over-identifying with the Work. One participant clearly stated the negative effects of overidentifying with his work on both himself and for his clients. He stated:

> I'm <participant name> and I'm a father. I'm <participant name> and I'm a husband. I'm <participant name> and I'm a proud member of a faith community. I'm <participant name> and I'm a heartbroken member of humanity. There are all sorts of things that I am. Only one of them is case manager, and to limit myself in that way limits the way I see my

> life. That's what can get you down that spiral. It is not having that perspective of there's more to me than what I do at work. It's the same thing when we label the people we work with. You're a drug user, you're a homeless senior. No, they're a senior who happens to be homeless or a person who happens to abuse substances. That's not all they are. They're often somebody who can paint or can drum or can sing amazingly. There is so much more to the people that we write off and also within ourselves because we've overidentified with one aspect. (Participant 12)

Wish List (37% participation rate; 6 incidents). Wish list factors associated with this category related to what participants wished in terms work/life balance. Participants spoke on having more time off and wellness events outside of the work neighborhood.

Time Off. Participants spoke on taking more time off as potentially beneficial to their work/life balance. One participant stated:

> It's worked in the past, and it'll work again. Not having to worry about work responsibilities and being able to totally relax and not have the upcoming workday or work week in the back of your mind constantly, or everywhere in your mind. Our work is so specific in assisting others, you're not really taking time to think about yourself. More of that would help. (Participant 2)

Wellness Events Outside of the Neighborhood. One participant spoke on wellness events outside of the work neighborhood as potentially helpful to their wellness. They stated, "Often to support wellness management wants to throw a big party the neighborhood. Well, I'm not going to come to that. No one's going to come to the Downtown East side on a day off or after a 12-hour shift" (Participant 11).

Category 5: Structural Supports

This category pertains to pay, benefits, work conditions, organizational infrastructure, staffing levels and availability, and security in the job. This category contained helping, hindering, and wish list incidents.

Helping (25% participation rate; 11 incidents). Helping incidents in this subcategory focused on incidents regarding pay, benefits, labor practices, and job security that produced a positive effect on their wellness. Themes regarding union membership, stable full-time work lines, and benefits/sick pay/vacation pay are illustrated with quotes below.

Union Membership. Participants in this category described incidents involving a positive effect on their wellness related to union membership. One participant spoke about union related job security and the flexibility to leave and come back to a position. She stated:

> The union speaks of it like you own this job, so I can take a temporary position anywhere with <employer> and always come back. If I feel like I'm burning out, or if I need to step away, I can do that, and then, come back to this job. I don't have that sense that if things get difficult, I have to leave and abandon these clients that I love and the job that I love for my own well-being. (Participant 4)

Another participant spoke about appreciating the predictability of having a collective agreement and incident guidelines. They stated,

> I love collective agreements because I don't have to try to figure out what's fair. I just look it up, this is what we do. I don't have to try and decide when something comes up. Similarly, occasionally I help by producing a summary document of what to do in the case of specific incidents. It feels good to try to help others know what procedures to follow in a given situation. (Participant 14)

Full-time. One participant stated that receiving a full-time work line that facilitates his parenting schedule had been helpful for his wellness. He stated, "I got a full-time line because of my parenting schedule, I had to apply for it over the course of two years. Having the space for my kids given to me by this regular set schedule really helps" (Participant 10).

Sick Days/Benefits. One participant stated that receiving sick days and benefits has been helpful for their wellness. They stated, "For the first time ever I have sick days and benefits. What is this insane perk of being able to take a paid day off? Physio and massage are so important for me in my health. Benefits help my wellness" (Participant 15).

Hindering (69% participation rate; 28 incidents). Hindering incidents in this subcategory focused on incidents regarding pay, benefits, labor practices, and job security that produced a negative effect on their wellness. Themes regarding insufficient staffing, working overtime, lack of training, labor practices, and insufficient pay are illustrated with quotes below.

Staffing. Participant incidents in this category often centred on a lack of sufficient staff as hindering their wellness. One participant described the difficulty in not having enough staff to respond to multiple simultaneous overdoses. They stated:

> There was an overdose happening out front and then even while we tried to attend to this young man who didn't make it, we were being called to go attend to other people at the same time. We had four people already overdosing, and the policy is that attend in pairs. How can we go in pairs when we have five people working? (Participant 9)

Describing the effect of incidents like this on himself, the participant went on to say:

> You start thinking about yourself. Like what could I have done? Could I have been able to get there in time? If I had gotten there in time, maybe this wouldn't have happened. I forget that this is a staffing issue and I start to blame myself. (Participant 9)

One participant described the quality of care in her work building going down overall due to staffing shortages. They stated, “Just over the last weekend there were five overtime shifts call outs and no one showed up. It’s just bleak and then the building gets bleak. The quality of care goes down with just one person around” (Participant 11). One participant described the effect of chronic single staffing as, “I feel like overwhelmed and frustrated and less able to have any task completion satisfaction” (Participant 13).

One participant spoke about the demoralizing effects of not being able to find staff that will work even for overtime pay. They stated, “Spending time begging people to come in for overtime and they won’t. It also makes me feel the job that you have is so undesirable that literally nobody will do it even for overtime pay” (Participant 13).

Working Overtime. Participants identified incidents involving working overtime as hindering their wellness. One participant stated:

> I realized that around the 12-hour mark I’m not as decent a human as I was when I began my shift and I know that it’s going to have a ripple impact, so I try to avoid excessive working because it just doesn’t benefit anyone. Unfortunately, there are certain sites that are having staffing challenges. I've neglected to pick up shifts at those places if I think I’m going to get stuck there for 16 hours. I, generally speaking, would rather be mentally well than make that money. I learned that the hard way. (Participant 15)

Training. Participant described incidents involving a lack of training or feeling new to the job as hindering to their wellness. One participant described an incident in which they had to put an oral airway into an overdosing client without having been trained on the procedure. They stated:

> The guy was not breathing, he was very stiff. I pound the bag valve mask and I'm doing the squeezing and there wasn't any air going in. We got out an oral airway and I'm thinking I have never put in one of these damn things but holy crap, it went in. We gave him the Narcan and continued breathing for him, then started seeing a couple breaths come on his own. This one stuck out because we were supposed to have trained to do this, and I had not even observed it being done. We succeeded though but wow really not ok. (Participant 14)

One participant described an incident involving a lack of experience and training while responding to her second overdose. She stated:

> I was basically just frozen. I had everything in my hand, but I hadn't actually done this before really. I knew the woman who went down and for how bad the OD was and having built some level of rapport with her over the last few years, it was like one of those ones that would've I think affected me more deeply if she didn't make it. Fortunately, she did but it really shook me. (Participant 15)

One participant described the impact of being new to the job and feeling incompetent. They stated, "I get butterflies and the little voice inside my head goes, 'You're not good for this job. You can't do this.' Then I start feeling sick." (Participant 5). Similarly, participants identified incidents in which coworkers are not well trained or experienced as hindering. One participant stated:

> I was getting constantly scheduled with brand new casuals all the time so I was never really able to take a break at all because I couldn't leave this brand-new person by themselves. If somebody overdosed, they wouldn't be able to respond to it. It's just more

> stress and anxiety and feeling unsupported. Not really giving a lot of faith to my employer. (Participant 2)

Labor Practices. Participants spoke about a variety of incidents involving labor practices at work that are hindering to their wellness. One participant described the lack of a panic button when working alone as detrimental to her wellness. She stated:

> It's ridiculous because I'm the only person at my job who works alone. I don't have a panic button even though I've asked a couple of times. I had a phone in one hand and then a needle on the other with the Narcan and no button to press for help. (Participant 3)

Another participant spoke on having to stand for too long, a lack of breaks, a lack of staff, and broken equipment as detrimental to their wellness. They stated:

> Having to stand for hours on my shift. Not enough staff or breaks. That has caused me a lot of grief and stress and anxiety. Sometimes it affected my compassion towards the residents. Broken piece of shit equipment too. It ties to not feeling respected. It erodes your confidence in the organization and everyone. (Participant 7)

One participant spoke about insufficient admin and support as hindering. He stated, "The admin and support functions are under-resourced. Because of that, that increases the load on all the operational people. It makes you disappointed when realize your success is being limited by under-resourcing. It's depressing" (Participant 14).

Pay. Participants identified incidents involving insufficient pay as hindering to their wellness. One participant reported that not having vacation time and not being able to afford to take time off as being unsustainable. They stated, "I'm not making a lot of money for what I do. There's no spaciousness, no ability to take time off because I can't afford it. Last year the amount of work that I had to do almost killed me" (Participant 8). Speaking about frustration

regarding low pay, another participant stated, “I really shouldn’t really be supervising a building for $21 fucking dollars an hour, are you kidding me? <Employer> doesn’t care that $21 an hour isn’t getting us housing, enough food, and everything” (Participant 7). One participant stated that they feel they are balancing a housing crisis with the overdose crisis. They stated, “The city is not affordable. Dealing with an overdose crisis at work and going home dealing with a housing crisis makes me feel a lack of care. I’m not making enough money to feel secure at home” (Participant 10).

Wish List (63% participation rate; 24 incidents). Wish list factors associated with this category related to what participants wished in terms of pay, benefits, labor practices, and job security. Themes regarding the improved pay, time off/benefits, training, staffing, and union/human resources support are illustrated below with quotes.

Improved Pay. Participants spoke about improved pay as having the potential to help their wellness. On participant stated:

> Valuing the work that frontline workers do not just in the sense of what you do is so noble. That’s lovely. I appreciate it, but one of the biggest stresses that frontline workers face is the fact that we aren’t getting paid enough to take care of ourselves. Not that we’re in it for the money, obviously, but taking away the financial stress, especially if living in the lower mainland would go a long way to wellness. (Participant 12)

Echoing this, another participant stated, “What would help is not feeling stressed out about paying rent every month. It feels so precarious. I have to hustle. I can’t take breaks, or I can’t go on a vacation right because I can’t afford it” (Participant 15). Speaking about the impact of a potential raise, another participant stated, “I have to be constantly calm at work, but I have

seven bills to manage, because I can't afford to pay these bills and I'm being sent to collections. How can I stay calm? A raise would help" (Participant 9).

Speaking about the potential of a pay raise assisting with staffing shortages, another participant stated, "A raise makes people feel appreciated and it would keep other people around and would attract more people to the job, but they don't happen, we're underpaid and nothing changes" (Participant 13). Speaking about a desire for adequate funding both for the work site and for staff, this same participant stated, "I would be so excited and so happy if we were properly funded. I would feel like people were actually recognizing the importance of what we do" (Participant 13).

Time Off. Participants spoke on time off as potentially beneficial to their wellness. One participant spoke on the need for paid mental health days. They stated:

> I don't think any organization offers mental health days in terms of paid days off when a crisis happens at work. So many people come back to work before they can't afford it. It's not good for them and it's not good for us or for our clients. You can't frame it as needing time off for mental health, you have to give some other reason. Changing that would help. (Participant 15)

Speaking about the potential impact of having funded time off, another participant stated:

> Getting a break from all of the trauma, and chaos, and violence, and all of that because it's compounding so rapidly. To stop that and for me to be still, and rest, and sleep. If I had actual funded time off rather than having to sneak it in or feeling that I can't afford it that would be great. (Participant 10)

Benefits. Participants stated that benefits would help their wellness. One participant stated, "We are responding first without the support that real first [chuckles] responders do. We

don’t have benefits. We don't have risk pay. There’s no support funding to meet the demand of what's happening. These things would help” (Participant 8).

Training. Participants spoke on increased training as being potentially beneficial in general. One participant stated:

> Going to an emergency first aid community care training once every three years is just not enough. I think that a lot more regular training in first aid and on education in all levels would assist with that confidence. Have someone invested in my abilities in improving my skills all the time would increase faith in myself and my ability to handle things. (Participant 8)

One participant identified increased training for new hires as potentially beneficial. They stated, “New people should take a trauma-informed training when they’re hired. In-depth on difficult personalities and conflict resolution. That stuff is learned when you're at the job, but I think more training would be helpful” (Participant 11).

Staffing. Participants talked about the need for increased staffing as potentially helpful. One participant stated:

> The organization is hurting sometimes in terms of force double-shifts, forced overtime, and working alone. It doesn’t help if people’s wellness is to be stuck at work without support all the time. All of a sudden everyone’s burned out. They need to find a way to solve this staffing crisis. (Participant 15)

Union/Human Resources. Participants spoke on the desire for increased support from unions and human resource support. One participant stated:

> More support from the union, because we don’t always feel supported by the union. It would feel so much better because you are not always going to be on the same page with

> your management, but having someone behind you, who you know is always going to do things in your best interest, makes you feel reassured, makes you feel like you're not the one who's always wrong here. (Participant 9)

Another participant stated the desire for a human resources unit that is confidential. They stated:

> In my work there isn't an HR unit that is really private. That would be a resource that I would use fairly regularly to be able to run things through people, get a second opinion on stuff. All the things that I do when I reach out to a friend but specifically around work stuff. (Participant 13)

In the following chapter, these results will be linked with existing literature, novel findings will be noted, and implications will be discussed.

Chapter Five: Discussion

The following discussion will address the findings from the contextual questions and the ECIT results. Results will be compared with the existing literature and novel contributions highlighted. Study limitations will be discussed. The chapter will conclude with a discussion of social justice related implications and suggestions for practice, policy, and future research will be made.

The Contextual Results

The findings obtained from two contextual questions are discussed within this section: "what brought you to the work?" and "what does wellness mean to you?". Results from these questions aid in understanding what participants reported as helping, hindering, and wish list factors regarding their wellness. They will be discussed in context with the current literature.

What brought you to the work?

Three main themes and five subthemes summarized the responses of participants to this question. These themes are *meaningful work* (subthemes: *offering support to people in need* and *personal growth*), *personal experience with the population being supported* (subthemes: *worker experience with similar challenges*, *worker's family experience with similar challenges*, and *worker's family member in a similar field*), and *natural skill/aptitude for the work*. There is little information within the literature on what specifically motivates people to engage in community mental health work. However, there are several lines of research regarding what motivates social workers to enter their profession. There are meaningful differences regarding training, support, frequency of first responder duties, and visibility between CMHWs and social workers. Still, both professions share a deep interpersonal engagement with their clients and the need to navigate systemic supports and limitations. Similarly, literature descriptions of the motivations of social workers fit well with the motivations described by the CMHWs in the current study.

Meaningful Work. The theme of personal meaning motivating helping work is well described in the social work literature. Qualitative inquiries have described social workers as motivated by a meaningful desire to improve society through helping others and that acts of helping others result in personal growth (Buchbinder, 2007; Cree, 2013; Maes & Kalofonos, 2013). Quantitative inquiry similarly finds altruistic motivations as being more significant than the economic or structural workplace supports available with the profession (Borzaga & Tortia, 2006; Stevens et al., 2012; Wilson & McCrystal, 2007). This motivation corresponds with research on lived experience, finding that burnout threatens workers' ability to continue in the meaningful career they desire, resulting in feelings of shame and confusion (Judd et al., 2017; Pines, 2017). Participants in this study matched the literature in reporting that personal meaning both brought them to the work and that following through on this meaningful motivation was personally rewarding. These results provide context for incident categories involving success in following through on meaningful motivations.

These contextual results provide background to the *collective ethics* incident category. Lining up with Reynold's (2011) *justice doing* framework, the participants in this study chose to do this work out of a connected sense of ethical helping purpose and reported that their wellness is supported when they can successfully act in line with this purpose. Within the *collective ethics* category, participants described incidents congruent with their deeper motivations as helping their wellness and incidents incongruent with these motivations hindered their wellness. Matching Reynold's (2011) *spiritual pain* theme and representing a mismatch in the *values* area of Maslach's (2001) job-person model, these hindering incidents involved workers having to behave in ways that contradict what brought them to the work. The potential link between ethical

congruence and helping/hindering incidents will be discussed further in the *collective ethics* category section of this discussion.

There is also a potential connection between the hindering aspects of the *work-life balance* category and what these participants reported brought them to the work. It is possible that the personal and meaningful nature of these workers' motivations presents a challenge in drawing boundaries between work and other areas of their lives. As this work is tied up with meaningful purpose, participants may easily over-identify with the work, work too much, think about work all the time, and not take adequate breaks. The work may feel too important to set aside. This possibility will be discussed further in the *work-life balance* category and suggestions for future research sections.

Personal Experience with the Population and Natural Aptitude. Participant responses regarding personal experience with the population and natural skill/aptitude similarly match previous findings. Social workers in qualitative inquiry have named difficult experiences in their family of origin as simultaneously informing their desire to enter the field and giving them early natural training in the necessary skills (Buchbinder, 2007). Quantitative inquiry has found comparable results regarding life experiences similar to with their clients as motivating social workers (Stevens et al., 2012). Matching the words of participants in the current study, Debyser et al.'s (2019) study of people that have transitioned from peer (or client) to worker found that this transition gave participants a sense of well-being, usefulness, connection, and integration, while allowing them to feel that they are making meaningful contributions in the fight against stigma related to mental health challenges. Summing up the elements of these themes together, Cree's (2013) collection of narratives written by people entering the social work field details previous hardship, a sense of meaningful use of skills, and the influence of key people in their

lives in discussing why the authors entered the field. The participants in the current study told similar stories, stating that their own experiences with substance use, homelessness, marginalization, and family members having either experienced or been involved with supporting those experiencing similar challenges brought them to the work and provided an important source of sustaining motivation in the work.

While these personal experiences provide the necessary motivation, it is possible that they also represent a vulnerability. Previous research has found that a history of previous trauma is a risk factor in the development of STS and PTSD (Cusack et al., 2018; Hensel et al., 2015; Ivicic & Motta, 2017; Kessler et al., 2017). Given the challenging nature of these participants' personal histories, it is possible that they have had several traumatic experiences before beginning community mental health work. A formal assessment of trauma history was beyond the scope of the current study and further research is needed. Still, the potential connection between participants' personal histories, meaningful motivations, and helping and hindering factors is a major theme of the current study and will be discussed further throughout the remainder of this chapter.

What Does Wellness Mean to You?

Participant responses to this contextual question were grouped into five themes: *balance, awareness and acceptance, connection, motivation/agency,* and *physical health*. The themes of *balance, awareness and acceptance,* and *motivation/agency* fit with literature describing wellness as subjective, interconnected, dynamic, and holistic (Roscoe, 2009). Participants spoke of striving for balance, while being aware of and accepting the shifting nature of this balance as it interacts with the challenges in their lives. They reported that being aware of this shifting equilibrium while having a sense of agency and motivation in engaging with what keeps them

balanced was wellness. This provides context for incidents within the *work-life balance* and *individual strategies to maintain wellness* categories as these incidents frequently directly corresponded with participants' wellness definitions.

Going beyond the holistic elements, participants in the current study named several other wellness elements that match with the literature. The *motivation and agency* theme fit within the personal meaning aspects of *spiritual* wellness descriptions (Hettler, 1980; Renger et al., 2000) and the autonomy, environmental mastery, and purpose in life SWB domains (Ryff, 1989a, 1989b). Participants spoke about having the motivation and agency to engage in deeply meaningful, social-justice focused activities in their lives as a part of their wellness. Defining wellness as feeling agency in responding to injustice also sets in context the *collective ethics* incident category. This category involves successfully acting out participants' definition of wellness.

The theme of connection fits into literature descriptions of *social*, *emotional* and *spiritual* wellness dimensions (T. Adams, Bezner, & Steinhardt, 1997b; Hettler, 1980; Renger et al., 2000) as well as the positive relations with others SWB domain (Ryff, 1989a, 1989b). Adding context to the *social support* and *collective ethics* incident categories, social connection represents both a helping factor and a definition of wellness for these participants.

The theme of *physical activity and diet* matches with physical health wellness definitions in the literature (Durlak, 2000) as well as the environmental and personal growth SWB domains (Ryff, 1989a, 1989b) . This theme adds context to the *physical activity and diet* subcategory within the *individual strategies to maintain wellness* category. Notably, one participant described noticing that chronic injuries and pain flare up when they are not doing well. This provides a

clear example of the connection between physical health and wellness/SWB for some participants.

Finally, there is a possible connection between participant wellness and PTG. The current model for PTG involves a seismic traumatic event that challenges the individual, with corresponding rumination, coping success, social support, and continued engagement with the traumatic events (Tedeschi et al., 2018f). Participants' wellness definitions contained a mindful recognition and acceptance of challenging events, the agency and motivation to take meaningful action in response, connected social support, and continued engagement in life's challenges. This definition of wellness is a potential recipe for PTG. The connection between PTG and participant responses will be discussed further within the incident category suggestions for research, policy, and practice sections.

Critical Incident and Wish List Categories

The critical incidents reported by the participants were summarized into five categories with thirteen subcategories. These categories reflect what they believed had helped or hindered their personal wellness while responding to the fentanyl overdose crisis. Also included are wish list factors: potential incidents that participants reported would help their wellness if they had been available or would help their wellness in the future.

For the purpose of organizing this discussion, the five incident categories have been organized into the layered environmental systems described by Bronfenbrenner's (1979) ecological systems theory (EST). The EST was chosen as an organizing framework to make clear the systemic inequity that exists between participants in the current study and the broader social systems that impact their wellness. As detailed in the following discussion, participants have little power to influence the availability and quality of the supports they are provided with. Rather, these supports are informed by societal attitudes towards their clients and the low level of

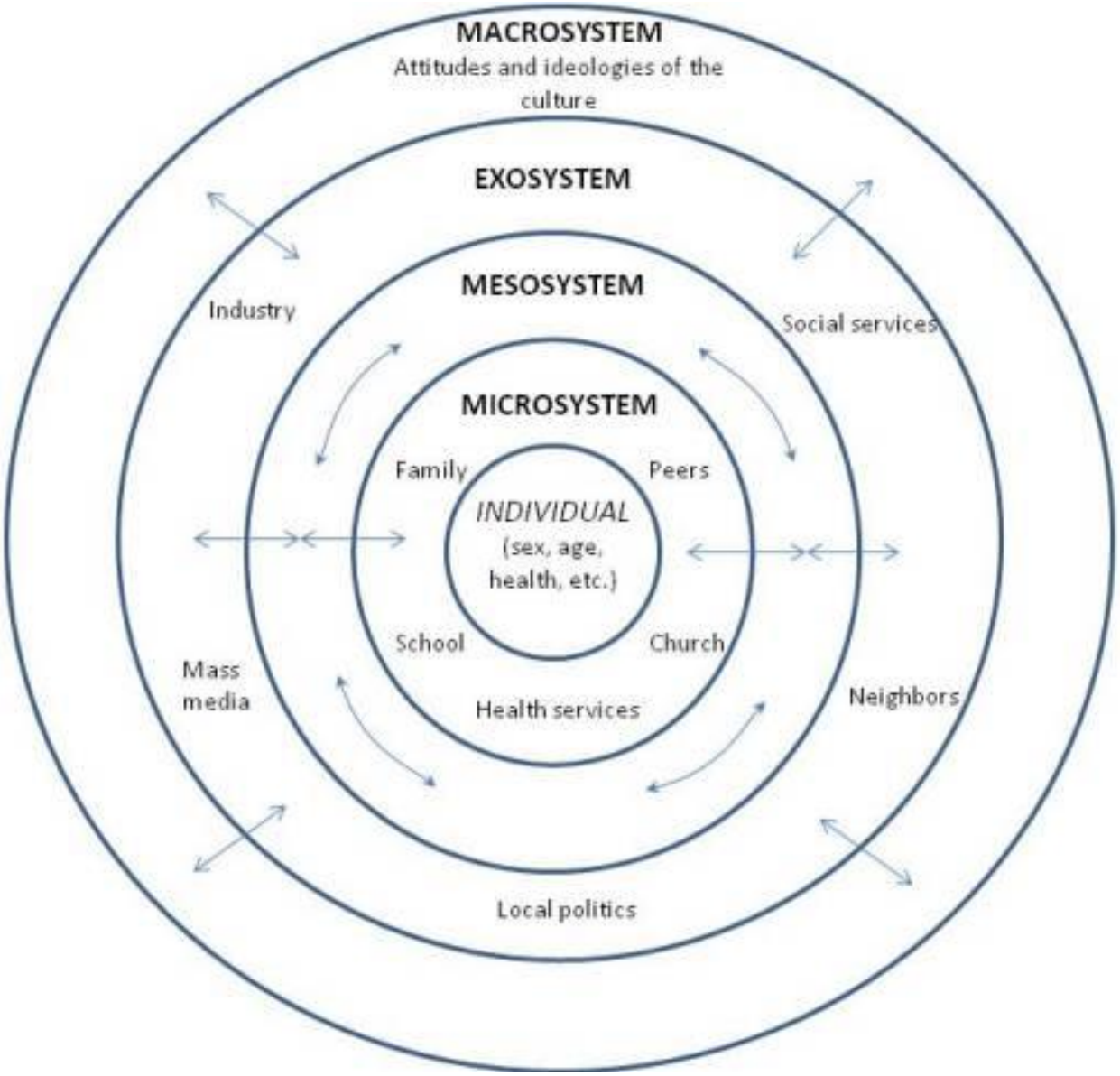
importance that Canadian society places upon caring for the clients that these participants serve. The systemic inequity involved in participants' wellness is discussed further in the social justice implications section.

Originally developed as a framework for understanding child development, the EST examines the interconnections between the various layered settings in which developmental events take place and the person's subjective experience with these settings. The EST has been previously adapted for use in occupational health research and will be similarly adapted here (Enns et al., 2016; Schultz, Stowell, Feuerstein, & Gatchel, 2007). The EST describes the person nested within four concentric systemic layers, with the person having the most direct impact on the layers closest to them and having increasingly less direct agency in affecting outer layers. These layers include, from closest to most distant from the person: the *microsystem*, *mesosystem*, *exosystem*, and *macrosystem*. Within this model, the *person* is defined as including individual biological traits as well as mental and emotional resources. The *microsystem* describes the system closest to the person and relationships within this system are direct and bi-directional in nature. This includes the various activities, roles, and relationships experienced by the person. The *mesosystem* describes interactions between parts of the person's microsystems, with elements of their microsystem interconnecting and influencing each other. This includes relationships among and between work, home, and social life. The *exosystem* describes larger social systems, such as work setting, the activities of organizational bodies and larger social groups. The individual person is not necessarily an active participant in the *exosystem*, however the various systems that the person interacts with affect and are affected by it. The *macrosystem* describes the broader environment within which the person lives, including belief systems and cultural values, economic factors, societal structure, and political systems. See Figure 1 for a

visual representation of these nested systemic layer and Table 5 a breakdown of incident categories within the EST framework.

Figure 1

Ecological Systems Theory



Note. Image from Hchokr at English Wikipedia, CC BY-SA 3.0 <https://creativecommons.org/licenses/by-sa/3.0>, via Wikimedia Commons. https://commons.wikimedia.org/wiki/File:Bronfenbrenner%27s_Ecological_Theory_of_Development_(English).jpg

Table 5

Categorization of Incident Categories According to Ecological Systems Theory

Environmental System	Category
Macrosystem The broader environment within which the person lives, including belief systems and cultural values, economic factors, societal structure, political systems, etc.	1: *Collective Ethics* Participant beliefs about why the work is important, what motivates them to act, how they believe society should regard and behave towards their clients, and the interaction between these beliefs and their work lives.
Exosystem The larger social systems, such as work setting, the activities of organizational bodies, larger social groups, etc. The individual person is not necessarily an active participant in the *exosystem*, however the various systems that the person interacts with affect and are affected by the *exosystem*.	5: *Structural Supports* Pay, benefits, work conditions, organizational infrastructure, staffing levels and availability, and security in the job.
Mesosystem Describes the interactions between different parts of a person's microsystem. This is where a person's microsystems are interconnected and influencing each other. This includes relationships between work, home, social life, etc.	4: *Work-life Balance* Participant efforts to maintain separation between their work and personal lives, as well as difficulties experienced in accomplishing this.
Microsystem Describes the system closest to the person and the one they have direct contact with. This includes the various activities, roles, and relationships experiences by the person. Interactions in a microsystem are bi-directional.	2: *Social Support* Participant social support.
Person Describes the role of personal characteristics play in social interactions, including a person's mental and emotional resources.	3: *Individual Strategies to Maintain Wellness* Participants' individual strategies to maintain wellness.

The discussion will begin with the *macrosystem* and move in descending order through the layers to the *person*. Incident categories within these layers will be discussed in contrast with existing literature within the following sections. It should be noted that some categories may not fit entirely within a single layer, and that instances in which this occurs will be discussed.

Macrosystem

The *macrosystem* describes the broader environment in which a person lives, encompassing all the other systems that affect them (Bronfenbrenner, 1979). The *macrosystem* includes belief systems and cultural values, economic factors, societal structure, and political systems that inform public policy and social support systems. *Category 1: collective ethics* fits within this macro level.

Category 1: Collective Ethics. This category contains incidents that connected with participants' social justice-based motivations. Participants reported shared ethical beliefs that are in opposition to dominant cultural norms regarding substance use, mental health challenges, and poverty. They described these beliefs as bringing them to this work and stated throughout this category that their wellness is helped or hindered in connection with being able to enact and follow through on these beliefs. This category was placed into the *macrosystem* to reflect the participant' desires to oppose and change mainstream beliefs about their clients. For example:

> Not having a safe drug supply and people's callous interaction with the overdose crisis harms my wellness. The desire to cut funds to systems that save people's lives when we lose minimum one person a day in this community harms my wellness. It just doesn't make any sense. (Participant 16)

Despite the lack of individual influence these participants have in changing broad cultural beliefs and structures, they are motivated by the desire to reduce and redress the negative impacts of this larger systemic layer on their clients and themselves.

***Subcategory 1 (A): Purpose to the Work*.** Participants in the current study specifically stated that they view this work as a significant calling and that being able to act on that calling in their work duties supports their wellness. The link between engaging in meaningful activity and reduced burnout has been previously made in physician and nursing populations (Gama et al., 2014; Shanafelt et al., 2009). Similarly, research on the lived experience of burnout has found links between a lack of feelings of significance to the work and burnout (Pines, 2017). Reynolds' (2011) *justice doing* concept captures and describes the positive effect that participants described in being able to successfully follow through on the ethical purpose they assigned to this work. In addition, the overlapping and shared meaning that participants ascribed to the work lends support to Reynolds (2009) *collective ethics* concept and provides further context to the strong helping effect that participants described within the *social support* category. Finally, the overall helping effect that participants reported in connection with congruence between their motivations and actions signifies a match within the *values* and *reward* areas of the job-person model of burnout (Maslach et al., 2001). Finally, this helping factor matches well with the purpose in life SWB domain (Ryff, 1989a, 1989b) and spiritual wellness dimension (Hettler, 1980). The helping effect of this congruence will be discussed further in the suggestions for future research, practice, and policy sections.

Subcategory 1 (B): Client Interactions. Helping incidents within this subcategory centred on connecting with clients, success in offering support to clients, and in seeing clients doing well. Incidents involving positive interactions with clients may be seen as direct

expressions of the social justice-based motivations that brought these participants to the work. Participants reported high levels of personal reward as a result, and a subsequent boost to their wellness. These results match with previous research findings that contact with clients is highly rewarding for CMHWs (Mctiernan & Mcdonald, 2015; Reid et al., 1999; Wirth et al., 2019). These results also fit well within Reynolds' (2011) description of *justice doing* and signify a match within the *values* and *rewards* areas of the job-person model of burnout (Maslach et al., 2001).

Hindering incidents within this subcategory centred on client overdose and conflict with clients. The cumulative effects of incidents of these types, particularly client overdose, match Reynolds' (2011, 2009) description of *spiritual pain*. Societal structures and limited resources result in workers doing what they can to reduce harm, but they are ultimately unable to change the systemic reality of their clients' lives. These interactions also represent a mismatch in the job-person model areas of *control* and *values* (Maslach et al., 2001) Following predictions by this model, participant reports of the impact of these incidents resemble descriptions of burnout symptoms. Participants have insufficient control to prevent overdose and manage conflict with clients and this lack of agency forces them to act in ways that are not in line with their values; their wellness is hindered as a result.

Beyond a mere hinderance to participant wellness, overdose incidents within this subcategory may fit into the DSM-5's diagnostic description of a "criterion A" traumatic event, potentially leading to the development of PTSD and/or STS. Participants reported frequent direct involvement with the deaths or near-deaths of their clients. They described these events as destroying their sense of safety, intruding into their personal lives, and creating a lasting emotional impact. However, as the participants in this study stated that they are doing well, it is

possible that the helping incidents reported throughout the current study are providing some mitigation of the risks involved with traumatic stress. The meaning and deeper purpose to the work that participants reported as a primary motivator to engage in this work may also be providing the continued motivation necessary to cope with these risks and prevent or manage potential PTSD. This possibility is discussed further in the social justice implications, suggestions for future research, policy, practice, and limitations sections.

Subcategory 1 (C): Being Realistic about the Crisis. Incidents in this subcategory highlighted the helping effect that accepting the crisis and releasing personal responsibility for solving it had on participants. This fits into Reynolds' (2011, 2012) suggestion that making conscious decisions regarding what the worker may take fairly responsibility for and what should be attributed to the difficulties involved in maintaining justice in an unjust system promotes worker sustainability. In job-person model terms, participant inability to change the larger system represents a mismatch in the *values, control*, and *workload* areas (Maslach et al., 2001). . Participants in the current study were unable to change the societal norms that are not providing adequate, humane support to their clients and when they release personal responsibility for fixing these support systems and focus on what they do have control over, their wellness improves. This finding has potential implications for practitioners supporting similar workers and is discussed in the suggestions for practice section.

Subcategory 1 (D): Societal Recognition. Incidents in this subcategory focus on being recognized by society. Reflecting societal ignorance regarding the day-to-day lives of substance users, participants reported believing that the general public is largely unaware of the work they do. In response, participants reported feeling that they have little control, that their efforts are useless, and that there is little hope for change. Incidents in this category involve the job-person

areas of *control, fairness*, and *rewards* (Maslach et al., 2001), and their reported impact in the current study matches with previous research finding *emotional exhaustion* and cynicism associated with mismatches in these areas (Baker, O'Brien, & Salahuddin, 2007). In contrast, in discussing wish list items, participants described formal recognition as being potential useful in terms of improving moral and pride in the work, and potentially increasing the resources available to them. However, as this formal societal recognition is involved with the larger societal attitudes captured by the *mesosystem*, the participants in the current study have little influence on changing these attitudes. In contrast, psychologists and the field of psychology does have the influence needed to begin changing societal perceptions. The urgent necessity of changing these perceptions and subsequently increasing supports and resources for these participants and their clients is discussed within the *ecosystem/category 5: structural supports* and social justice implication sections.

Subcategory 1 (E): Crisis Intervention Policy and Practice. This subcategory centred on the hindering effect of incidents involving being unable to intervene in the crisis is ways that line up with participant ethics. Participants reported feelings of shame, hopelessness, loss of motivation, anger, cynicism, and sadness in response. Incidents of this kind match with Reynolds' (2011) suggestion that social structures and limited resources force workers to behave in ways that go against their ethics, resulting in *spiritual pain* and burnout. Pines (2017), similarly suggests that finding meaningful work and then being unable to succeed in that work causes burnout. Finally, these incidents represent a mismatch on the job-person model areas of *control* and *values* (Maslach et al., 2001). Wish list items involved systemic antidotes to this area mismatch: stigma reduction, increased services, better coordination of services, and client/worker informed interventions. This subcategory speaks again to the symptoms of negative

and miss-informed societal perceptions about substance users. As stated throughout this discussion, psychologists and the field of psychology have a responsibility to begin advocating for changes in these perceptions and subsequent positive changes to crisis intervention policy and practice. This responsibility is discussed further in the social justice implications and suggestions for policy sections.

Connection Between Collective Ethics and Burnout, STS, and PTSD. The work these participants do also involves repeated contact with traumatic events, putting them at risk for negative traumatic stress outcomes. As previously stated within this discussion, the participants in this study reported personal histories that may represent a vulnerability to STS and PTSD. At the same time, participants reported that their potentially traumatic histories informed the deeper social justice-based meaning that brought them to this work and, throughout this category, they reported that congruence with this meaningful motivation is a helping factor. This potentially marks traumatic personal histories as representing both a risk and a helping factor in community mental health work. Trauma history as a helping factor is a novel finding. The implications of this finding are discussed further in the social justice implications and suggestions for practice and policy sections.

Exosystem

The *exosystem* is the larger social system in which the person lives (Bronfenbrenner, 1979); this system includes the work setting, the activities of organizational bodies, and larger social groups. The *exosystem* is influenced by the dictates of the *macrosystem* and exerts influence on the systems below it, but the individual person does not necessarily have direct influence on the *exosystem*. *Category 5: structural supports* fits within this e*xosystem* level.

Category 5: Structural Supports. Participants identified incidents involving low staffing levels, lack of training, working overtime, challenging labor practices and low pay as detrimental to their wellness. They stated a desire for support in these areas along with the need for access to benefits and more time off. It is notable that the desire for a workplace that ensures these structural supports was not among the reasons that these participants stated as informing their work motivations, and has not been reported as motivating similar workers (Cree, 2013; Stevens et al., 2012). While these workers urgently need improved structural supports, the meaning they assign to this work may keep them engaged despite a lack of adequate support.

The hindering incidents within this category represent a mismatch within the *workload*, *control*, and *reward* areas of Maslach's (2001) job-person model of burnout and imply that this work fits within the high strain (high demand/low control) job category of Karasek's (1979) job demand-control model. Following predictions made by both models, participants described symptoms of burnout in response and previous research has found robust links between a lack of worker control, insufficient organizational support and burnout (G. M. Alarcon, 2011; Awa et al., 2010; Bakker et al., 2014; G. W. Evans et al., 2012; Leiter & Maslach, 2003; Ray et al., 2013). Finally, the hindering incidents in this category represent a major challenge to participants ability to function well within the environmental mastery SWB domain (Ryff, 1989a, 1989b) and the environment and occupational wellness dimensions (Hettler, 1980).

In addition to burnout symptoms, participants in the current study reported symptoms that resemble STS and PTSD in connection with insufficient structural support. They described blaming themselves personally for client deaths rather than focusing on the lack of systemic supports involving these events. They report feeling strong shame, sadness, incompetence, and loss of faith in themselves and their employers as a result. Insufficient organizational support has

been previously linked with increases in STS (K. Cohen & Collens, 2013; Kulkarni, Bell, Hartman, & Herman-Smith, 2013; Newell, 2010) and PTSD (S. K. Brooks et al., 2016; Skogstad et al., 2013). The danger of developing STS and PTSD combined with the lack of access to adequate structural supports represents a major failing of the system in protecting these workers from the harmful effects of their work. Participants stated clearly what would help in this area: improved staffing, adequate access to time off and benefits, adequate regular training, improved human resources/union support, and increased pay. The lack of adequate supports of this kind is likely a direct result of negative societal attitudes towards the clients these workers serve and a subsequent lack of resources for workers. The urgent need to support and advocate for improved supports of this kind in accordance with worker wishes is discussed further in the social justice implications and suggestions for practice and policy section.

Mesosystem

The *mesosystem* describes the interactions between different parts of a person's microsystem (Bronfenbrenner, 1979). In the context of the present study, the *Mesosystem* primarily related to the interaction of participants' work and personal lives, including home, social, and self-care related microsystems. *Category 4: work-life balance* fits within this system.

Category 4: Work-Life Balance. Incidents in this category focused on participants' efforts to maintain separation between their work and personal lives. Work-life balance has been defined as "a high level of engagement in work life as well as non-work life with minimal conflict between social roles in work and nonwork life" (Sirgy & Lee, 2018, p. 232). Participants in the current study consistently stated that the work they do can become all-encompassing and easily invades their non-work lives. The results discussed in the "What brought you to the work?" section may relate to this work-life challenge. Within those results, one participant

specifically called the work a “sacred calling” (participant 10) and it is possible that the responsibility that participants feel in connection with this work being deeply meaningful makes creating boundaries between it and their personal lives difficult. This potential link between challenges in work-life balance and engagement in meaningful caretaking work is deserving of further research and is discussed in the suggestions for future research section.

Hindering incidents in this category represent a mismatch in the job-person model areas of *workload*, *control*, and *fairness* (Maslach et al., 2001) and provide another example of participant job demands outstripping available resources. Participants reported feeling a lack of control and symptoms matching *emotional exhaustion* and *depersonalization* in response. This matches similar findings regarding structural challenges to work-life balance in community settings (Cetrano et al., 2017; Gifkins, Johnston, Loudoun, & Troth, 2020; Luther et al., 2017). Finally, the hindering incidents in this category represent a major challenge to participants ability to function well within the environmental mastery SWB domain (Ryff, 1989a, 1989b) and represent a challenge within the environment and occupational wellness dimensions (Hettler, 1980).

Participants’ descriptions of difficulty maintaining work-life boundaries indicates a potential risk for STS and PTSD. They reported being triggered by reminders of traumatic events, hypervigilance, rumination on concern for clients, believing that traumatic events were endless, believing that the world is not a safe place, and negative perceptions of themselves. This matches recent research in similar populations finding links between work-life balance and symptoms of burnout, STS, and general challenges in self-care engagement (Bae et al., 2020; Cetrano et al., 2017; E. M. Martin, Myers, & Brickman, 2020; Schwartz et al., 2019; Tsai, Jones,

Klee, & Deegan, 2020). As indicated throughout the current study, these results strongly highlight the need to improve trauma informed supports for CMHWs.

Helping incidents in this category largely involved downtime recovery and separating from thoughts and emotions regarding clients when outside of work. Downtime recovery has been described as, "A state of physical relaxation and psychological detachment that can occur within any of three major life domains: paid work, home/family work, leisure" (Dugan & Barnes-Farrell, 2017, p. 47). These authors suggest that people in high-strain jobs (high demands and low control) lack the ability to take downtime at work and as such are benefitted when they can compensate with home and leisure downtime. Previous research has found that this downtime can create a restorative buffer for workers (Dugan & Barnes-Farrell, 2017; Gifkins et al., 2020). Participants in the current study stated that engaging in relaxing activities with the intention of decompressing and restoring themselves was very beneficial to their wellness. Similarly, they stated that creating boundaries around the non-work aspects of their lives was helpful. In general, these helping incidents match with previous research suggesting that strong boundaries against engaging in work-related thoughts and discussion when off shift is beneficial (J. J. Lee & Miller, 2013). These incidents may be considered examples of high functioning within the SWB environmental mastery domain (Ryff, 1989a, 1989b) and environment and occupational wellness dimensions (Hettler, 1980). Regarding wish list items, participants stated that an increased ability to take time off and to have planned wellness events away from the work environment would improve their wellness. Suggestions on supporting work-life boundaries are discussed further in the suggestions for practice and policy sections.

Microsystem

The *Microsystem* describes the systems closest to the person and the one they have direct contact with (Bronfenbrenner, 1979). This includes the various activities, roles, and relationships experienced by the person and interactions in this system are bi-directional. *Category 2: social support* fits within the *microsystem*.

Category 2: Social Support. This category brought together subcategories involving social support from colleagues and non-colleagues, management, and professional support services. These subcategories share much in common across incidents and will be discussed largely as a whole, with important individual subcategory elements highlighted.

Social support both in the workplace and in workers' lives has been previously identified as an important resource in populations doing similar work (Mette et al., 2020; Stansfeld & Candy, 2006; Wirth et al., 2019). Particular benefit has been identified in connection with work environments featuring strong, connected team work (Coyle, 2005; Crawford et al., 2010; Lloyd et al., 2002). Participants in the current study echo these findings, stating that accepting, respectful, and connected support from coworkers was invaluable to their wellness. These incidents represent a match in the *community* job-person area (Maslach et al., 2001) and have been previously linked with reduced levels of burnout (Ray et al., 2013). They fit well within the social wellness dimension (Hettler, 1980) and positive relations with others SWB domain (Ryff, 1989a, 1989b). These incidents also support Reynolds (2011) suggestion that approaching the work these participants do with a sense of *solidarity,* connection, and support is paramount in sustaining wellness.

It is possible that the incidents within this category are assisting participants in the prevention of STS and PTSD. Previous research has found social support to be a robust key

factor in preventing PTSD (S. K. Brooks et al., 2016; Dinenberg, McCaslin, Bates, & Cohen, 2014; Skogstad et al., 2013; Zalta et al., 2021). Specifically, it is suggested that social support assists in reframing and reappraising traumatic events while reducing negative appraisals of the self, the situation, and the future (Guay, Billette, & Marchand, 2006; Zalta et al., 2021). Matching this, participants in the current study described debriefing with coworkers as reducing shame and isolation while instilling hope for both themselves and their clients.

Beyond preventing STS and PTSD, these incidents may also be promoting the development of PTG. Previous research has identified social support as having a significant impact on the development of PTG (Sattler et al., 2014; Tedeschi et al., 2018a). Participants described a "therapeutic" (Participant 4) effect in response to positive social support, detailing a renewed sense of positive self-identity, resilience, and hope. Participants spoke of social support from management as particularly helpful in this regard, describing an increase in work engagement, inspiration, and agency in response. Previous research has identified support from management as especially important in promoting both PTG and burnout prevention (Christian et al., 2011; Shakespeare-Finch & Daley, 2017). The possibility of these workers experiencing PTG through the support described in this category is discussed further in the suggestions for future research, policy, and practice sections of this discussion.

Finally, participants described professional support services that are independent from the workplace as helpful. It has been suggested that workers initiating this type of professional support for themselves indicates a high level of work-related distress (Mette et al., 2020). The high level of stress and suffering participants experience in response to their work is abundantly clear throughout the results of this study. The need to improve supports for workers in response to this suffering is further highlighted in the social justice implications section.

Regarding hindering incidents in this category, participants described isolation, impersonal contact, and interpersonal conflict. Participants described incidents of this type as resulting in negative rumination, poor appraisals of themselves and their work, and emotional exhaustion. Previous research has found that the disruptive effects of negative social reactions in general have a strong effect on the likelihood of both burnout and PTSD development (Zalta et al., 2021). Similarly, previous research has linked negative social support from coworkers with burnout symptoms (Aronsson et al., 2017; Charoensukmongkol, Moqbel, & Gutierrez-Wirsching, 2016). Hindering incidents regarding management also matched previous findings linking perceived negative support from management with burnout symptoms (Aronsson et al., 2017; Charoensukmongkol et al., 2016; Dallender & Nolan, 2002; Hannigan, Edwards, Coyle, Fothergill, & Burnard, 2000a). Participants reported feeling particularly effected by perceived social pressure from management to do more than they are able, often blaming themselves rather than the lack of social and structural supports involved with their work. These incidents represent a mismatch in the job-person area of *community* (Maslach et al., 2001).

The wish list items within this category represent an urgent agenda of practice and policy suggestions for supporting these participants. They will be discussed further in the social justice implications and suggestions for research, policy, and practice sections.

Person

At the centre of the concentric, layered systems is the *person* (Bronfenbrenner, 1979). The person in this context describes personal characteristics, including mental and emotional resources. *Category 3: individual strategies to maintain wellness* will be discussed in this section.

Subcategory 3 (A): Mindfulness and Spiritual Practices. The positive role that mindfulness plays in ameliorating burnout symptoms is well documented (Dreison et al., 2018; J. Johnson et al., 2018; Suleiman-Martos et al., 2020; N. Z. Taylor & Millear, 2016; Trowbridge & Mische Lawson, 2016). These incidents also fit well into the spiritual and emotional wellness dimensions (Hettler, 1980) and the self-acceptance and environmental mastery SWB domains (Ryff, 1989a, 1989b). The participants in the current study described mindfulness as helping them in two specific ways. The first was in grounding and gaining perspective on their reactions to the work. This helping element lines up with previous research with healthcare workers finding that the ability to ground and gain perspective improve potentially stressful interactions with clients and helps workers purposefully choose beneficial coping strategies (Guillaumie, Boiral, & Champagne, 2017; Irving, Dobkin, & Park, 2009; Wampole & Bressi, 2020). The second aspect regarded using mindfulness to assist in accepting and processing their emotional reactions. Mindfulness has been found to increase emotion identification, regulation, and acceptance (Hill & Updegraff, 2012; Hülsheger, Alberts, Feinholdt, & Lang, 2013; Wampole & Bressi, 2020). Regulating and accepting emotion has been found to aid in adaptive emotional processing (Greenberg, 2010; Pascual-Leone & Greenberg, 2007). Furthermore, mindfulness has been connected with the facilitation of PTG through the encouragement of deliberate rumination, behavioural regulation, and meaning making (Chopko & Schwartz, 2009; Hanley, Peterson, Canto, & Garland, 2015; Tedeschi & Blevins, 2015; Williams, Skalisky, Erickson, & Thoburn, 2020). Accordingly, it is possible that participants' mindfulness practices are assisting in the development of PTG. This possibility will be further discussed in the suggestions future research and practice sections.

Subcategory 3 (B): Physical Activity and Diet. While continued research is suggested, systemic review of the literature has found links between maintaining physical activity and reducing burnout (Naczenski, de Vries, van Hooff, & Kompier, 2017). Specifically, links have been found between exercise and reduced *emotional exhaustion* (Peterson et al., 2008). Participants in the current study reported incidents supporting this link between exercise and burnout reduction, describing exercise in general and particularly during the middle of the workday as helping. These incidents fit well into the physical wellness dimension (Hettler, 1980) and the environmental mastery SWB domain (Ryff, 1989a, 1989b). Regarding hindering incidents in this category, participants reported the detrimental effects of both under and over-eating to mitigate stress. This finding matches previous research finding links between under and over-eating, chronic stress, and burnout in healthcare workers (Esquivel, 2021; Melamed & Toker, 2006). Finally, longitudinal research has found that changes in exercise levels are associated with decreases and increases in burnout (Lindwall, Gerber, Jonsdottir, Börjesson, & Ahlborg, 2014). Considering this link between changes in exercise levels and burnout, policy makers may consider facilitating and incentivising exercise and healthy diet in supporting the wellness of these workers. This suggestion will be discussed in the suggestions for research and practice sections.

Subcategory 3 (C): Creative Expression. The use of creative arts in managing and preventing stress is an emerging area of research (L. Martin et al., 2018). Positive results linking creative arts and reductions in burnout symptoms have been found with long-term care, hospice, and healthcare workers (Bittman et al., 2004; Cheek, Bradley, Parr, & Lan, 2003; Kacem et al., 2020; Van Westrhenena & Fritz, 2013). Links have been made between the purposeful use of calm music and lowered stress levels (Linnemann, Ditzen, Strahler, Doerr, & Nater, 2015).

Matching these findings, participant in the current study described using creative activities and music to calm and renew themselves.

In addition to reducing stress, it has been proposed that the creative arts have the potential to facilitate PTG (Reed et al., 2020). These authors suggest that creative processes may help workers process emotional reactions to traumatic experiences, resulting in a reconstruction of the meaning of those experiences. These authors also suggest that enacting creative arts interventions with a group/community approach has the potential to deepen and strengthen work relationships. The results of the current study support this suggestion, with participants reporting that creative activities helped them gain perspective and renew themselves, particularly when done in connection with others. The potential for supporting PTG within CMHWs is discussed further in the suggestions for future research section.

Subcategory 3 (D): Substance Use. While some participants spoke about the beneficial effects of cannabis use, participants largely described hindering incidents regarding alcohol and cannabis along with social pressure to use alcohol in coping. The use of substances as a disengagement coping strategy and social pressure to do so has been documented in similar populations (Beer, Phillips, & Quinn, 2021), and a correlational link between increased alcohol use and burnout has been well established (Awa et al., 2010; J. Johnson et al., 2018). Participants' statements in the current study described substance use as a disengagement coping strategy and reported increased burnout symptoms as a result. Previous research has suggested that substance use as a coping strategy increases when active coping strategies aren't perceived as available (Corbin, Farmer, & Nolen-Hoekesma, 2013). Participants in the current study frequently reported feeling a lack of control and agency in supporting both themselves and their clients. It is possible that this perception of a lack of available options is contributing to

participant substance use as coping. Further research into the substance use motives of CMHW populations is needed.

Limitations of the Study

There are several limitations of the current study that should be noted. These limitations are reported to assist the reader in interpreting and evaluating the findings of this study. These limitations involve participant memory effects, usability, difficulty in linking the contextual and incident data without further research, and researcher subjectivity.

The first limitation regards the influence of participant memory-related factors. While participants were informed ahead of time that they would be asked about what was helping and hindering their wellness, they were not prompted to begin reflecting on and recording specific incidents before the interview. Participants were given the opportunity to add incidents during the second interview, but most participants elected to add information to previously reported incidents and very few new incidents were added. It is possible that the unreliable nature of human memory caused incidents to be forgotten or distorted as time passes.

The second limitation involves usability of the results of this study with similar populations. Generalizability is not the aim of exploratory qualitative research and was not the goal of this study, rather, this study sought to discover usable information that may illuminate the experience of the participants. Several limiting factors should be considered in evaluating the usability of this information. The inclusion criteria involved selecting participants that self-identify as doing well. This subjective self-definition of doing well honours and values the unique experience of the individuals in the study, however, the application of what helped and hindered them may differ from what helps people who do not self-identify as doing well. It is possible that the greater number of helping incidents reported may indicate a confirmation bias

towards incidents that support their positive wellness self-definition. It is also possible that because these participants are doing well, they are not experiencing as many hindering incidents. Conversely, workers who are not doing well may be facing greater challenges and interpreting these challenges in a less positive light. This study also took place in a specific geographic region with an elevated concentration of overdose incidents in comparison to many areas of Canada. It is possible that workers experience in other regions differs. This study also took place pre-Covid-19 pandemic. It is possible that the addition of Covid-related concerns has increased the stressors that these participants are facing along with what they may identify as helping and hindering.

The third limitation centres on the ability of this study to make in-depth exploration of the links between the incidents and contextual results. This study focused on the exploratory identification of helping and hindering factors regarding participant's wellness, rather than correlation and causation between incidents and impacts. For example, questions regarding potential links between the meaning that participants reported as bringing them to the work and incidents involving the meaning of the work were not within the scope of this study. Further longitudinal research is required in response to this limitation.

The fourth limitation regards the subjective judgment of the researcher. As detailed in the researcher subjectivity statement, I have previous experience working as a CMHW. I hold beliefs regarding the ethical responsibility involved with this work and feel a sense of deeper meaning and purpose in supporting these workers. My personal experience as CMHW also informs my belief that this work is difficult and there are inadequate supports being provided to workers. My experience and associated beliefs about this work translate into limitations and strengths that the reader should continue in evaluating this research. For example, being known and trusted by this

community of workers likely facilitated recruitment. Within interviews, being known and trusted may have assisted participants in feeling comfortable talking about the personally challenging and emotionally impactful aspects of their experiences. My sense of the ethical responsibility involved with this work resulted in a strong desire to center and honor the perspective of the participants in this study, and the extensive credibility checks woven into the ECIT were strictly adhered to with this aim in mind. Finally, my awareness that that my beliefs would impact this study provided strong motivation to ground its formulation and data analysis in the literature in order to ensure a broad, integrated perspective was maintained.

Social Justice Implications

Canadian society assigns low value to substance users. As a result, they have become dehumanized and deemed unworthy of adequate care. Fentanyl related poisoning is killing them in alarming numbers, and, in contrast to the rapid national response to the Covid pandemic, they are receiving inadequate attention and support. The participants in the current study put themselves in close human-to-human contact with substance users in an attempt to redress this societal inequity. Their work is important, ethical, and meaningful, and it costs the participants something. They reported frequent horrendous and horrific work experiences and described *emotional exhaustion*, rumination, traumatic re-experiencing, intrusions into their personal lives, feelings of low self-worth, hopelessness, damage to relationships, physical pain, and more as a result. They also reported a clear lack of the structural supports necessary to continue maintaining their wellness in the face of these challenges. Allowing workers of this kind to continue putting their health and wellness at risk without the supports they require is unethical and unjust and must not continue.

Participants repeatedly stated that positive changes in societal views of their work and subsequent improvements in the policy based structural supports available both to their clients

and to themselves would greatly assist their wellness. As made clear through the EST organization of these results, these participants do not possess the systemic power necessary to make these changes on their own. However, psychologists and the field of psychology does possess some of the necessary systemic influence. We have misused this influence in the past and have an ethical responsibility utilize it in humane and ethical ways now (CPA, 2000; Sinacore & Ginsberg, 2015b). Research attention and psychological support are not enough. The field of psychology must band together in vocal public solidarity with these workers and their clients. We must shine our spotlight on the inequity and injustice they experience. We must offer to amplify their voices. We must join with them in demanding the resources and supportive policies necessary for them to continue their important work. We risk continued complicity in the injustice they face otherwise; if we do not act in support, if we do not offer to join in allyship, then we risk becoming a part of the problem they are attempting to mend. The results of the current study writ large represent an ethical imperative; we must offer allyship and act in solidarity with these workers to change the conditions they face, immediately. Suggestions for practice, policy, and research to this end are detailed in the following sections.

Suggestions for Policy and Practice

The current study was conducted to discover information that may be used in practical ways to support CMHWs. Suggestions for policy and practice to this end are discussed below.

Policy

Several implications for policy are suggested by the current study. Grouped broadly, they regard structural supports and traumatic stress supports.

First, the results of the current study point towards the urgent need to improve the structural supports available to these workers. Participants identified a lack of structural supports

as a major hindrance to their wellness and this category featured the highest number of wish list items. They described the need for improved staffing levels, accessible and judgment-free time off, improved benefits, regular training, increased human resources/union support, and increased pay. These are clear, tangible, and well-researched areas in which the resources available to workers can be improved to match the demands put upon them and provide them with the agency to care for themselves more effectively. In responding to the ethical imperative to advocate for these workers, psychologists and academics should partner with organizations employing CMHWs in advocating for the increased resources necessary in providing these supports.

Second, participants throughout this study spoke about several helping incidents that may be assisting in mitigating the traumatic stress involved with their work. Integrating elements of what they stated helped in this regard into organizational policy has the potential to magnify this mitigation. Mirroring the structural support suggestions above, it has been previously suggested that managers should be aware of key risk factors, that employees are trained in psychological first aid and specialized training, that workshops on emotional/psychological well-being are provided, and that organizations provide opportunity for simulated crisis training (S. K. Brooks et al., 2016). In addition, the results from the current study highlight the need to institute policies that increase the availability of non-judgmental social support in the workplace. Participants' suggestions regarding the building of teams that allow for vulnerable and authentic debriefing, acknowledgment, and normalization of the potentially traumatic impacts of this work, the sharing of wellness information with each other, a sense of responsiveness from management, and accessible options regarding counselling services and community supports may be taken as guiding principles in improving these policies. In responding to the ethical imperative to improve

supports for CMHWs, psychologists should offer reduced scale and pro-bono services in assisting organizations as they improve trauma-informed worker supports.

Practice

The results of the current study suggest several areas to explore in providing counselling support. Participants described the meaning of the work, work-life balance, social support, and mindfulness, diet, and exercise as important areas. The use of a career construction model may be useful in these areas in a counselling context. Career construction models seek to assist clients in "telling vocational stories about their work lives and their current transitions and troubles, integrate the vocational stories into an identity narrative about self and work, use that narrative to make meaning of the transition and regulate emotions, script the next scene in the occupational plot, and prompt action to construct a more satisfying life" (Savickas, 2013, p. 168).

By integrating the existential and social justice themes detailed throughout this discussion, counsellors may assist their clients in gaining a deeper understanding and integration of several potentially helpful narratives. These narratives may include what brought their clients to helping work, what is specifically meaningful about the work to them, what wellness means to them, what individual and *collective ethics* they endorse, the effects of having these ethics frustrated, what personal responsibility they may take, and what solidarity-focused social support is available.

Once awareness of these meaning-laden narratives and their impacts have been made more explicit, counsellors may consider how best to assist workers in improving the quality of their external social supports, in focusing their individual strategies for maintaining wellness, and in maintaining authenticity in their work. Particular attention should be paid to fostering the conditions linked with PTG throughout the support offered to workers, with consideration paid to

rumination and coping success, and the utilization of social support. Counsellors may instill confidence in the sustainability of this work by gently suggesting to workers that, with the right supports in place, engagement with the stress they feel in pursuing meaningful work can go beyond avoiding or managing burnout/STS/PTSD, potentially resulting in positive, long-lasting, growth. In responding to the ethical imperative to support these workers, psychologists should consider offering their services at sliding scale or pro bono rates as needed.

Suggestions for Future Research

The current ECIT study helped identify what CMHWs with clients affected by the fentanyl overdose crisis who self-identified as doing well found helpful and hindering with their wellness along with what they wished was available in the past or will be available in the future. The findings of the study point towards a possible expansion of the empirical knowledge base related to support of CMHWs and people doing similar work. Potential directions for future research regarding the meaning that workers assign to the work and the fostering of PTG are discussed below.

Meaningful Work

The interaction between the reasons that participants state drew them to the work, their definitions of wellness, and the incident categories suggest several areas of future research.

The first suggestion relates to participants' potential trauma histories. The trauma histories of the participants in the current study were not evaluated, nor were their current levels of STS or PTSD. However, their responses regarding what brought them to the work indicate that previous traumas are a possibility. Future research investigating the levels of previous trauma present among CMHWs and how best to ensure that these potential histories are utilized as a strength while mitigating risk could illuminate this potential avenue of worker support. A grounded theory study seeking to understand the connection between trauma history and

STS/PTSD risk/strength that includes screening measures for previous trauma, STS, PTSD, and PTG matches well with this research suggestion.

The second area for future research is regarding the potential connection between meaningful motivations and work-life boundaries. The current study did not specifically ask if the important deeper meaning that the participants assign to the work creates challenges in making boundaries between work and their personal lives. However, participants did describe challenges involving the interaction of these two areas. A qualitative exploration of this possible interaction using a phenomenological approach to help describe participants experiences making work-life boundaries or a grounded theory approach to help understand the role of meaningful work in making these boundaries would provide valuable information in supporting workers holistic wellness and information on the maintenance of work-life boundaries in general.

The third suggestion for future research is regarding support for and application of Reynolds (2011) *justice doing*-based burnout prevention framework. To date, this framework has been largely theoretical. Through identification of the role of meaning and social support in participants' wellness, the results of this study provide empirical support for the themes within this framework. Reynolds has suggested that *justice doing* may be best supported in a group format, has outlined a potential outline for these groups (Reynolds, 2010), and is currently running groups of this kind in a non-research context. These groups focus on making the *collective ethics* of frontline workers more explicit, on normalizing and processing the *spiritual pain* they experience, on assisting them in identifying what they may reasonably take individual responsibility for in the work, and in fostering a sense of social support and *solidarity*. A mixed method study exploring what workers have to say on these topics in a group context and the

effect on their perceived stress, burnout, potential PTG and sense of wellness would provide further information on the utility of this framework.

The fourth area for future research regards the effects of mindfulness within this population. The positive influence of mindfulness practices regarding grounding, regulation, gaining perspective, and taking purposeful coping action has been well researched, with the current study matching previous positive results. Authentic functioning, or being aware of and in congruence with one's true self, has been proposed as a mediator between mindfulness and work engagement (Leroy, Anseel, Dimitrova, & Sels, 2013) and has been linked with reduced *emotional exhaustion* and increased job satisfaction (Hülsheger et al., 2013). Mindfulness practices have also been linked with an increased sense of meaning in life, with improved self-awareness suggested as causing this increase (Allan, Bott, & Suh, 2015; Chu & Mak, 2020; Heppner & Kernis, 2007). Considering that these participants in the current study stated that meaningful purpose brought them to this work and that incidents supporting this authentic purpose helped their wellness, it is possible that using mindfulness to strengthen authenticity may provide an additional wellness resource. A study focused specifically on investigating this potential would further illuminate this possibility.

Post Traumatic Growth

In describing their meaningful motivations, their definitions of wellness, and what is helping their wellness, participants in the current study touched on several elements that have been previously identified as promoting PTG. They also made various statements through the results suggesting that PTG may be taking place. Research specifically investigating the presence of PTG and identifying what elements are supporting it within this population would allow for more purposeful PTG fostering interventions and a deepening of our understanding of PTG in

general. Qualitative inquiries exploring these themes and quantitative inquiries specifically measuring levels of PTG within this population and its correlation with motivations, social supports, and individual coping strategies would provide valuable information in supporting the development of PTG.

Knowledge Translation

The results of the current study stipulate an ethical responsibility to support and advocate for the population studied. Therefore, several methods of knowledge translation will be employed. First, in collaboration with a graphic designer, the results will be condensed into an easy-to-read pamphlet and offered to organizations, unions, and workers involved in similar work. Second, the author is in the process of designing workshop focused on communicating and integrating the results of the current study. This workshop will take place in a group format with the intention of allowing the participants the opportunity to explore and process the impact of the reported categories in their own lives. The author is currently engaged in outreach with community support organization within Vancouver's DTES to raise awareness of the availability of this workshop. Third, applications to present the information discovered by the current study at academic conferences will be submitted. Fourth, the current study will be submitted to peer-reviewed academic journals for publication.

Conclusion

The intention of this study was to make a meaningful contribution towards understanding how CMHWs maintain wellness while responding to the fentanyl overdose crisis through the identification of what is helping, hindering, and what might help the workers that self-identify as doing well. The results illuminate several influences and impacts on their wellness and provide clear applications regarding research, practice, policy. The experiences of the participants in this

study may be used as areas of exploration, strengthening, and normalization for counsellors supporting similar workers and may be used to inform supportive workplace policy. This study also suggests several specific areas of important future worker sustainability research. Finally, the results of this study make clear the need for the field of psychology to increase both advocacy and support for these workers in immediate and tangible ways.

This study brings attention to the potential role that meaning within the work plays within CMHW wellness while also adding lived experience information regarding the importance of social support, work-life balance, individual strategies, and structural supports to the literature. CMHWs are filling a vital and risk-laden role in addressing overdose-related public health crises and supporting the marginalized populations most effected by crises of this kind. As the fentanyl poisoning crisis and similar social inequality-rooted challenges continue it is my hope that this study provides valuable exploratory information to practitioners, policy makers, and researchers seeking to support and advocate for more equitable and inclusive social support systems.

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Appendices

Appendix A: Interview Guide

Participant #: _____
Date: _____
Interview Start Time: _____

The following interview sections will be covered with all participants, however, some wording or order of questions may vary.

Research Question: How do Community Mental Health Workers Maintain Wellness While Responding to the Fentanyl Overdose Crisis?

Interview Sections:

1. Overview and consent: Researcher will go over the interview process with the participant and present the kinds of questions that will be asked. Informed consent for the study will be discussed, including consent to audio-record the interview and inviting the participant to indicate any comfort needs they may have for the interview process. Participant will be invited to ask any questions they might have. If they wish to continue, participants will sign the consent form.
2. Interview: Participant will be invited to share their experiences focusing on the following:
    a. Contextualization
    b. Identifying helping and hindering factors
    c. Identifying wish list items.
3. Demographics: Participant will be invited to complete the demographics form.

Introduction

Thank you for agreeing to be interviewed and for agreeing to have this interview recorded. As you know, I am investigating how Community Mental Health Workers Maintain Wellness While Responding to the Fentanyl Overdose Crisis. This is the first of two interviews, and its purpose is to collect information on what is helping and what is hindering you in maintaining wellness. It is possible that reflecting on this may bring up some emotions for you. Please let me know if at any point you would like to pause the interview or change topic. Our interview today will have four general sections: contextualizing questions, what you experience as helpful or beneficial, what you experienced as hindering or unhelpful, and what might have been helpful if it had occurred. Any questions so far?

1. Contextualizing Component
    a. As a way of getting started, between one and ten, with one being very poor and ten being very good, how would you rate your personal wellness?
    b. Could you tell me how long you have been doing community mental health related work?
    c. What is your current job, and how long have you been in this position?
    d. What other mental health related jobs or positions have held?

e. What brought you to this type of work?
f. Have you been present during a drug overdose within the last year?
g. You volunteered to participate in this study because you feel that you are successfully maintaining personal wellness despite stress at work. What does personal wellness mean to you?

SUMMARIZE at end of section

2. Helpful Critical Incident Component
    a. Tell me about something that has helped you in maintaining personal wellness while working with clients affected by the fentanyl overdose crisis?
        i. Probes:
            1. How was it helpful?
            2. What contributed to the helpfulness of the experience?
            3. How did it impact you?
            4. Can you give me a specific example of how it was helpful?

Helpful Factor and what it means to participant (What do you mean by…?)	***Importance (How did it help? Tell me what it was about… that you found so helpful.)***	***Example (What led to it? Incident. Outcome of incident.)***

Repeat until the participant cannot think of any more helpful incidents.

SUMMARIZE at end of section

3. Hindering Critical Incident Component
    a. Tell me about something that has not helped you in maintaining personal wellness while working with clients affected by the fentanyl overdose crisis?
        i. Probes:
            1. How was it unhelpful?
            2. What contributed to the unhelpfulness of the experience?
            3. How did it impact you?
            4. Can you give me a specific example of how it was not helpful?

Unhelpful Factor and what it means to participant (What do you mean by…?)	***Importance (How did it not help? Tell me what it was about… that you found so unhelpful.)***	***Example (What led to it? Incident. Outcome of incident.)***

Repeat until the participant cannot think of any more unhelpful incidents.

SUMMARIZE at end of section

4. Wish List Component
    a. I'm interested in knowing what might have been helpful in maintaining wellness, and what might be helpful in the future.

Wish List Item and what it means to participant (What do you mean by…?)	***Importance (How would it have helped? Tell me what it was about… that you would find so helpful.)***	***Example (In what circumstance might this be helpful?)***

Repeat until the participant cannot think of any potentially helpful incidents.

SUMMARIZE at end of section

Closing

- Summary of all critical incidents to end interview and confirm understanding with participant.
- Check if participants are noticing any disturbance as a result of the interview.

Thank you so much for meeting with me today and sharing your experiences for this study. In the upcoming months, I will be contacting you with a summary of the themes that came from our interview today. I will be asking you to go over the summary to provide feedback. I will be particularly interested in the summary reflecting your experience as accurately as possible. It is important that you feel your story has been accurately captured and described. In the meantime, please don't hesitate to contact me if you have any other questions about the study. I look forward to speaking with you at the follow up if not sooner.

Appendix B: Demographic Questionnaire

Demographics Questionnaire

How do Community Mental Health Workers Maintain Wellness While Responding to the Fentanyl Overdose Crisis?

Directions: For the following open-ended questions, fill in the blanks to the best of your ability. If you require additional space for your response, feel free to write on the back of the form.

For the multiple choice questions place an X next to the answer(s) that best represent you. 1.

1. **Gender: _____**
2. **Age at date of interview: _____**
3. **Ethnicity: _____**
4. **Job Title: _____**
5. **Time spent in current position: _____**
6. **Time spent doing community mental health work in total: _____**

Appendix C: Study Recruitment Letter to Colleagues and Friends

Dear colleagues and friends,

I am a PhD candidate at UBC in Counselling Psychology, and have begun recruitment for my dissertation research in which I am investigating how Community Mental Health Workers maintain personal wellness while supporting clients experiencing fentanyl related drug overdoses.

I am contacting you in the hopes that you may know someone who might be interested in participating in this project. I am looking for adults of any age and gender that self-identify as doing well and are willing to talk about their experience maintaining personal wellness while responding to the fentanyl overdose crisis. The study will include an in-person interview (average two hours), and a follow up interview by phone or email (approximately one hour).

I have attached three information formats: a poster, a study summary, and a detailed letter to prospective participants. I would be very grateful if you would forward any or all of this information to your networks and to specific individuals who may be interested. I welcome any questions, and will be happy to provide hard copies of these documents as needed.

The goal of this study is to understand how workers that are successfully maintaining wellness while responding to the overdose crisis are doing so. What is experienced as helpful or beneficial, what is experienced as unhelpful or hindering, and what might be added to increase benefit. This information has the potential to help improve the wellness of workers as they respond to this crisis, and help provide recommendations for improving supports for workers in general.

Participation in this study will be maintained strictly confidential. With that in mind, please do not tell me the names or information about who you refer to this study; similarly, I will not confirm the names of individuals who contact me or choose to participate.

In summary, I am seeking adult participants that:

- Are doing community mental health work.
    - This may include people doing work in:
        - homeless shelters,
        - community drop-in centres,
        - low-barrier housing units,
        - community-based health clinics and outreach teams,
        - safe-injection sites,
        - and any other community involved contexts.
- That have direct contact with clients experiencing fentanyl related overdoses.
- That self-identify as successfully maintaining wellness despite the challenges involved in their work.
- That are willing to talk about their experiences maintaining wellness.

The study will include an in-person interview (approximately one to two hours), and a follow up interview by phone or email (approximately one hour).

My sincerest thanks for supporting my research and helping disseminate this to your networks.

Warmest regards,

Matthew McDaniel
PhD Candidate, Counselling Psychology

University of British Columbia
Department of Educational & Counselling Psychology, and Special Education

Appendix D: Consent Form

Consent Form

Study: How do Community Mental Health Workers Maintain Wellness While Responding to the Fentanyl Overdose Crisis?

I. Who is conducting the study?
Principal Investigator: Dr. William Borgen, Department of Educational and Counselling Psychology and Special Education, UBC, XXX, XXX@ubc.ca.

Co-Investigator: Matthew McDaniel, MA, Department of Educational and Counselling Psychology and Special Education, UBC, XXX, XXX@gmail.com.

This research is being conducted as part of the dissertation requirement for a doctoral degree in Counselling Psychology. Once completed, the dissertation will be a public document that will be available through the UBC library.

II. Why are we doing this study?

Purpose: You are being invited to take part in this research study because of your experience maintaining personal wellness while responding to the fentanyl overdose crisis. We are doing this study to learn more about what is helping workers that are successfully maintaining wellness while responding to the overdose crisis are doing so. What is experienced as helpful or beneficial, what is experienced as unhelpful or hindering, and what might be added to increase benefit. This information has the potential to help improve the wellness of workers as they respond to this crisis, and help provide recommendations for improving supports for workers in general.

III. How is the study done?

If you say yes, here is how we will do the study:

1. You will be asked to rate your personal wellness on a scale between 1 and 10.
2. An interview: You will participate in an in-person interview at a location of your choosing. The interview will take between one and two hours. You will be briefly asked about your job duties what led you to your work before being asked to reflect on and describe what has been helpful, what has been unhelpful, and what might be helpful in maintaining your wellness. The interview will be audio recorded so that we can concentrate on what you have to say, rather than taking notes.
3. Demographics questionnaire: You will be asked to provide some basic demographic information. This form will take approximately five minutes.
4. Follow up interview: At a later date, once your interview has been transcribed and analyzed, you will be asked to review the identified themes to make sure they accurately describe your experience. This can be done by phone or email and will take approximately one hour or less.

IV. Results of the study

The results of this research will be reported in a dissertation that will be accessible to the public. They may also be published in academic journals, integrated into community knowledge exchanges, and featured in dissemination and discussion groups for workers like yourself.

If you would like to receive a final copy of the results, please provide an email address or mailing address where you can be contacted: _____

V. Is there any way being in this study could be bad for you?

We do not think there is anything in this study that will harm you. However, we understand that supporting clients as they experience the effects of the fentanyl overdose crisis is potentially a very difficult task. You may find that sharing your experiences brings up strong emotions or memories. All questions are optional, and you may pause or stop the interview at any time. You are not required to provide an explanation for your desire to pause or stop the interview. Please let your interviewer know if you have any concerns.

VI. Will being in this study help you in any way?

You may find it helpful to talk about your experiences maintaining wellness while responding to the overdose crisis. It is our hope that others may also benefit from what we find in this study.

VI. Will I be compensated for my time?

You will not be paid for your participation in this study.

VII. How will your privacy be maintained?

Your identity will be kept strictly confidential. Participants will be identified only by a participant number; no names, initials or other identifying information will be used when the results of the study are reported. Only the two investigators identified on this form will have access to the digital recordings and study documents. All digital documents will be encrypted, and password protected and paper files will be kept in a locked filing cabinet. Files will be kept for five years and then will be destroyed.

Information that discloses your identity will not be released without your consent unless required by law.

VIII. Questions or concerns?

If you have any questions or want further information about the study, please contact Matthew McDaniel at XXX or XXX@gmail.com. You may also contact Dr. William Borgen at XXX or XXX@ubc.ca.

If you have any concerns or complaints about your rights as a research participant and/or your experiences while participating in this study, contact the Research Participant Complaint Line in the UBC Office of Research Ethics at 604-822-8598 or if long distance e-mail RSIL@ors.ubc.ca or call toll free 1-877-822-8598.

IX. Participant consent

Your participation in the study is entirely up to you. You may refuse to answer any question, or withdraw from the study at any time without negative consequences and without providing an explanation.

If there is anything we can do that will make participation in this study more accessible to you, please let us know and we will do our best to accommodate your need(s).

☐ I have read the above and I consent to being part of the Fibromyalgia and Healthcare study.

☐ I have received a copy of this consent form for my own records.

Signature: _____

Printed Name: _____

Date: _____

Appendix E: Study Recruitment Letter to Prospective Participants

Dear Prospective Participant,

My name is Matthew McDaniel, and I am studying how Community Mental Health Workers maintain personal wellness while working with clients affected by the fentanyl overdose crisis. This research project is a requirement for the completion of my doctoral degree in Counselling Psychology at the University of British Columbia. You have received this letter because one of the individuals I have reached out to thought you might be interested participating in this study.

The goal of this study is to understand how workers that are successfully maintaining wellness while responding to the overdose crisis are doing so. What is experienced as helpful or beneficial, what is experienced as unhelpful or hindering, and what might be added to increase benefit. This information has the potential to help improve the wellness of workers as they respond to this crisis, and help provide recommendations for improving supports for workers in general.

Participation is confidential and entirely up to you. I will not be informed that you received this letter unless you choose to contact me directly.

I am looking for adults of any age and gender that self-identify as doing well and are willing to talk about their experience maintaining personal wellness while responding to the fentanyl overdose crisis. The study will include an in-person interview (average two hours), and a follow up interview by phone or email (approximately one hour).

If you say "yes" to participating in this study:

Our interview will focus on your experiences maintaining wellness, particularly those instances or interactions you found to be helpful or beneficial, and unhelpful or hindering.

To best focus on what you are saying, I will request your permission to record the interview. Some demographic information will be collected as well. **All information will be kept strictly confidential and all questions are optional to answer.**

In the months following your original interview, I will send you a summary of the results of our interview, for your review. You will be asked to confirm whether or not they accurately represent your experience, and will be asked to provide feedback to ensure you are comfortable with how the findings capture your experience.

How we keep this information confidential:

Each participant will be assigned a code number. The audiotapes will be transcribed, removing all identifying information. Participants will only be referred to by the code number (never by name or initials). All paper documents will be kept in a locked filing cabinet, and computer documents will be encrypted and password protected. Only myself and my research supervisor, Dr. William Borgen will have access to the original files.

Contact Information

If you are interested in participating in the study or finding out more information, please contact Matthew McDaniel (Primary Researcher, Co-investigator) at XXX or XXX@gmail.com. This research is being conducted as a component of the dissertation requirement for his doctoral degree in Counselling Psychology at the University of British Columbia.

You may also contact Dr. William Borgen (Principal Investigator), Professor, Counselling Psychology Program, UBC at XXX, XXX@ubc.ca.

In summary:

In summary, I am seeking adult participants that:

- Are doing community mental health work.
    - This may include people doing work in:
        - homeless shelters,
        - community drop-in centres,
        - low-barrier housing units,
        - community-based health clinics and outreach teams,
        - safe-injection sites,
        - and any other community involved contexts.
- That have direct contact with clients experiencing fentanyl related overdoses.
- That self-identify as successfully maintaining wellness despite the challenges involved in their work.
- That are willing to talk about their experiences maintaining wellness.

Again, your participation is completely voluntary. You may refuse to participate in any section of the study, or withdraw at any time without negative consequence or providing an explanation.

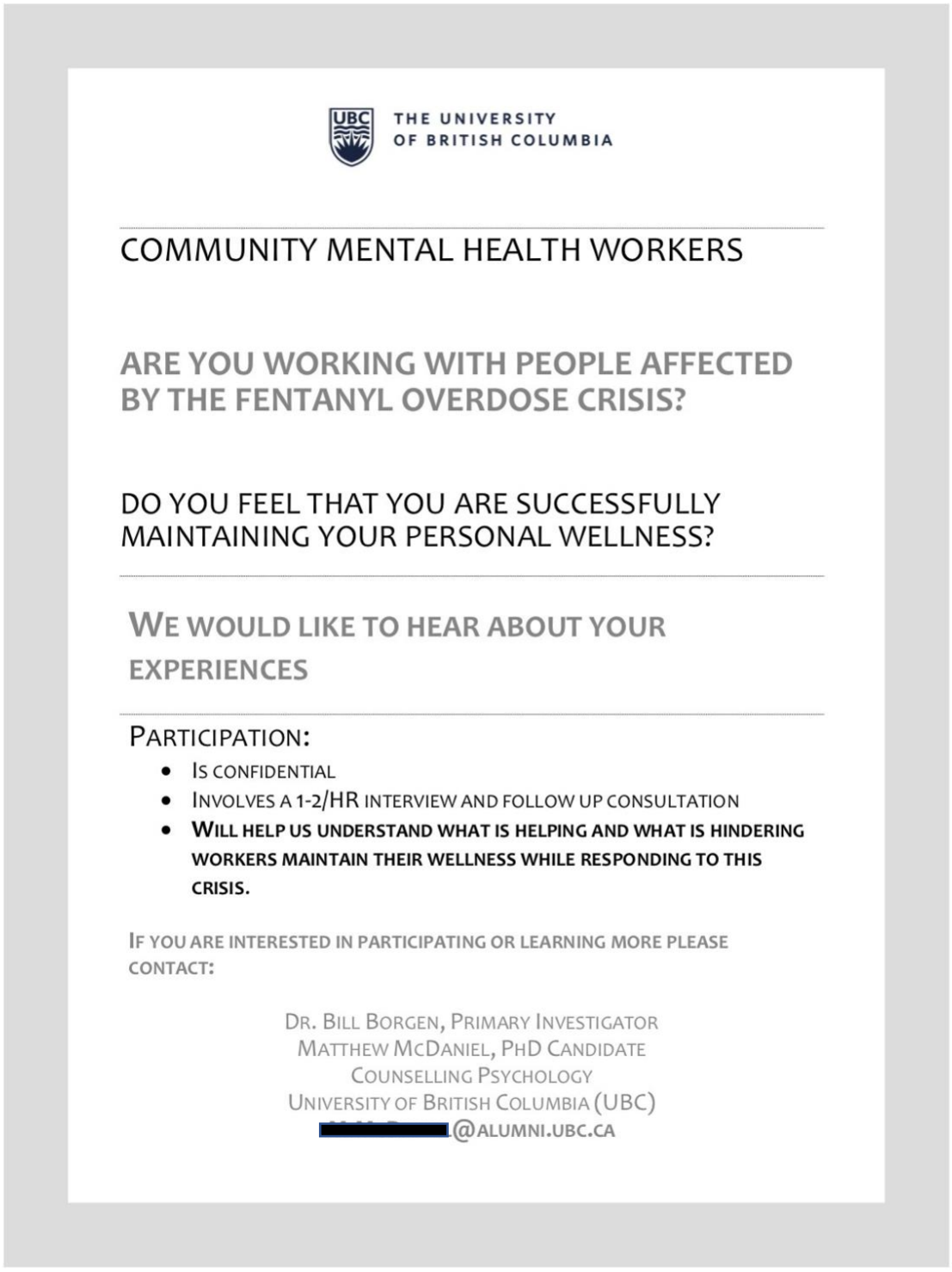
My sincerest thanks in advance. I welcome any questions you may have, and I look forward to hearing from you.

Warmest regards,

Matthew McDaniel

PhD Candidate, Counselling Psychology
University of British Columbia
Department of Educational & Counselling Psychology, and Special Education

Appendix F: Recruitment Poster



THE UNIVERSITY OF BRITISH COLUMBIA

COMMUNITY MENTAL HEALTH WORKERS

ARE YOU WORKING WITH PEOPLE AFFECTED BY THE FENTANYL OVERDOSE CRISIS?

DO YOU FEEL THAT YOU ARE SUCCESSFULLY MAINTAINING YOUR PERSONAL WELLNESS?

WE WOULD LIKE TO HEAR ABOUT YOUR EXPERIENCES

PARTICIPATION:

- IS CONFIDENTIAL
- INVOLVES A 1-2/HR INTERVIEW AND FOLLOW UP CONSULTATION
- **WILL HELP US UNDERSTAND WHAT IS HELPING AND WHAT IS HINDERING WORKERS MAINTAIN THEIR WELLNESS WHILE RESPONDING TO THIS CRISIS.**

IF YOU ARE INTERESTED IN PARTICIPATING OR LEARNING MORE PLEASE CONTACT:

DR. BILL BORGEN, PRIMARY INVESTIGATOR
MATTHEW MCDANIEL, PHD CANDIDATE
COUNSELLING PSYCHOLOGY
UNIVERSITY OF BRITISH COLUMBIA (UBC)
[redacted]@ALUMNI.UBC.CA