Telephone support workers at the New Zealand National Telehealth Service: Experiences and meaning-making.

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ABSTRACT

Since their creation, the number of mental health helplines in operation have risen dramatically. Varying by organisation, helplines are staffed by telephone support workers (TSWs) who are either volunteers, professionals and/or paraprofessionals. Evidence suggests that helplines are an effective source of support, but TSWs are exposed to several unique stressors that can lead to both possible and negative outcomes. Studies on TSWs have explored several outcomes ranging from burnout and vicarious trauma to vicarious post-traumatic growth and compassion satisfaction. Despite this, there is a limited understanding of the pathway to impairment for TSWs and there is a paucity of research on the positive consequences. Moreover, research has primarily focused on volunteer TSWs rather than paraprofessionals. Paraprofessionals, however, may be more at risk due to their increased exposure to the stressors of the TSW role. Using a qualitative approach and guided by a Critical Realist methodology, the current study utilised semi-structured interviews to explore and examine the experiences of paraprofessional TSWs at the New Zealand National Telehealth Service. Data were analysed using thematic analysis. Results indicated that TSWs experience a range of outcomes, such as enhanced confidence, greater resilience, improved self-worth, along with feelings of inadequacy or thoughts of self-doubt, a fluctuating ability to empathise and elements of uncertainty. TSWs are prone to exhaustion that may be increased by personal and corporate processes, which can impact their ability to empathise and influences the depersonalisation of callers. Although they have a strong desire to support their callers, TSWs recognise that some callers require support that is beyond the scope of the service and/or the training of the TSW, which can contribute to feelings of helplessness or thoughts of inadequacies. Findings are discussed in terms of the support requirements of TSWs, such as the management of uncertainty by drawing on the concept of wisdom.

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Attestation of Authorship

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

Signed:

Date: 29th January 2021

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Ehara taku toa i te toa takitahi, engari he toa takitini.

My strength is not that of a single warrior but that of many.

Ethics approval

As the current study involves human participants, an ethics application was submitted to the Auckland University of Technology Ethics Committee (AUTEC). An ethics approval was granted by AUTEC on the 6th of July 2020 (approval number: 20/127).

CHAPTER I: INTRODUCTION

The global landscape of mental health

Recent data collated from 63 countries indicated that 29% of the combined population have experienced a common mental health condition at some stage in life, such as a mood, anxiety, or substance use problem (Steel et al., 2014). Between 1990 and 2017, the Global Burden of Disease Study has reported on the incidence, prevalence and years lived with disability (YLD), in relation to 354 conditions across 195 countries (James et al., 2018). For almost 3 decades, depressive disorders have been one of the top three leading causes of YLD, and mental health disorders overall have accounted for roughly 14% of age standardised YLD (James et al., 2018). Globally, the number of deaths from suicide increased by 6.7% between 1990 – 2016, and in 2016 there was 817,000 deaths from suicide (Naghavi, 2019). A report by The New Zealand Mental Health Commissioner (MHC) outlines the extent of the problem in Aotearoa (MHC, 2020). The Commissioner highlights that one in five New Zealanders will live with a mental health condition each year, and 50-80% of the population will experience a mental illness and/or an addiction over a lifetime (MHC, 2020). Mental illness is more common among priority populations, such as Māori and Pacific peoples. In fact, one in three Māori and one in four Pacific peoples experience some form of mental illness (MHC, 2020). Moreover, the New Zealand Mental Health Inquiry of 2018 emphasised the trend in suicide rates in New Zealand: suicides have increased over the last four years, 2017-18 had the highest rate since 1999, the youth suicide rate is among the worst of the OECD countries the, and, in 2015, 525 people took their own lives (He Ara Oranga, 2018).

Mental health helplines

The way in which people seek and receive support for distress has evolved over time (Mishara & Côté, 2013). During the 20th century there was an increase in one-on-one professional help, such as psychotherapy and counselling. Additionally, understanding of psychological conditions and treatments grew (Mishara & Côté, 2013). Knowledge and technology have altered how people are supported and how they access it during times of distress. For instance, the invention of the telephone offered an alternative point of access to such services (Mishara & Côté, 2013). The origins of mental health helplines can be traced back to not-for-profit organisations, such as the Salvation Army's anti-suicide bureau that was established in London in 1906 (Mishara et al., 2007A). Modern helplines are based on two approaches, one by the Samaritan Organisation that was founded by the Reverend Chad Varah in 1953, and the other by the Los Angeles Suicide Prevention Centre that was established in 1958 (Mishara et al., 2007A). For example, nondirective listening and befriending of callers were typical features to the Samaritans approach (Mishara et al., 2007A). The Los Angeles Suicide Prevention Centre was more directive and solution focused, which was emphasised by their use of evaluations, referrals, and follow-

ups (Mishara et al., 2007A). Since the 1950's, the number of services in operation have risen dramatically. In fact, the World Health Organisation (WHO) estimate over 1000 mental health helplines worldwide (WHO, 2018).

In their study on the seeking of mental health treatment in 16 countries, the WHO identified that many people either fail to access treatment or access is delayed by 1-30 years, but this differs between conditions (Wang et al., 2007). Various barriers have been identified, including difficulties in recognising or expressing concerns, a desire to be self-reliant, and various forms of mental health stigma (Gulliver et al., 2010). "The [New Zealand Mental Health] system does not respond adequately to people in serious distress, to prevent them from 'tipping over' into crisis situations" (He Ara Oranga, 2018, p.11). Mental health helplines, and the anonymity that they can provide, may lessen the barrier of stigma, with respect to suicidal thoughts and mental health concerns, in the hopes of increasing help seeking behaviours (WHO, 2018). A helpline is a viable platform to normalise mental health concerns, to disseminate information on common signs and symptoms as well as to provide immediate assistance during a crisis.

Globally, mental health helplines are managed by various organisations, such as The Samaritans, Lifeline and many others operating in over 40 different countries (Dunkley & Whelan, 2006). Between 2018-2019, staff at the UK Samaritans answered 3.6 million calls (Samaritans UK, 2019) and Lifeline Australia answered 731,646 calls (Lifeline Australia, 2019). In New Zealand, between 2016-2017, The National Telehealth Service's (NTS) mental health and addictions (MHA) lines (specifically, the Depression, The Alcohol and Drug, and Gambling Helplines) had 44,831 people making contact for support, with estimates indicating year-on-year increases (NTS, 2017). In addition to phone calls, the services also support people using SMS messaging and web-based applications, such as email or chat (Samaritans UK, 2019; Lifeline Australia, 2019; The National Telehealth Service, 2017). Adding a further 47,238 contacts to Lifeline Australia (Lifeline Australia, 2019) and 1.008 million contacts to the UK Samaritans (Samaritans UK, 2019). These statistics suggest that thousands of paid staff and/or volunteers are required across the organisations to support those in need.

The National Telehealth Service

In 2015, the New Zealand Ministry of Health established the NTS in partnership with Homecare Medical, which is owned by two primary health organisations, ProCare and Pegasus Health (NTS, 2020). The NTS operates under a 10-year agreement with the Ministry of Health and is funded by several organisations, including the Ministry of Health, the Accident Compensation Corporation, the Health Promotion Agency, the Ministry of Social Development, and the Department of Corrections (NTS, 2020). The NTS provides New Zealanders with free physical, mental and social support through various platforms that include calls, text messages and webchat, which are accessible 24 hours a day, seven days a week (NTS, 2020). A workforce of over 350 people, spanning eight clinical teams – that include registered nurses, psychologists, counsellors, health advisors, amongst others – work out of four

contact centres in Auckland, Wellington, Christchurch and Dunedin, including many work-from-home staff (NTS, 2020). The NTS MHA services include, but is not limited to, the Depression Helpline, Need to Talk (1737), the Alcohol and Drug Helpline, the Gambling Helpline, RecoveRing, and Safe to Talk (NTS, 2020). The team consists of registered psychologists, psychotherapists and counsellors, and un-registered health advisors that have, or are studying towards, a degree in counselling, social work, or psychology. Health advisors, from here on, will be referred to as paraprofessionals. Employees of a helpline will be referred to as telephone support workers (TSWs), which will encompass registered, volunteers, and paraprofessionals, unless stated otherwise.

The efficacy of helplines

The effectiveness of a helpline is evaluated in relation to the immediate and long-term effects for the caller (Hoffberg et al., 2020). Relieving the caller's psychological distress or de-escalating a crisis would be an immediate concern, which could then be followed with promotion of adaptive coping and/or engagement with long-term supports. Gould et al. (2007) investigated the outcomes of suicidal callers, and a companion study by Kalafat et al. (2007) explored non-suicidal callers. Each study examined change during the call and up to three weeks post-call. A helpline was shown to be effective in decreasing crisis states and hopelessness in non-suicidal callers (Kalafat et al., 2007). Similarly, for suicidal callers, a helpline was effective in reducing suicidality, with follow-up assessments showing further decreases in hopelessness and psychological pain (Gould et al., 2007). A noteworthy limitation of the available evidence is the lack of data on crisis support through online chat and SMS (Evans et al., 2013; Hoffberg et al., 2020; Mishara & Côté, 2013), which is particularly concerning given the emerging preference among youth for support that is accessible via new media sources (Crosby Budinger et al., 2014). While the limited range of studies supports the use of text and chat services (Evans et al., 2013), with one study showing comparable results to telephone counselling (Mokkenstorm et al., 2016), there is conflicting evidence. A study by Sindahl et al. (2018) found that text services were less effective for suicidal texters. The authors came to the conclusion that texting may be an insufficient method of supporting those who are suicidal, and that this medium may need to be supplemented with other methods for suicidal people (Sindahl et al., 2018). Despite a consistent lack of a controlled condition and a high risk of bias, the accumulated evidence suggests that mental health helplines are an effective method of alleviating a crisis situation or a distressed state (Hoffberg et al., 2020).

Consequences for telephone support workers

It has been proposed that TSWs are less vulnerable to the consequences of psychological distress due to their limited contact with callers and the anonymity of their role (Ghahramanlou & Brodbeck, 2000). However, a recent publication indicated that TSWs are vulnerable to several negative consequences and there is an increased risk in those with maladaptive coping, less work experience and increased exposure to distressed individuals (Kitchingman et al., 2018C). These consequences may also

negatively influence efficacy of the TSWs (Kitchingman et al., 2018B), which may pose a risk to the caller. A model of functional impairment for TSW's has been proposed which involves an affective response to empathic engagement, psychological distress, and coping (Kitchingman et al., 2018B), but further research is needed to expand the model to ascertain a more comprehensive understanding of the pathway to impairment (Kitchingman et al., 2018A). In doing so, this might ensure that TSWs are more capable of identifying the negative consequences and then taking suitable steps to mitigate these. Conversely, it seems that minimal attention has been given to the positive consequences (Kitchingman et al., 2018C; Willems et al., 2020). A recent systematic review did not explore the positive aspects (Kitchingman et al., 2018C) and another could only source five studies discussing positive consequences (Willems et al., 2020). TSWs have discussed several positive outcomes, such as increased motivation, greater purpose in life, interconnectedness, and personal growth (Willems et al., 2020). The positive experiences were also associated with levels of satisfaction related to their role and satisfaction more generally. Despite this knowledge, the authors emphasised a paucity of research on the wellbeing of TSWs and the factors that enable positive wellbeing (Willems et al., 2020).

Research focused on health professionals offers some insight into the consequences of a helping role more generally. It is well understood that registered practitioners can be adversely affected by their role and these consequences are often discussed in relation to various concepts, such as burnout, vicarious traumatisation, secondary traumatic stress, and compassion fatigue (Turgoose & Maddox, 2017). A comprehensive outline of each concept is provided in Chapter II. There is, however, a considerable amount of overlap between the concepts, thus limiting the development of a more concrete understanding of how each manifest (Newell et al., 2016). Contextual factors also influence how a person can be impacted by their role. For instance, organisational factors (O'Connor et al., 2018) and maladaptive coping styles have contributed towards burnout (Simpson et al., 2018); Adams and Riggs (2008) found that defence mechanisms play a role in the formation of vicarious trauma; and a personal trauma history is often connected to secondary traumatic stress (Hensel et al., 2015) and compassion fatigue (Turgoose & Maddox, 2017). Ultimately, it is plausible that the antecedents and consequences differ by profession and personal history, and an exploration of each concept within a certain role may produce a deeper understanding of the mechanisms and outcomes that could be discreet to each profession.

Outline of the current study

The range of consequences to TSWs and how these conditions interact is not well understood. The current study will utilise a Critical Realist (CR) methodology and thematic analyses (TA) as the method, both of which will be used to delve into the diverse consequences for TSWs. TA, as outlined by Braun and Clarke (2006), is a relatively flexible and structured method that can be used to identify patterns of meaning within a qualitative dataset (Braun & Clarke, 2006). A CR study engages with existing theories in the search of the most accurate interpretation of reality, but it suggests that all

theories are fallible (Fletcher, 2016). However, some theories may approximate reality better than others (Bygstad & Munkvold, 2011). For instance, if evident in the sample, CR may allow us to understand if burnout or compassion fatigue is a more accurate interpretation of a negative consequence for TSWs. Research on health professionals has shown that personal interpretations and various contextual factors play an important role in how people are impacted by their role, which is another reason that a CR approach is well suited to this study. A CR approach acknowledges the interplay between personal and contextual factors in the search of mechanisms that produce observable trends (Fletcher, 2016). CR and TA may therefore allow us to ascertain the contextual and discrete factors that produce a consequence.

CHAPTER II: LITERATURE REVIEW

Justification for mental health helplines

Mental health helplines are a readily available resource for anyone in a crisis. A crisis can occur when a person recognises that they lack the personal resources to manage a situation (Caplan, 1964). Caplan (1964) explains that people react to a crisis in four stages: 1. An event produces a preliminary rise in tension that prompts customary problem-solving; 2. If these prove to be ineffective then tensions will continue to rise; 3. Emergency or novel problem-solving techniques are attempted and, if these are ineffective, tensions are likely to increase; and 4. Unless the problem is resolved, or avoided through resignation or cognitive distortion, tensions will mount and may result in distress. It is likely that a person will experience various subjective feelings, such as fear, guilt, anxiety, or helplessness, which contribute towards a sense of disorganisation and a decreased ability to function effectively (Caplan, 1964). A person may draw from previously used maladaptive responses as a form of problem-solving (Caplan, 1964), including suicidal behaviours or substance use. During a crisis it is common for a person to become more amenable to assistance from a variety of sources, which has become the foundation of crisis interventions (Caplan, 1964). Crises are not confined to a certain time of day and, for this reason, a person may need help at any point. Mental health helplines have therefore adopted a 24-hour service delivery model (Kalafat et al., 2007).

Essentials skills for the telephone support worker

The skills and techniques used during a call tend to vary across organisations (Mishara et al., 2007A). Emotional support and non-judgmental active listening are two commonly used skills (Hall & Schlosar, 1995; Kalafat et al., 2007; WHO, 2018). Broadly speaking, Mishara et al. (2007A) proposed that services tend to prioritise two basic service models: active listening and collaborative problem-solving (Mishara et al., 2007A). In both models, the telephone support worker (TSW) would initially establish a good relationship with the caller, which is essential for the helping relationship (Mishara et al., 2007A). The TSW's use of active listening allows the caller to freely express themselves, and the TSW's responses (that may include reflections or reformulations) demonstrate attentiveness and compassion, while simultaneously allowing the caller to feel understood and calmer (Mishara et al., 2007A). It is assumed that the act of being heard and validated allows the caller to discover their own alternative solutions to their situation (Mishara et al., 2007A). When using collaborative problem-solving, the TSW creates a space wherein the service user can focus on their problem and assess their own situation (Mishara et al., 2007A). The service user's self-examination of their situation allows them to produce novel solutions and, with the support of the TSW, the caller can seek out suitable resources to resolve their problem (Mishara et al., 2007A). It is expected that the service user will leave a call, from either model, with a renewed sense of hope, security, and composure (Mishara et al., 2007A). Alternatives approaches to self-harm become more apparent, and the caller's ability to recognise

internal and external resources is more pronounced (Mishara et al., 2007A). Generally, collaborative problem solving is a more directive approach whereas active listening embodies a more nondirective style.

To successfully meet the needs of a service user, it is essential that a TSW adapt their approach based on the individual characteristics of each caller. Using a technique of silent monitoring of 617 calls taken by 110 trained volunteers, Mishara and Daigle (1997) assessed effective intervention styles with suicidal callers. A TSW's response was coded using a set of 20 predefined categories, and outcomes were assessed based on three factors: change in suicidal urgency from the start to the end of a call, changes in state depression, and the caller's ability to maintain a safety contract following the call. Analyses of the data revealed two broad intervention styles, directive (investigatory and with direct questions) and nondirective (Rogerian, e.g., active listening) techniques. In the context of calls that adopted some directive features, a greater proportion of nondirective/Rogerian features were associated with more significant decreases in depression, an increased likelihood of making a safety contract and maintaining this post-call, but results varied based on caller type. New callers demonstrated better outcomes from a nondirective style and repeat callers benefited from a more directive approach. Therefore, change is influenced by the TSW's ability to recognise and adapt their approach based on the needs and unique history of the service user. Expanding on these findings, Mishara et al. (2007B) investigated the relationship between the characteristic of an intervention and the short-term outcomes of 1,431 crisis calls. The authors found that a supportive approach was the strongest predictor of positive outcomes, which included: moral support, validations, reframing, sharing experiences, and suggesting a call back. Overall, Mishara et al. (2007B) concluded that the essential elements and key competencies for a TSW were their capacity to establish a rapport while also demonstrating empathy and respect as a means of helping the caller to nurture a deeper sense of belonging. However, it is possible that these are innate qualities of a TSW that may not be easily taught during a training program (Mishara et al., 2007B). Therefore, some TSWs may not possess or easily learn the aforementioned qualities, meaning that they may struggle to identify when or how to modify their approach. Not only could this leave the caller in a vulnerable state, but it could also mean that the TSW does not obtain a sense of achievement from their work.

Stressors associated with the role

Mental health helplines utilise electronic forms of communication to support individuals seeking help during a crisis. The distinct features of a helpline produce several challenges for TSWs. One of the defining features of a helpline is the anonymity that they offer to the caller (WHO, 2018). This privacy may be an appealing aspect for service users, but it can also increase the complexities of a call for the TSW. Suler (2004) highlighted that a lack of face-to-face contact can produce a sense of dis-inhibition and a person may feel less restricted in sharing details that they might not ordinarily do so in face-to-face settings. This assertion is substantiated by the work of Coman et al (2001), who found

that clients became more forthright when interacting via the telephone. Therefore, a possibility exists for TSWs to hear a multitude of traumatic experiences from callers that provide a large amount of detail, which may leave the TSW vulnerable to various consequences. Additionally, a caller enters the conversation with an ability to end the interaction at any moment, which could be distressing for the TSW, particularly if the caller is in crisis (O'Sullivan & Whelan, 2011). For some callers, engagement with a service may consist of a single interaction and a caller may not initiate future contact to report on their progress (Rosenfield, 1996). TSWs also do not have access to visual signs that can guide their understanding or direct their responses, and, as such, there is a greater reliance on auditory clues, such as the caller's voice and background noises (O'Sullivan & Whelan, 2011). Therefore, it is possible that a TSW could misattribute certain cues, which could produce distressing conclusions about the caller's current state (O'Sullivan & Whelan, 2011). Coman et al (2001, p, 254) illustrates that TSWs must "be especially attuned to every sound, every silence, inflection and qualities of speech including tone, pitch and speed." However, it is unlikely that each TSW would react in a similar fashion if presented with a comparable scenario, particularly because aspects of the call may be beyond that person's present moment awareness.

People who contact mental health helplines can become dependent on these services for a variety of reasons. Some may become repeat callers because they are actively addressing their difficulties, while others may approach the service with the intent to be challenging, abusive, or because they are lonely (Rosenfield, 1996). There is also a subsection of repeat callers that make contact purely for the purposes of sexual gratification (Hall & Schlosar, 1995). Given the role of helplines, staff are often in contact with callers that are in active states of crisis or distress (Kalafat et al., 2007). The study by Gould et al. (2007) examined changes in a caller's suicidal state from the start to the conclusion of a call and then again 3 weeks post-call. In the initial assessment, 1085 suicide callers were assessed, and 380 were included in the follow-up. Of the suicidal callers, nearly 60% reported a previous suicidal attempt, which is one of the most robust predictors for completed suicides (Gould et al., 2007). Despite seeing reductions in caller's intent to die during initial contact, suicidal ideation remained for a substantial proportion of callers and these people often continued to contact the service. While this may indicate that helplines are effective for suicidal callers, Gould et al. (2007) proposed that this group of people may be forming an inappropriate reliance on a helpline rather than accessing community mental health services. It has been suggested that a caller may develop such a dependence because it less confronting or anxiety provoking compared to face-to-face services (Bassilios et al., 2014). Repeat callers have implications on service delivery because resources may be diverted from those that need support. Additionally, TSWs may become ill-equipped to provide the empathy that other callers require (Hall & Schlosar, 1995).

A definition of a paraprofessional

Mental health helplines are staffed by trained professionals, paraprofessionals or volunteers that offer brief, one-off interventions (Kalafat et al., 2007). A volunteer is a person that donates their time and services without receiving remuneration. The definitions of 'professional' and 'paraprofessional' have varied in studies on TSWs. In a report by Mishara et al. (2016) professionals are those with a college or university degree. With regard to paraprofessionals, they generally have not completed formal clinical training in fields such as psychology, psychiatry, social work, or nursing (Durlak, 1979). Therefore, a paraprofessional is someone that is not registered with a practising body. It should be clarified that within the context of the current study, a paraprofessional may be working towards an under-graduate, post-graduate or a certificate in a related field of study, such as psychology, counselling, or social work.

The negative effects of the telephone support role

A recent review by Kitchingman and colleagues (2018C) examined several publications to ascertain the impact of the role on TSWs. Their initial database search revealed 207 articles published between 1973 and 2013, with the majority being conducted from the year 2000 onwards. Once each study was screened and evaluated against inclusion criteria, seven were included in the final review. These seven studies investigated outcomes for volunteer, professional and paraprofessional TSWs. Overall, the review reported that TSWs were vulnerable to various consequences, such as vicarious trauma, stress, and burnout, but there was an increased risk for those with maladaptive coping, less work experience and increased exposure to distressed individuals (Kitchingman et al., 2018C). In a related study, Kitchingman et al. (2017) investigated elements of functional impairment in 210 volunteer TSWs at a service in Australia, focussing on emotion regulation, psychological distress, suicidal ideation, and help-seeking intentions. Although this study was focused on volunteer TSWs it offers general insight into the impact on TSWs. The authors defined functional impairment as a reduced ability to manage typical daily activities in social, occupational, and other important areas of functioning (Kitchingman et al., 2017). Functional impairment and psychological distress were evident in a significant proportion of support workers, specifically in those with inadequate emotion regulation abilities and low help-seeking behaviours (Kitchingman et al., 2017). This is concerning given the knowledge that greater functional impairment has been connected to a decrease in a TSW's likelihood to use recommended skills (Kitchingman et al., 2018B). Research demonstrates that there is a general risk to TSWs; however, a more comprehensive understanding of the path to impairment is yet to be identified (Kitchingman et al., 2018A). Understanding this pathway in more detail might ensure that TSWs are more capable of identifying the negative consequences and then taking suitable steps to maintain optimal functionality in various important domains.

In comparison to face-to-face practitioners, it has been proposed that TSWs are less vulnerable to the consequences of psychological distress due to their limited contact with callers and the anonymity of their role (Ghahramanlou & Brodbeck, 2000). However, unlike face-to-face practitioners, TSWs are exposed to several unique stressors, such as repetitive and/or sexual gratification callers (Hall & Schlosar, 1995), the lack of visual cues (Coman et al., 2001) and knowledge about the outcome of a caller (Cyr & Dowrick, 1991). While engagement with a helpline may be beneficial for the caller, it does, however, mean that the TSWs are often in contact with people during states of distress or crisis (Gould et al., 2007; Kalafat et al., 2007), which may have a lasting effect on the TSWs themselves. Evidence suggests that expressions of empathy and respect are key factors that lead to positive change in distressed individuals (Mishara et al., 2007B). In registered professionals, it is well understood that empathetic engagement with distressed clients can lead to several negative consequences, such as secondary traumatic stress and/or burnout (Temitope & Williams, 2015; Simpson et al., 2018).

Burnout and telephone support workers

The definition of burnout outlined by Maslach and Jackson is the most well recognised (O'Connor et al., 2018). Burnout is characterised by three distinct domains – exhaustion, depersonalisation, and a self-perceived ineffectiveness – and is often consequential of persistent exposure to challenging interpersonal stressors (Maslach et al., 2001). Ultimately, it is a state of mental exhaustion that may emerge due to long-term exposure to situations that are emotionally, physically and mentally demanding (Simpson et al., 2018). The exhaustion domain is typified by a depletion of resources and feeling burdened by one's professional role, as well as being representative of the underlying stress component of the construct (Maslach et al., 2001). Careers that are emotionally demanding, such as telephone support work, can affect a service provider's ability to engage effectively with a person (Maslach et al., 2001). This domain, however, does not occur in isolation, it elicits certain internal and external responses, such as becoming more detached, cynical or disregarding a person's unique qualities, as a means of managing a demanding position, often resulting in a sense of depersonalisation (Maslach et al., 2001). Depersonalisation is a protective mechanism whereby the person cognitively distances themselves from their clients or callers by way of disregarding their individuality (Maslach et al., 2001). In the mind of the professional, paraprofessional or volunteer TSW, the caller is transformed into an object, so as to manage the demanding working environment (Maslach et al., 2001), which would in turn affect the TSW's interpersonal relationships and self-evaluations.

The third domain of burnout is a sense of ineffectiveness or a reduced sense of accomplishment (Maslach et al., 2001). A chronically demanding and overwhelming work environment that brings about a sense of fatigue or cynicism will negatively influence a person's self-perceived effectiveness (Maslach et al., 2001). Indeed, if a person is exhausted or holds a sense a of apathy for a caller, they may naturally struggle to acquire a sense accomplishment from their work (Maslach et al., 2001). Therefore, apathy might inhibit a TSW from truly connecting with the client's pain, thus preventing an effective working

relationship, and therefore rousing a sense of inefficacy for the TSW, due to their perceived inability to bring about change.

The available research on burnout in TSWs has focused on volunteers rather than paraprofessionals (Cyr & Dowrick, 1991; Kitchingman et al., 2018A; Roche & Ogden, 2017). This reveals a need for studies that concentrate on the impacts of the TSW role on paraprofessionals. Despite this, volunteer and paraprofessional TSWs work in similar environments and encounter similar demands, which means that the available data on TSW burnout can provide some insight into a related role. From a sample of 39 people, Cyr and Dowrick, (1991) identified that 54% of volunteers felt burnt-out while working. A noteworthy consideration is that participants in this study were sourced from two different helpline centres and the results did not illustrate the proportion of burnout associated to each centre, which may have provided clarity to the evolution of burnout. Data indicated that the primary factors that influenced burnout were volunteer turnover, lack of peer contact, and poor peer communication which may suggest that certain organisational factors are a key contributor to burnout in TSWs (Cyr & Dowrick, 1991). However, these facets may be associated with working environments or cultures at particular organisations.

The idea that working environments can contribute to burnout is perhaps accentuated by the findings of Kitchingman et al. (2018A) and Roche and Ogden (2017). Roche and Ogden (2017) measured burnout among 216 volunteer TSWs at the UK Samaritans. Their results revealed low levels of burnout, as evidenced by each subscale: emotional exhaustion and depersonalisation were low, and personal accomplishment was moderate to high. Kitchingman et al. (2018A) measured burnout, among 110 volunteer TSWs at Lifeline Australia, the weeks before and after completing a helpline shift. Burnout was low for the majority of participants at both time points. Similar to Cyr and Dowrick, (1991), it is interesting that Kitchingman et al. (2018A) found that overall psychological distress was impacted by several features, such as a low number of people working during the shift and a lack of contact with the in-shift support person. Meaning that there was, perhaps, a mismatch between TSW needs and organisational and/or peer support.

Previously, it was thought that burnout could be attributed to either the personal qualities that people bring to their role or aspects of their working environment. New theoretical frameworks related to burnout are considering individual and situational factors in a more integrative sense using a model of job-person fit (Maslach et al., 2001). A model of this type has typically focused on preliminary working aspects, such as choice of occupation, organisation or adjustment to a role; however, a job-person fit approach to burnout is focused on the long-term aspects of the work wherein the person is seeing the consequences of a more enduring mismatch (Maslach et al., 2001). It is thought that the likelihood of burnout varies in relation to the degree of match or mismatch between the person and their working environment across six distinct work domains: workload, control, community, reward, fairness

and values (Maslach et al., 2001). One or several of these domains may apply to the environment or experiences of paraprofessional TSWs.

A deeper understanding of the job-person fit model, in terms of the domains, may be useful when considering the TSW role. A person who feels a lack of recognition may devalue their work, a lack of perceived fairness in the workplace could diminish their self-worth and working in a role that does not align with their values could leave a person feeling constrained, which respectively relates to reward, fairness, and values (Maslach et al., 2001). A workload mismatch has generally focused on excessive demands that deplete a person's energy, but a mismatch could also be related to level of ability, type of work or displaying emotions that are inconsistent with a person's true feelings (Maslach et al., 2001). In relation to paraprofessional TSWs, a person may encounter service users with a challenging presentation, which could highlight a mismatch in the TSW's level of ability. A control mismatch is associated with a lack of influence over the resources to effectively do their work or a person may feel they have an insufficient amount authority to effectively do their work in a manner that is personally satisfying (Maslach et al., 2001). TSWs may hold a personal commitment to their work and their service users, but they could lack the necessary control or the resources to meet these personal commitments. A community mismatch may be derived from a lack of support or social contact (Maslach et al., 2001), which is already a known issue for volunteer TSWs (Cyr & Dowrick, 1991; Kitchingman et al., 2018A) and one that could apply to paraprofessional TSWs. Incorporating a job-person fit model may allow us to more accurately capture the mechanisms or systems that contribute towards paraprofessional TSW burnout.

Vicarious trauma and telephone support workers

Working with callers who have experienced a traumatic event can have a profound effect on the TSW. A client's graphic descriptions of their trauma experience may leave the TSW vulnerable to psychological alterations that can be unsettling, disruptive, and long-lasting, a process that has been termed vicarious traumatisation (VT; McCann & Pearlman, 1990). Grounded in constructivist self-development theory, VT is a negative internal adaptation that can occur out of the TSW's expressions of empathy for a person's trauma material (Pearlman & MacIan, 1995). Trauma experiences are considered to be transformative, and these adaptations emerge out of the interaction between personality characteristics and significant features of the trauma event, but the outcome is shaped by a person's social and cultural world (Pearlman & MacIan, 1995). It is thought that individual realities construct and shape cognitive structures known as schemas (a collection of mental frameworks encompassing beliefs, expectations, and assumptions) that influence how people engage with and make sense of their inner and outer world (McCann & Pearlman, 1990). Changes in these schemas can be referred to as disrupted cognitive beliefs.

A TSW's schemas can be disrupted by a caller's trauma material, but this effect is unique and based partially on the schemas that are more primary or salient to each person (McCann & Pearlman,

1990). Trauma content could influence the TSW's schemas related to dependency, sense of safety, power, independence, esteem, intimacy, frame of reference, and memory systems (McCann & Pearlman, 1990). For example, a caller that recounts their experiences of being deceived or violated may mean the TSW becomes suspicious or distrustful of others (McCann & Pearlman, 1990). Cognitive adaptations can alter how effectively the TSW works with the caller. For TSWs that prioritise power, a sense of powerlessness may develop from their work and they could then encourage callers to take action rather than aiding them in an exploration of the meaning of their responses to the trauma (McCann & Pearlman, 1990). Essentially, rather than holding a focus on symptoms, VT places a stronger emphasis on the unique meaning of a trauma experience and the resulting cognitive disruptions or adaptations (Canfield, 2005).

Several studies have explored the existence of VT in TSWs (Dunkley & Whelan, 2006; Furlonger & Taylor, 2013; Howlett & Collins, 2014). Dunkley and Whelan (2006) examined the influence of personal trauma history, coping styles and supervision on VT among 62 (26 volunteers and 36 paid) TSWs from organisations offering trauma support. A follow-up study by Furlonger and Taylor (2013) investigated the influence of supervision on 38 professional TSWs. Howlett and Collins (2014) conducted a qualitative study that focused on the risk of VT and the resilience of 10 volunteer TSWs. In the study by Dunkley & Whelan (2006), the average length of service of a TSW was 3.4 years; however, the authors did not illustrate the participants' professional status or their level of education. Based on the features of traumatisation (quantity of post-traumatic stress disorder [PTSD] symptoms and disrupted cognitive beliefs) overall levels of VT were low (Dunkley & Whelan, 2006). Despite this, five participants exhibited between high to very high average in disrupted cognitive beliefs, and 15 participants reported the existence of at least one symptom of PTSD, which suggests that TSWs are vulnerable to VT (Dunkley & Whelan, 2006). Low levels of PTSD symptoms in their sample were attributed to the use of single assessment point (Dunkley & Whelan, 2006), but this finding was consistent with the work of McCann and Pearlman (1990) who assert that PTSD symptoms associated with VT are likely to be transient.

When considering the manifestation of VT, various internal and externals factors appear to be involved. Research on trauma therapists has revealed a connection between a person's personal trauma history and increased levels of VT (Pearlman & MacIan, 1995). Similarly, Dunkley and Whelan (2006) discovered that a personal trauma history was associated with greater number of PTSD symptoms, but it was not predictive of further increases (Dunkley & Whelan, 2006). Coping, specifically non-productive coping (such as denying the problem or self-blame) was associated with increased cognitive distortions (Dunkley & Whelan, 2006). In the study by Dunkley and Whelan (2006), a large proportion of participants (27.9%) did not attend supervision. Although the receipt of supervision did not influence levels of VT, a strong supervisory working alliance was associated with lower disrupted cognitive beliefs (Dunkley & Whelan, 2006). As highlighted, research has been conducted on VT in volunteers and professionals, but there are no available, in-depth qualitative studies that focus on paraprofessional

TSWs. Given that VT is shaped by differences in personality traits, in conjunction with a person's social and cultural world (Pearlman & MacIan, 1995), this may suggest that VT manifests differently across various environments. Therefore, studies are needed to further understand a paraprofessional TSWs environment and if or how they are impacted by VT. In doing so, this would need to include an exploration of a paraprofessionals coping techniques and how they utilise supervision.

Secondary traumatic stress and telephone support workers

Influenced by the concept of PTSD, Charles Figley pioneered the term secondary traumatic stress (STS) to capture what he believed to be the cost of caring (Figley, 1995). He defined this reaction as "the natural consequent behaviours and emotions resulting from knowing about a traumatising event experienced by a significant other – the stress resulting from helping or wanting to help a traumatised or suffering person" (Figley, 1995, p. 7). Figley (1995) proposed that STS, like VT, is the result of empathetic engagement with a client that has experienced a traumatic event and who shares this in their therapeutic work. However, rather than focusing on the shift in cognitive processes, the concept of STS places a stronger emphasis on the more overt behavioural symptoms (Figley, 1995). Albeit to a lesser extent, the symptoms of STS can parallel the symptoms of PTSD, specifically those experienced by the person that experienced the primary traumatising event (Figley, 1995). The presentation of STS may include an array of PTSD symptoms that include intrusive thoughts, memories, or dreams, avoidance or detachment, diminished affect, irritability or anger, fatigue, concentration problems, and hypervigilance or an exaggerated startle response (Figley, 1995). While symptoms of burnout emerge gradually, STS differs to burnout in the sense that symptoms typically have a more rapid or immediate onset (Figley, 1995). A person may experience STS symptoms over the course of a month, and this would be considered a normal reaction to crisis-related content, but if they persist for six months or longer (following exposure to the trigger) then this would be considered STS disorder (Canfield, 2005).

STS is an outcome that may be applicable to paraprofessional TSWs. In addition to measuring burnout among 110 volunteer TSWs at Lifeline Australia, Kitchingman et al. (2018A) also assessed symptoms of STS the week before and after a shift on the helpline. Data from both timepoints revealed that TSWs experienced low amounts of STS symptoms (Kitchingman et al., 2018A). Despite this, the participants' anxiety, stress and STS symptoms were considerably higher the week proceeding their shift, which led the authors to suggest that TSWs experience psychological stress in anticipation of their shift on a helpline (Kitchingman et al., 2018A). This increase in STS symptoms, prior to a shift, may mean that TSWs revisit the traumatic material of past calls as preparatory action for subsequent shifts (Kitchingman et al., 2018A). The rise in STS symptoms prior to a shift warrants further investigation as this may indicate that TSWs need support at certain times. For instance, TSWs may benefit from pre-shift debriefings that focus on managing leftover content so that they can focus more effectively on their current shift. Kitchingman et al. (2018A) also discovered that a TSW's personal history, specifically those with a lived experience of suicide, reported greater levels of STS than those who had

no history of suicide. Therefore, TSWs with personal histories of suicide may be more susceptible to STS and may need additional supports. While Kitchingman et al. (2018A) found that their participants experienced low levels of STS, their study indicated when TSWs may be most in need of support and that people with certain backgrounds may be in greater need of support. To ensure that TSWs are provided with suitable support, further research is needed to ascertain if paraprofessional TSWs experience similar outcomes to volunteers.

Compassion fatigue and telephone support workers

Over the last two decades, the concept of compassion fatigue (CF) has received considerable attention and has become a widely researched consequence of working in the field of human services (Sinclair et al., 2017). It initially appeared within healthcare literature in an article by Joinson (1992), who used it to capture the loss of one's ability to nurture. Following this, Charles Figley appropriated the name, using it as a less stigmatising term to describe STS and the expression of this construct (Figley, 1995). Consequently, it is suggested that the term CF has been used erroneously within academic literature and used interchangeably with STS and VT (Newell & MacNeil, 2010). Figley (2002) offered further clarification on the concept and proposed that CF is, in fact, a potential STS reaction. Since then, research on CF has rapidly increased, with studies being conducted around the globe (Sinclair et al., 2017). However, after twenty years of research and over 350 peer reviewed articles, a broadly accepted definition does not exist and its association with compassion remains unclear (Sinclair et al., 2017).

Several models of CF can be found within the academic literature from the field of psychology. Figley (2002) suggests that it emerges from exposure to a client, a motivation to help (empathic concern), and an effort to mitigate the suffering of others (empathic response), of which the latter is influenced by the therapist's aptitude for recognising the pain of others (empathic ability; Figley, 2002). Therefore, a person's ability to empathise is what produces a vulnerability to CF, but this is influenced by other factors (Figley, 2002). The therapist will experience compassion stress, the residual emotional energy from offering empathy and the persistent desire to relieve the client's suffering, which can be minimised by obtaining a sense of achievement or by disengaging/distancing themselves from the needs of the client (Figley, 2002). Alternatively, the professional quality of life (Pro-QOL) scale outlines CF as being a combination of STS and burnout, and it assesses this by measuring client factors, work and/or personal environments in the manifestation of CF or its direct opposite – compassion satisfaction (CS; Stamm, 2005). A notable limitation of this model is that it does not integrate facets that are unique to compassion itself (Ledoux, 2015). Rather than estimating levels of CF, it is more likely that the Pro-QOL is assessing aspects of STS (Sinclair et al., 2017).

Various models of CF have also been outlined in the academic literature from the nursing profession. Austin et al. (2009) suggests that CF is the result of an inability to provide appropriate care, to meet the requirements of their role or to fulfil their moral obligation, causing disengagement and

distress. Coetzee and Klopper (2010) claim that CF is the manifestation of a progressive and cumulative process that begins with the prolonged, continuous and intense nature of one's work, the investment of personal resources, and exposure to stress, which produces a state of compassion discomfort (Coetzee & Klopper, 2010). Without suitable intervention, compassion discomfort produces compassion stress that will likely surpass the person's level of endurance and culminate in CF (Coetzee & Klopper, 2010). Therefore, it is the depletion of the person's compassionate energy, and this state has come about because the person has exceeded their restorative processes (Coetzee & Klopper, 2010). Similar to other models, Klimecki and Singer (2011) propose that CF is influenced by empathy but that it is contingent on the direction of one's empathy, which may take either an other-orientated or self-orientated focus. Those who have an other-orientated focus can differentiate between their own feelings and those of the client, whereas a person with a self-orientated focus blends their feelings with those of their clients (Klimecki & Singer, 2011). The other-orientated focus results in empathic concern and attempts to alleviate suffering, the self-orientated focus promotes personal distress and withdrawal, and the authors suggest that empathic distress is what we have come to call CF (Klimecki & Singer, 2011). Fundamentally, it seems that "CF refers to an acute onset of physical and emotional responses that culminate in a decrease in compassionate feelings towards others because of an individual's occupation" (Sinclair et al., 2017, p. 10).

CF was investigated by O'Sullivan and Whelan (2011) in their study on growth in TSWs. More specifically, O'Sullivan and Whelan (2011) examined the psychological and environment influences on growth, which included an assessment of CF. Sixty-four TSWs were included, of which 76.6% were volunteers and 23.4% had paid positions. The average number of hours worked per week was 4.11 and most participants (62.5%) worked on a casual basis, with the remainder working either part-time (35.9%) or full-time (1.6%). O'Sullivan and Whelan (2011) measured CF using the Pro-QOL, which is composed of 30 items that are answered on six-point Likert scale that range between zero (never) and five (very often). A total score that ranges between 8-17 would be concerning, and above 18 could indicate that a participant finds an element of their work frightening (Stamm, 2005). The authors found that 43.8% of participants scored less than eight (not concerning), 60.9% scored between 8-17 (concerning), and 17.2% of participants reported a score of over 17 (experiencing something frightening). When these scores were compared to practitioners in other fields, O'Sullivan and Whelan (2011) noted that TSWs experienced levels of CF similar to that of psychotherapists and slightly higher than mental health social workers. In a review of available evidence on TSWs, Willems et al. (2020) assessed the results of the study by O'Sullivan and Whelan (2011) and they noted that empathy was unrelated to CF. This result is rather significant because Figley (2002) suggests that empathy is a necessary precursor in the process of developing CF. Evidence from the study by O'Sullivan and Whelan (2011) would indicate that TSWs are vulnerable to CFs, and to a similar extent as face-to-face practitioners. Although, the lack of a relationship between empathy and CF suggests that the factors involved in the progression of this outcome, in TSWs, warrants further investigation.

The positive effects of the role

Previous research has provided insight on the risks to TSWs, but minimal attention has been given to the positive consequences (Kitchingman et al., 2018C, Willems et al., 2020). For instance, two systematic reviews have recently been completed, one that did not explore the positive aspects (Kitchingman et al., 2018C) and another that was only able to source five studies discussing positive consequences (Willems et al., 2020). In the latter, it was discovered that TSWs experienced positive outcomes in several areas, including, motivation, purpose in life, interconnectedness, and personal growth. The positive experiences were also associated with levels of satisfaction related to their role and satisfaction more generally. Despite this knowledge, the authors (Willems et al., 2020) emphasized that there is a paucity of research on the wellbeing of TSWs and the factors that enable this.

Vicarious post-traumatic growth and telephone support workers

In more general research, the concept of posttraumatic growth, as a constant, positive psychological outcome, has received a lot of attention (Lelorain et al., 2010; Morrill et al., 2008; Triplett et al., 2012; Wild & Paivio, 2004). Posttraumatic growth is described as an ongoing process and an outcome that occurs following a traumatic or challenging experience, and one that leads to positive change (Tedeschi & Calhoun, 2004). This positive change, or growth, may take several forms, such as a deeper appreciation for life, improved relationships, greater inner strength, recognising new directions in life, and spiritual fulfilment (Tedeschi & Calhoun, 2004). Reflecting on the aforementioned factors, posttraumatic growth is a process and an outcome that appears to be deeply personal in nature. Of those who directly experience a trauma, the benefits of posttraumatic growth are seen in measurements of life satisfaction (Triplett et al., 2012), quality of life (Morrill et al., 2008), happiness (Lelorain et al., 2010), and various forms of wellbeing (Wild & Paivio, 2004). Although there are differences, posttraumatic growth as outlined by Tedeschi and Calhoun (2004) it is similar to vicarious posttraumatic growth (VPTG). In comparison to posttraumatic growth, VPTG appears to be more abstract in nature and less integrated to one's self concept (Manning-Jones et al., 2015). For instance, people often focus on the resiliency of mankind rather than the self, they speak of a broadening to their spiritual side and an acceptance of a spiritual connection as a healing tool, and there is a recognition of the value in one's work for its beneficial effect on others (Manning-Jones et al., 2015).

The possibility of VPTG being an outcome for TSWs was explored in the study by O'Sullivan and Whelan (2011). While the objectives of their study were to assess the level of growth in TSWs, they simultaneously examined the aspects that influence it. Several psychological and environment factors were examined, specifically CF, empathy, environmental support (in-shift supervision) and calls per shift on a TSW's level of growth. O'Sullivan and Whelan (2011) examined the extent that factors influence a TSW levels of growth. All participants exhibited growth due to an adverse interaction with a caller, but individual scores were quite diverse, some reported high levels while others experienced little (O'Sullivan & Whelan, 2011). Overall, levels of growth were low, but this was attributed to the

predominant inclusion of volunteers that worked casually/part-time (O'Sullivan & Whelan, 2011). CF was a strong predictor of growth, i.e., increased growth coincided with greater levels of CF, but the number of calls taken on shift was related to lower levels of growth (O'Sullivan & Whelan, 2011). Consequently, O'Sullivan and Whelan (2011) proposed that there may be a 'threshold of adversity,' wherein a TSW reaches a point where continued growth is less likely. Contrary to expectations, empathy and environmental support had no influence on overall levels of growth (O'Sullivan & Whelan, 2011). Although, prior research suggests that empathy and support can protect therapists, from VT, and promote growth (Harrison & Westwood, 2009). It is possible that environmental support may protect a TSW's well-being following a traumatic call, rather than being a necessary component in the formation of growth (O'Sullivan & Whelan, 2011). However, the minimal number of hours that the volunteers worked may have influenced their connection with in-shift support. Volunteers may not work enough to build a sense of trust with their supervisors, which may affect the depth or quality of the support that is provided. Although empathy was not associated with overall growth it was connected to a single growth subscale (Spiritual Change) and this warrants further investigation on the influence of empathy and the various aspects of growth (O'Sullivan & Whelan, 2011). Whilst environmental support did not influence growth, this may be attributed to limitations in the tools that measured this component and future studies may want to explore supports that are specific to TSWs, such as one-to-one and group supervision (O'Sullivan & Whelan, 2011).

Research has illustrated various elements, or mechanisms, that facilitate VPTG including empathetic engagement, self-care, the passage of time, positive affect and optimism, personal trauma, and several interpersonal variables (Manning-Jones et al., 2015). In the context of the proposed study, interpersonal variables (i.e., social support), specifically peer support and/or professional supervision, may warrant closer examination. In fact, in terms of social support, peer support and/or professional supervision are thought to be the most beneficial (Manning-Jones et al., 2015). The aim of supervision is to develop a TSW's awareness and acceptance to a trauma response, while also breaking down or processing the response and associated feelings, and then facilitating the integration of positively transformed material (Taylor & Furlonger, 2011). It has also been suggested that supervision will increase the use of positive coping styles to manage the effect of VT (Taylor & Furlonger, 2011). Dunkley and Whelan (2006) found that a strong supervisory relationship is instrumental in mitigating the effects of VT, with levels decreasing in those with a stronger working alliance. This finding, however, was not replicated in another study (Furlonger & Taylor, 2013) and there is contradictory evidence in the efficacy of supervision (Rizkalla et al., 2017). Therefore, the availability and utilisation of supervision may not be enough for growth, this may be dependent associated features of the supervisory role. While various components contribute towards VPTG, organisational support, such as peer support and/or professional supervision, may be worthy of further investigation, for several reasons: their adaptability, and their capacity to instil effective coping and to transform negative related consequences.

Compassion satisfaction and telephone support workers

CS is a construct that has also been explored in connection to the positive effects of a helping role (Newell, 2016). A driving force behind CS is a sense empathy for others and this stimulates altruistic acts that work to lessen the distress of others (Radey & Figley, 2007). Essentially, CS is the pleasure that a person can acquire from being able to effectively help others (Stamm, 2005). A person's work may allow them to feel a sense of pleasure from helping people, which may come from supporting their colleagues, contributing to the workplace or to society in general (Stamm, 2005).

Radey and Figley (2007) outline a model that describes a potential mechanism behind CS. They explain how affect, resources, and self-care work to shift, what Radey and Figley describe as, the positivity-negativity ratio in favour of the production of CS. Affect can be defined as the broad array of feelings that we experience, and these range from positive (e.g., gratitude) to negative (e.g., irritability). Negative and positive affect have a varying influence on a person's behavioural responses (Radey & Figley, 2007). While negative affect leads to a narrower set of responses, positive affect broadens a person's abilities and allows for greater flexibility, in relation to thoughts and actions (Radey & Figley, 2007). This increased flexibility can have a flow on effect in the production of novel or innovative ways of working or caring for the self. In connection to this, positive affect can facilitate the production of resources that a person has available to them, which can be physical, intellectual, or social resources (Radey & Figley, 2007). A fundamental component in this process is self-care, and it is suggested that self-care acts as a mechanism to increase positive affect and personal resources (Radey & Figley, 2007). This raises a pertinent question: how much positivity is necessary to sustain a TSW in their role and offset the difficulties they face? The positivity-negativity ratio is a measure of positive versus negative affect over a given period, and this should favour positive experiences by roughly three to one (Radey & Figley, 2007). It is suggested that when there is a sufficiently greater proportion of positive to negative experiences, a person's morale will improve and they will be more productive (Radey & Figley, 2007), thus increasing the likelihood for CS.

Studies have also explored elements that produce a sense of satisfaction for TSWs. In addition to examining burnout in volunteer TSWs, Cyr and Dowrick (1991) explored factors of the TSW role that produced a sense of satisfaction. Participants in their study were asked to select from a list of 40 proposed satisfaction factors that were absent, as well as those that were present while in their role and that offset burnout (Cyr & Dowrick, 1991). The top three responses were recognising the benefits of the role, such as growth and human contact, having a supervisory relationship that offered encouragement and support, and feeling appreciated and knowing of their importance to the organisation (Cyr & Dowrick, 1991). The study by Cyr and Dowrick (1991) demonstrates that TSWs experience satisfaction from being in the role, however, their findings on satisfaction may relate more to their participants' job satisfaction. Job satisfaction is about the fulfilment and contentment that a person can acquire from their role, rather than their relationship to the work itself (Maslach et al., 2001).

Therefore, further research is needed to ascertain if aspects of the TSW role align with the concept of CS.

Other studies have been conducted that investigated broader aspects of satisfaction associated with the TSW role. A review of available evidence on volunteer TSWs highlighted how they draw motivation from various sources that can be categorised as other-orientated and self-orientated motivations (Willems et al., 2020). Other-orientated motivations included helping others, providing help to others that they once received, feeling a sense of altruism, and contributing to society (Willems et al., 2020). Self-orientated motivations encompassed a purpose in life, learning or being challenged, and developing new perspectives (Willems et al., 2020). However, these aspects were examined in relation to a person's decision to maintain a volunteering roll (Willems et al., 2020), which may mean that these findings are distinct to volunteering. It is possible that paraprofessional TSWs draw on a different set of CS factors that motivate them to stay in their role. Evidence from the nursing literature has highlighted variances in levels of CS based on various factors, such as age, gender, level of education and organisation differences (Sacco et al., 2015), which supports the need for further exploration of this concept across professions and organisations. Evidence certainly suggests that TSWs are drawing satisfaction from their role, but there is a lack of evidence on CS in paraprofessional TSWs. Given the premise that CS leads to increased motivation (Stamm, 2002), more research is needed to ascertain if and how paraprofessional TSWs experience CS.

Conclusion

The current review of literature has provided an outline of the available evidence on helplines and TSWs, focusing on some of the key effects and outcomes of the role, such as burnout, VT, CS and VPTG. Organisations that operate mental health helplines around the world have adopted various service delivery models, but their goal is to support a caller. For a caller to receive effective support, a TSW must adapt their approach in accordance with a caller's unique history and presentation and failing to do this may result in poor outcomes for the caller and the TSW. TSW outcomes, that are either positive or negative, are likely to be influenced by the format in which they conducted their work i.e., telephone calls or text messages. Interacting with people over the phone removes the ability to use visual signs, thus increasing the difficulty for a TSW to accurately assess a person's situation or presentation. Additionally, a TSW may be exposed to a large volume of calls that incorporate a level of detail that could be traumatising. TSW outcomes are also likely to be influenced by other stressors that are distinct to helplines, such as abusive or sexual gratification callers, large amounts of callers' in active states of distress, and callers who have formed an unhelpful reliance on a helpline.

Available evidence has highlighted how TSWs can experience various negative and positive outcomes. Negative outcomes can include burnout, VT, STS and/or CF. Positive outcomes have included VPTG and CS. There is, however, a lack of research on the positive consequences that TSW

experience and the available evidence has focused on volunteer TSWs rather than paraprofessionals. Further research on the positive consequences is essential as this can offer further insight on the transformative and motivational aspects that help to retain a TSW in their role. Given that volunteers work a minimal number of hours per shift and per week, they may be less exposed to the stressors associated with mental health helplines. This is of particular importance because increased exposure is associated with greater negative outcomes. Conversely, paraprofessionals are paid to perform their role and can work a greater number of hours, thus increasing their exposure to helpline stressors and potential adverse consequences. Research on the negative and positive consequences for volunteers may apply to paraprofessionals, but further research is needed to ascertain if and how they are impacted by TSW role. This information is of benefit because it may ensure that paraprofessional TSWs are supported more effectively, which would likely have a flow on effect to caller outcomes.

CHAPTER III: METHOD

The aim of the research

The objectives of the current research study were to explore and examine the experiences of paraprofessional mental health and addictions (MHA) telephone support workers (TSWs) at the New Zealand (NZ) National Telehealth Service (NTS). It was expected that the study would enhance current knowledge on the experiences of TSWs, regarding the negative and positive aspects of the role. Data were collected using semi-structured interviews (SSI), thematic analyses (TA) was used to analyse the data and construct themes that would fulfil the research question, and underlying the study was a Critical Realist (CR) methodology.

Methodology

All research is guided by ontological (i.e., the nature of reality, what is real) and epistemological (i.e., what is considered knowledge) foundations. CR is a combination of a realist ontology (much of reality exists independent to our own awareness) and an interpretive epistemology (a real world exists, but our interpretation of it is socially constructed and it may be imperfect; Bygstad & Munkvold, 2011). A central tenet of CR is that our perspective of reality should not be reduced or limited by our understanding of reality (Fletcher, 2016). In this sense, if knowledge is reduced purely to what can be empirically studied then we are limiting our ability to understand the various forms of reality. Therefore, in terms of an epistemology, CR does not make it possible to find a singular truth, but rather an interpretation of knowledge that exists within a layered reality (Bygstad & Munkvold, 2011).

A CR perspective of ontology is that reality is stratified into three levels of existence: the empirical, the actual, and the real (Fletcher, 2016). While mediated by individual experience and interpretation, observable and measurable events are those that occur at the empirical level. However, events can occur irrespective of our awareness of them, which is said to happen at the actual level. One may experience a traumatic event (at the empirical level) and this may lead to a negative internal reaction (at the actual level). Following this, a person makes sense of their experience and potentially engages in various processes that transform the experience (at the real level). In this description there is an interplay between the varying levels of reality and the existence of a causal mechanism, i.e., the interpretation of a traumatic event.

Mechanisms could be defined as an intrinsic property of an object or structure exerting a force and producing an event (Fletcher, 2016). The effect of this mechanism may be contextually dependent: two people experiencing the same event may interpret and act on it in varying ways. Therefore, a mechanism might allow us to recognise an outcome, but it does not necessarily predict its occurrence in the future (Bygstad & Munkvold, 2011). Each person may interpret the same event differently because of their use of language, their cultural background, their gender or even their social status, all

of which influence their perspective on reality. CR was chosen as a methodology for the proposed study due to its focus on understanding these causal mechanisms and their influence on each level of reality.

Recruitment of participants

Participant recruitment was facilitated by the team managers at the NTS, who are referred to as People Leaders. A Consent Form (Appendix C) and Information Sheet (Appendix B), provided by the primary researcher, were emailed by the People Leaders to the relevant staff in their respect teams. Selection criteria were as follows: 1. Each person should have worked for the organisation (the NTS) for a minimum of six months; and 2. They must be a paid paraprofessional, i.e., not registered with a professional body. The six-month criterion was included to allow for acclimation to the role. The People Leaders were asked to forward information of the study without encouraging or discouraging participation.

To ensure consistency, the People Leaders were provided with a pre-written email (Appendix E) that could be distributed to their teams. This email indicated that those who were interested in participating in the study should contact the researcher directly with any additional questions and that they did not have to inform anyone at the NTS if they wished to participate or not. These points were included to mitigate potential coercion (by the People Leaders or other staff members) to take part and to ensure confidentiality for the participants. The Information Sheet supported the process of informed consent, and this was supplemented with the option of asking the researcher additional questions. Each participant was informed and consented to take part in the research.

It was anticipated that 10-12 people would take part, however, participation was impacted by COVID-19, which meant that the total number of participants was *n*=9. Although this did not meet expectations, once the transcripts of the nine participants had been assessed the data reached a point of saturation and it is unlikely that the inclusion of additional participants would have revealed more information. Basic demographics of the participants are provided in Table 1.

Table 1. Participant descriptive statistics

Characteristics		*n*=9	Mean
Gender	Male	4	
	Female	5	
Age			
	21-30	3	
	30-40	3	
	40-50	2	
	50-60	1	
Ethnicity	NZ European	3	
	NZ Maori and NZ European	2	

	NZ European and other	2	
	European and other	2	
Service lines	1-2	2	
	3-4	3	
	5-10	0	
	11+	4	
Time employed	8 months - 1 year	3	
	1-2 years	4	
	5 years+	2	
Hours per week			33.89
	24-29	2	
	30-40	7	

Data collection

Data collection consisted of a series of individual in-depth interviews that were guided by a SSI schedule (Appendix D). The purpose of a SSI is to draw out an interviewee's subjective understanding of a particular area or phenomenon (McIntosh & Morse, 2015). A SSI is a format that cuts across methodological associations and is not bound to any particular philosophical frameworks; it can actually accommodate the philosophical commitments of feminist, phenomenological and critical methodological research aims (McIntosh & Morse, 2015).

SSI's are particularly relevant when there is adequate objective knowledge on a particular phenomenon but there may be inadequate subjective knowledge (McIntosh & Morse, 2015). As evidenced by the range of information that was drawn on Chapter II, there is a relatively modest amount of objective evidence on volunteer TSW's, their role and the impact of this. McIntosh & Morse (2015) explain that this information is what forms the framework of a SSI and it guides the development of the interview questions. For TSW's, it was clear that various negative and positive consequences are part of their reality, but the available evidence did not capture how these experiences manifested, particularly in paraprofessional TSW's.

Existing evidence informed the creation of the SSI interview schedule. For example, one of the questions included in the interview schedule was: "Have you struggled because of your role and, if so, what signs suggested this?" We are aware that TSW's can struggle because of their role, and this can manifest in several ways, such as burnout or vicarious trauma. While the question explores "struggles" and "signs," the landscape of this question is open to interpretation, thus allowing the interviewee to elaborate using their own experience. While the phrasing and order may vary, the SSI questions or topics to be covered were predetermined and presented to each participant (Merriam & Tisdell, 2015). This flexibility allows the researcher to respond and interact more fluidly with each participant, enabling a person's perspective on the world and new ideas to flow freely out of the conversation (Merriam &

Tisdell, 2015). Encouraging an open dialogue, on areas important to the participants, the interview schedule was designed to facilitate a discourse that met the research aims.

Each participant was informed that the interview would be audio-recorded for transcription. Given the travel, health and social restrictions related to COVID-19 during 2020, participation in the study was only made available via electronic methods, such as a telephone, Zoom or Skype interview. In qualitative studies, the primary means of data collection is often face-to-face interviewing and telephone interviews are considered more suitable for shorter, more structured interviews (Sturges & Hanrahan, 2004). However, interviewing via electronic methods offered an advantage in the context of the current study. The NTS operates out of several cities in New Zealand, therefore, the use of electronic methods increased the ability to participate.

Some suggest that the ability to establish and maintain a rapport with an interviewee is constructed out of the physicality of face-to-face interviewing, and therefore it is essential to the interview process (Gillham, 2005). However, regardless of the method that is used, the efficacy of an interview may depend on the interviewer's ability to engage with a participant. The researcher has several years of experience conducting quantitative interviews via telephone and has been a TSW for the last two years. During this time, he has developed a range of skills to interact with an interviewee or a caller, e.g., listening for auditory clues. For instance, a pause, a quick response or a certain tone might indicate the need for a follow-up or a clarification question. It is thought that the researcher's ability to reflect on these elements may have deepened the rapport with the interviewees.

It is possible that the quality and the range of data might have been impacted by the physical distance. A study by Sturges and Hanrahan (2004) utilised both telephone and face-to-face interviewing. When data from each method were compared, the range, nature and depth of participant responses were comparable. Despite this, to offset any potential disadvantages of conducting the interviews via digital communications, video calling was considered. It was believed that video calling via Zoom or Skype may be a more comfortable medium, for certain participants, and it could provide certain benefits over face-to-face interviewing. The remote and informal nature of this medium has been discussed as positive aspects that may counteract the 'pressure of presence' an interviewee may feel during a physical, face-to-face interview (Weller, 2017). Weller (2017) suggests that the spatial distance offered by video calling may allow an interviewee to feel at ease, thus encouraging them to provide responses that they might not have been willing to share in a face-to-face interview. Given the main researchers experience, it is suggested that this may have offset the potential losses from the lack of a physical of face-to-face interview. Moreover, his working relationship with the potential interviewees could be compared to a pre-established rapport, which may assist the interview process.

The average length of an interview was 67 minutes (range 54-83 minutes), and they were audio-recorded for transcription. Eight interviews took place on a Zoom call and one was conducted over the telephone. The main researcher personally transcribed each interview verbatim. Each participant had

the opportunity to review their transcript for accuracy, and one participant chose to review their transcript. No participant requested any amendments.

Data analyses

The current study utilised the qualitative data analyses programme QSR NVivo v.12. The transcribed materials were analysed using TA. TA was chosen because of its theoretical flexibility whereby it can be applied to a variety of methodological frameworks and research questions (Braun & Clarke, 2006). While maintaining a focus on the material or the data itself, a CR study explores how a person constructs meaning out of their experiences and how their broader social systems influence this meaning (Braun & Clarke, 2006). "[TA] can be a method that works both to reflect reality and to unpick or unravel the surface of 'reality'" (Braun & Clarke, 2006, p.81), thus making it an appropriate method of analysis for this study.

TA uses a structured process to identify patterns of meaning or "themes" in a qualitative dataset (Braun & Clarke, 2006). The proposed study followed the steps set out by Braun and Clarke (2006). The process involves six distinct but iterative stages: 1. Familiarisation with the dataset through repeated readings of the transcripts and listening to the audio recordings; 2. Identification of noteworthy aspects which are relevant to the research question and which will be the preliminary codes; 3. Collation of codes to produce overarching themes, which are supported by adequate data extracts; 4. Review of themes to ascertain if they capture the essence of the coded extracts, if these are coherent with the full data set, and if the themes are distinct enough; 5. Definition of the themes, by recognising the unique stories that underscore each theme and considering how these blend to produce the broader narrative, which allow a name for each theme to be generated; and 6. Writing of the final report, merging the themes into a cohesive narrative that is backed-up by compelling data extracts and contextualised against relevant literature.

As recommended by Braun and Clarke (2006), it is important to clearly outline the theoretical framework in which the analyses will be conducted. Data were analysed at both the semantic and latent levels. A semantic analysis allowed the researcher to identify the explicit or surface meanings of the participants' experiences. Utilisation of a CR methodology, however, did require a modest level of interpretation to identify the underlying mechanisms that produce observable trends, which was at the latent level. Data can be analysed either inductively, driven by the data itself, or deductively, which is influenced by theory (Braun & Clarke, 2006). An inductive analysis, therefore, does not funnel or force the data into a pre-existing theoretical model (Braun & Clarke, 2006). For this study, TA analyses was conducted using an inductive approach.

Ethical considerations

Human participation necessitated an ethics application prior to the commencement of data collection, which was submitted to the Auckland University of Technology Ethics Committee

(AUTEC). An application was submitted to AUTEC on the 28th of April 2020, and approval was granted on the 6th of July 2020 (approval number: 20/127; Appendix A). Once approval was granted, an Information Sheet and Consent Form were distributed to relevant employees within the MHA team, by their respective People Leaders. Any person interested in the study was invited to email the main researcher with any questions. This action promoted the transparency of the study and allowed participants to ask clarification questions.

Several actions were taken to maintain confidentiality throughout the study. The names of the participants were removed from all study documents and replaced with a unique identifier. Each unique identifier was based on the participants order of enrolment within the study, e.g., 'Participant One', 'Participant Two', etc. Each person was informed that their involvement in the study would not be shared with the NTS. Prior to the commencement of the interview, each participant was encouraged to refrain from using callers' or employees' names, but if this were to occur each participant was informed that any names would be removed from the transcript. Digital copies of audio recordings and transcripts will be securely retained by AUT for a period of ten years, at the end of which these documents will be destroyed.

To avoid any potential coercive influence from the primary researcher, he did not discuss the study with any staff member until they approached him to ask questions related to the study. While the primary researcher has a working relationship with the potential participants, he does not hold a managerial position, which may have offset any potential conflict of interest. Additionally, participants were reassured that information disclosed in the interviews will not be discussed further following the interview; that is, the primary researcher will not discuss any details of the interviews with the NTS management, with other participants, or with other staff members.

Trustworthiness

Several measures exist to examine the quality of a research project (Morrow, 2005). Morrow (2005) highlights several standards for qualitative research, such as validity, credibility, rigor, and trustworthiness. Typically, the standards that are used to measure trustworthiness will vary in relation to the theory that underpins the research: how one would evaluate a grounded theory study will differ to a critical ethnographic study (Morrow, 2005). However, Morrow (2005) suggests that there are several qualities that can be used across paradigms, which are social validity, subjectivity and reflexivity, adequacy of data, and adequacy of interpretation. Due to the scope of this study, the maintenance of trustworthiness will be discussed in relation to reflexivity and subjectivity.

Reflexivity and subjectivity

Researchers that are rooted in qualitative methods acknowledge that the entire process, from data collection to analysis, is steeped in subjectivity (Morrow, 2005). Depending on the paradigm, subjectivity is handled in various ways, from being limited or controlled to being embraced and

integrated (Morrow, 2005). "[C]ritical theorists are more likely to embrace the positioning of the researcher as co-constructor of meaning, as integral to the interpretation of the data, and as unapologetically political in purpose" (Morrow, 2005, p.254). A CR researcher does not treat their data as a manifestation of what occurs in the real world; the researcher must interpret the data and make inferences as to the causal structures that may be producing the phenomena under investigation (Willig, 2013). However, this raises the question of whose voice is being heard, the participant or the researcher? There are numerous factors that influence the collection and interpretation of data, such as the researcher's assumptions and biases, their own emotional involvement with the topic, and the actual interactions with the participants (Morrow, 2005). As such, it has become standard practice for qualitative researchers to explicitly state their own assumptions and biases (Morrow, 2005).

Reflexivity is a process of reflecting and stating one's biases and assumptions that originate from one's personal and professional experiences (Morrow, 2005). Willig (2013) expands on this to explain that personal reflexivity is a process of reflecting on who we are as researchers and what has shaped our perspective on reality, which could include our values, experiences, interests, beliefs or political commitments. What follows is a personal statement on the primary researcher's experiences of being a TSW. I have worked for The NTS for approximately two years in a full-time position. In this time, I have held several roles that include paraprofessional TSW, in-shift support person, and Quality Reviewer. As a TSW, I have received in-bound communications from members of the public and offered appropriate support, which could be emotional support, suggestions for self-care or collaborative action planning. As an in-shift support person, I supported my team members after difficult and/or complex calls. As a Quality Reviewer, I have routinely reviewed and produced feedback on the work of other team members, which is moderated and distributed by the People Leaders of each team. Over time, I have come to recognise the emotional demands of the role and the importance of self-care to maintain one's professional responsibilities. At present, I do not believe that I have experienced burnout or vicarious trauma, however, assuming the role of Quality Reviewer was due, in part, to a sense of emotional exhaustion. The partial distance from the role of TSW was beneficial for my own mental health. These experiences inspired me to pursue this piece of research to ascertain if TSWs could be supported more appropriately.

Reflexivity also involves a continuous and evolving process of evaluation that facilitates insight and understanding (Willing, 2013). To enable this, Morrow (2005) encourages consultation with research teams or peers who can discuss and reflect on the investigator's reactions to the research activities. As part of an ongoing commitment to reflexivity, the primary researcher routinely discussed the data analyses process with his primary supervisor. Consultation with the primary supervisor occurred throughout the entire research process. During the analysis phase, the primary researcher consulted with the supervisor to ensure his interpretations were derived from the participants' experiences and not from his own.

Qualitative researchers draw from a range of techniques to ensure that they maintain and represent their participants' realities (Morrow, 2005). This is particularly relevant if the interviewer is integrated into the culture being studied or is familiar with the phenomenon being investigated (Morrow, 2005). Given the primary researcher's role at the NTS, he is firmly integrated in and familiar with the working environment, and he has a good working relationship with his colleagues. For this dilemma, Morrow (2005) provided direction and offered several techniques. Firstly, she encourages the researcher to seek clarification from the participants on their experiences, as this will allow the researcher to delve further into their subjective realities. Secondly, the interviewer can assume the role of the naïve enquirer (Morrow, 2005). In this regard, the interviewer presents themselves as a curious novice to the client's world. These strategies were implemented throughout the data collection process. For instance, the interviewer routinely asked variants of the following questions "could you elaborate on that point" or "I am quite curious about this last point, can you tell me more." Additionally, he would often present clarification questions, first by paraphrasing the participants words and then asking, "have I understood that correctly." The participants would offer clarification or confirmation. To further maintain the representation of the participants' realities, each person was given the option to review and amend their own transcripts. However, Morrow (2005) proposes that this is not a sufficient method because a person's memory is fallible and the interview itself acts an event that produces change. Therefore, Morrow (2005) suggests the use of focus groups as a forum to present emergent data and to receive direct feedback from participants. However, it was not feasible to include this procedure due to the scale of the study and the necessity of maintaining the participants' confidentiality. It was anticipated that the strategies of clarification-seeking and the naïve enquirer would enable the researcher to approximate the participants' individual realities.

CHAPTER IV: FINDINGS

Introduction

Analysis of the data allowed for the identification of five main themes, each containing several subthemes. The five main themes are: *1. We are dealing with a lot, and our role is to stay in the moment; 2. How I feel from doing this work; 3. Creating a sense of distance; 4. Doing our work in a supportive space; and 5. The work adds value to my life, which is motivating*. A summary of each theme and subtheme is provided in Table 2.

Table 2. Summary of themes and subthemes

1. We are dealing with a lot, and our role is to stay in the moment
1.1. We do not necessarily see change, which can be difficult
1.2 What is going on in the background for me
1.3 We may choose to, or we have to, go beyond what we're here for
2. How I feel from doing this work
2A. Circumstances that influence the ability to empathise
2B. Am I enough for this role?
2C. Uncomfortably working with the unknown
3. Creating a sense of distance
3A. Separating from what we do
3B. Keeping work and home life separate
4. Doing our work in a supportive space
4.1. Having variety in the work
4.2. What we give to a caller can also be helpful for us
4.3. Talking about the work in a personally meaningful context
5. The work adds value to my life, which is motivating
5.1. The role fits with my identity
5.2. Personal growth
5.3. I'm more prepared to help

Theme 1. We are dealing with a lot, and our role is to stay in the moment

The participants expressed a feeling of being overworked, which was primarily a result of the volume of calls that the service receives. Several subthemes underscored the dominant theme and contributed to the participants overall sense of burden. The participants discussed the volume of interactions, the range of content that service users share, and the pace of the work, which constructed the reality that the participants are dealing with, that they are overloaded with work. Moreover, several participants discussed the telehealth environment as being quite distinct, particularly in comparison to face-to-face practice. "Telehealth is a very unique setting because, you know, you would never have a client load that big in a day if you were doing face-to-face interventions, and it can be overwhelming" (Participant 1).

In terms of feeling overworked, other contributing factors included a difficulty in regulating the duration of a call and the amount of text interactions they received. For the participants, an understanding of a face-to-face practitioner's workload was instrumental in recognising the extent of their own workload. Meaning, the participants compared their own workload to the expected workload of face-to-face practitioners, which led to conclusion that their own workload was likely to be greater. Moreover, the participants felt that their own workload was harder to regulate compared to that of face-to-face practitioners. Participants 8 and 6 provided details on their experiences with the workload. "I find it too, too demanding. I find it too fast, and I do feel like I'm, at times, I feel like I'm a factory worker on a production line" (Participant 8).

> If you were a face-to-face counsellor, you wouldn't have four people in the room and turning individually to each one of them, giving a snippet of a line. Then to the next one, doing something different. Your attention's divided. I don't like it, at all. (Participant 6)

Despite the overall breadth, volume and duration of the calls, the scope of their role is clear. Although callers may need or expect more than this, the role of the participants is to provide callers with brief emotional support. Brief emotional support involved validations, reflections, and empathy as a means of reducing distress and facilitating a caller's natural ability to problem solve. Additionally, if needed, the participants could direct callers to external services for more substantial support. Essentially, the participants recognised that it is necessary to stay within the service parameters to meet the needs of a caller, to the extent that is expected of them. However, people may contact the service with an expectation of support that is more akin to long-term therapy. Therefore, the participants cannot fully meet the needs of a service user because this would be beyond the service boundaries, which requires an understanding and acceptance of the limitations of the service. "We're not there to solve those bigger problems that might have gotten them into that state, but to check-in and see what can we, what can I do to help them, right now" (Participant 8).

Theme 1.1. We do not necessarily see change, which can be difficult

The intention behind the service is to offer callers brief emotional support. Staying within the purview of the service added a level of complexity to the work. It appeared that the participants devote their time and effort to their work, and they are continuously using emotional energy to connect and support the service users. Despite what they give, the participants recognised that there is often a lack of change in the service users, which can feel somewhat unfulfilling and/or draining.

> Verbally, they'll tell you that they are, but I guess it would be good to know that you've supported someone in a longer-term way and that would be good in terms of us - to feel like we've had an effect. (Participant 2)

> If they hang up or if we end the conversation without making a huge amount of progress because of situational things or a lack of willingness to change or systems or something, then it's kind of just left there, and it can take a while to kind of take that out of your system because you don't really have that catharsis, almost, with them. (Participant 4)

The nature of the helpline (providing brief emotional support, as outlined in theme 1), coupled with unpredictable nature of the calls (lack of knowledge on a caller's outcome), means that participants

are not necessarily seeing the benefits of their work and they can be left with a feeling of unfulfillment, which added to the weight of their workload.

Theme 1.2. What is going on in the background for me

In addition to calls with service users, several background issues were highlighted that contributed to the weight of the work and made it more straining. Key areas were personal issues (e.g., family bereavement), background corporate processes (e.g., knowing about calls waiting), and the participants awareness to the wider mental health system (e.g., knowing people must often wait for support). Some calls had a personal element for the participants. For instance, a participant reflected on calls that involved family bereavement, and (in the past) this had triggered an emotional response due to similar circumstances. “I would say that it's not necessarily like the most intense calls or the most unusual calls that are the most, kind of, triggering for us, it can just be what's going on for us” (Participant 2).

Some of the services corporate systems contributed to the participants concern with the work. Their concerns included the dispersal of interactions among the team, knowing the quantity of interactions that are waiting and the possibility of being negatively evaluated by the company. On top of the demands of the role, the corporate systems meant that the participants were carrying an additional load by way of frustrations or worries. “People listen to our calls and we're sort of assessed on these calls. So, that can be quite intimidating. You know, always having that in the back of your mind as well” (Participant 5).

Given the brief nature of the role, an aspect of the service is sign-posting, which means that the participants direct service users to more substantial community support. Several participants had an impression of the New Zealand Mental Health and Addictions system: the participants believed that these supports have a backlog of clients or they have restrictions that may preclude people. This was an enduring concern for several participants, and it contributed to the weight of their work. “Sometimes that sort of cynicism, slash knowledge of the systems, can mess with the feeling that I get at the end of the call” (Participant 4).

Theme 1.3. We may choose to, or we have to, go beyond what we’re here for

Several participants spoke of wanting to work beyond the parameters of the role, and this exacerbated the demands they placed on themselves. For participant 4, their impression of the New Zealand Mental Health and Addictions system led them to self-appropriate the service user’s care, for the duration of the interaction. They forced themselves to give the caller something that was beyond the expectations of the service. For example, rather than focusing on an individual problem that could be resolved in a short call, several participants felt that they needed to extend the duration of the call to meet all of the service user’s needs, which added additional pressures and produced feelings of helplessness.

> I kind of manipulate myself into wanting to give a lot more to that person than is necessary in the role of our work because I want to sort of be the person that makes a difference for them, which isn't really possible if I look at it, you know - black and white - because it's just a phone call. But, also, kind of puts me in that position of feeling as helpless as them, because I know that what they're saying is true. (Participant 4)

Several participants spoke of service users that stretch the boundaries of a brief intervention service, which means that participants are presented with situations that they cannot resolve by providing emotional support. Participant 6 reflected on a call that involved a paramedic who discussed events following the Christchurch terrorist attack. Not only are participants presented with traumatic material, but they can also feel a sense of powerless because their actions do not directly result in change for the caller.

> He described how he took a child out that had been shot, I think, in the leg. He said that the child said something to him, like, - I can't remember exactly what, but - why was that man angry? And that kind of, I mean, that messed me up, hearing that. That stood out a lot because I didn't really know what to say to the paramedic at all. (Participant 6)

Some interactions may be inherently complex due to the nature of the content or they could evolve into something that is beyond the service boundaries. The example from Participant 6 was a conversation that involved trauma related content, and this made the call more challenging because they were unsure on what was best for the caller. Overall, participants reported that a greater number of service users are presenting with expectations that are beyond the scope of the service, which added an additional challenge for the participants. Service users often contacted the service with an expectation of receiving more than brief emotional support, which highlights the participants' inability to produce long-term change for callers.

Theme 2. How I feel from doing this work

Several participants discussed some of the consequences of the work, and these involved empathy, inadequacy, and uncertainty, which are outlined as three unique subthemes.

Theme 2A. Circumstances that influence the ability to empathise

Among the participants, empathy was identified as an important resource for conducting their work because it enables them to connect with callers. Several participants felt that their ability to empathise with callers fluctuates through consistent use of this attribute. Several circumstances were associated with participants' levels of empathy, most notably, the quantity of service users, the number of calls waiting to be answered, consistent calls from regular service users, and the content of the interactions. Participant 6 spoke of the call waiting board that is displayed in the office, which indicates the amount of work that the participants have ahead of them.

> I was looking at volumes, not people, in a way. So, I was constantly kind of looking up at the board going, 'shit there's like five, ten in the queue,' and maybe rushing calls. Maybe. Probably, I guess, probably being less - maybe - a little less empathetic, as well. (Participant 6)

Elements within the company highlighted the demand for the service and this, in turn, produced a sense of urgency. To compensate for the pressure, participants distanced themselves from the service

users' humanity, which influenced the participants' ability to empathise. Participant 8 reflected on the volume and content of calls, and the impact of these on their ability to express empathy:

> Sometimes I have to catch myself to not become a little, well, resentful to begin with, and then even a little and bitter sometimes about hearing complaints and negativity every four minutes or after those gaps between calls. It can be hard to stay positive sometimes, and I think, for me, that's because of the sheer volume of calls. (Participant 8)

The volume of calls that involved negative content that the participants dealt with over a prolonged period contributed to a diminished empathic ability due to a sense of exhaustion. Restoring one's empathic ability was typically accomplished by taking time away from the work and engaging in self-care activities.

Theme 2B. Am I enough for this role?

Several participants questioned their place in the organisation by highlighting a self-perceived inadequacy. The inadequacy became more concentrated during periods of burnout i.e., feeling empathically strained or physically drained from the volume of calls, but questioning one's ability could also occur following an interaction with a complex service user or a call that had a poor outcome. Participants felt inadequate when they recognised a discrepancy between their own level of ability and the support that the service user required or when they compared their level of training to that of their colleagues. "There are times where I've also felt really inadequate. That I don't or perhaps shouldn't be doing what I'm doing because I don't have the training that most of my colleagues have had" (Participant 9).

Participant 7 commented on their own feelings of inadequacy, which they discussed in connection to an interaction that they felt was beyond their current capabilities. "I do get the feeling sometimes I'm almost like not qualified to do this" (Participant 7). Underscoring these aspects is an expectation of what a participant should be able to accomplish in a brief intervention. This subtheme is associated with subtheme *1.3. We may choose to, or we have to, go beyond what we're here for*. A service user's complex presentation or situation can provoke a participant's urge to care, but due to their own level of training, or the brief intervention format, the participants were not be able to support the service user to the extent that may be expecting.

Theme 2C. Uncomfortably working with the unknown

At the forefront of a participant's work is an ever-present atmosphere of uncertainty. Many recognised it on entering the profession and it became a common aspect of the work. On commencement of the role, participants felt a sense of uncertainty in what the next call will entail, which can foster increased anxiety. Other forms of uncertainty would continue to emerge as the role progressed, particularly the uncertainty associated with the safety of service users or their long-term outcomes. On many occasions, participants had to handle distressing interactions, some that involved suicidal or self-harm behaviours. In these situations, the service users' level of control over terminating the interaction is unsettling for the participants.

> When you're sitting there, someone just hangs up on you, you know, you feel powerless. There's a sense of hopelessness there as well because you haven't been able to control the situation and you don't know now what that person is doing once that phone is down. (Participant 5)

Safety protocols that involve emergency services are in place to protect service users, but participants rarely know the outcome. Participants can become invested in supporting the service user, and the lack of a short- or long-term outcome can create a sense of hopelessness. Those who had been in the role for a prolonged period of time spoke of becoming more accustomed to or accepting of the uncertainty.

> I'm comfortable with it now because of what we do offer. Kind of makes it all kind of worth it, and I understand this is just the job that we do. It is brief intervention and part of the, part of that is that we don't have an outcome, a lot of the time. (Participant 2)

Over time, however, the participants also developed a set of techniques to manage, a sense of support from the organisation and they evolved in their role, which are aspects that will be discussed in subsequent themes.

Theme 3. Creating a sense of distance

Participants navigated the work by creating a sense of distance from it. Distance was created in both a physical and a cognitive sense using two distinct techniques: mentally separating from what they hear and keeping a clear separation between work and home life. Creating an internal and external distance from the work allowed the participants to protect themselves.

Theme 3A. Separating from what we do

Some of the participants had cultivated a protective skill that allowed them to separate from the emotional content of a call, which Participant 3 commented on. In terms of separating from the emotional content, this participant accomplished this by recognising that they will feel an emotion due to a call, but they do not feel a sense of ownership of these emotions and this distinction resulted in a separation. “I've always been very good at separating my emotions from emotions of other people suffering” (Participant 3).

Several participants commented on the importance of making a distinction between their own emotions and the service users’ emotions that a participant may feel empathically. To clarify, a participant may feel an emotion because of an interaction with a caller, but a participant did not feel an ownership to this emotion. In recognising the distinction, this technique allowed the participant to separate from the content of the interaction. A similar process is discussed and elaborated on by Participant 2:

> They've called to get an objective person to talk to, and that's what we are. They don't know us, whether they understand that or not, you know. We have to understand that this person is not angry or upset or grieving because of anything relating to us. (Participant 2)

To separate from the emotional content, Participant 2 commented on the importance of recognising that what is revealed during the interaction, such as the service users’ emotions and/or experiences, are not occurring because of the participant. A participant could engage with a service user

(e.g., ask questions or provide reflections) and this may evoke an emotional response from the service user, but this is a necessary component in conducting their work. The service users' emotions would exist regardless of the involvement of the participant, and this distinction produced an internal distance for the participant.

Theme 3B. Keeping work and home life separate

Managing the role was also influenced by the participants' act of maintaining a clear separation between work and home. For many, this was made possible by an environment that is specifically allocated to the work, which was either in a corporate office or in a participant's home office. The participants perceive the working space as a receptacle or cognitive depository for what had occurred during the shift and this allowed it to be left behind at the end of the day. Participant 5 reflected on how they handle the outcome of a bad call at the end of their working day:

> I don't take it home. That's one I've learnt over the years. Once I leave the building, that's my job, and I can't change what's happened that day. If there are consequences of a bad call, then I'll deal with it when it comes. (Participant 5)

The participant utilised the corporate space to confine the work and the emotional consequences. Essentially, the workspace acted as if it was cognitive depository for a caller's emotional material, which facilitated a separation from the content of a call at the end of the participants' working day. Other participants provided similar examples, such as creating a separate space in their home for work or removing a piece of jewellery to mark the end of the day. These techniques allowed for an acknowledgement of the emotional toll while also being a method that worked to separate the challenges of the day from the participant.

Theme 4. Doing our work in a supportive space

Navigating the work was made easier when it was conducted in a supportive space, which was described in several ways. Firstly, a participant felt a sense of support from their colleagues. The participants appreciated that they worked with likeminded people who are experienced in the field of telehealth. Secondly, the participants felt that a supportive space was created by the amount of control they had, which came from adapting their work environment. This ability emphasised the autonomy that they could exert while being in a role that had elements beyond their influence, such as the callers they engage with. Participant 1 and 6 commented on their ability to converse with their colleagues, which had restorative and supportive capacities. "I think that that's something that is really valuable to me in the fast-paced environment, because otherwise, if you're feeling unsupported, it's harder" (Participant 1).

> I've got colleagues that understand and that get it. If I was working in a factory somewhere, I probably wouldn't have that you know? So, it's given me a really lucky place to go every day. Where I can be myself, with my experiences and my quirks, and all of that shit, and just people accept me. (Participant 6)

Support was also felt in having the ability to adapt the working environment. Adaptability came in several forms, either having the choice to take a time limited break, modifying their working hours, or having the choice to work from home. Controlling these features of the workspace gave the participants an increased sense of agency to do what is personally supportive, which was instrumental in keeping the participants in their role. “I think, honestly, right now, the practicality of the job keeps me here, right now. Being able to be home, work from home and have that control over my job.” (Participant 8)

Theme 4.1. Having variety in the work

The participants spoke of how significant it was to have variety in their work and how they found this feature supportive. At the NTS, participants respond to interactions from several helplines (e.g., the Depression Helpline, the Gambling Helpline or the Alcohol and Drug Helpline) and some have taken on additional roles, such as shift supervisor. Although the range of helplines added to the workload, there was also a supportive element to the variety of the content that they handle. The variety of roles and helplines allowed the participants to preserve some of the emotional energy that aids their ability to connect with service users. Participant 2 spoke of variety in different respects, such as various roles or working with service users across varying interaction methods.

> I guess it's meant, for me, that I'm not on calls all the time, which makes a massive difference. We'll find on shift, as a supervisor, a lot of people will come in and ask, can I please be put on texts because they want to mix it up, and I know what that's like because you just want to change it up for a little bit because it's so intense being on calls. (Participant 2)

Having a sense of variety was also discussed by participant 4, who explained the benefit of working across different helplines. This person commented on the level of empathy that is needed to be expressed, which would differ across the helplines. “If it was constantly just the Depression helpline or need to talk, and you know, very sad people in very difficult positions, it could become more and more draining as the eight hours go on” (Participant 4). It seemed that certain presentations warranted different levels of empathy and the variety of helplines allowed for one’s level of empathy to be moderated, which worked as a protective mechanism for the participants. In essence, it is the variety in content, caller presentations and situations that each helpline attracted that provided the participants with a temporary reprieve from the conversations that might be more emotionally demanding.

Theme 4.2. What we give to a caller can also be helpful for us

Despite being emotionally taxing, several participants spoke of how the work was mutually beneficially, for both themselves and the service users. Participants spoke of the passive influence that the work can have on themselves and how this inadvertently flowed back to them. For instance, participants could intentionally draw from the techniques that they are imparting such as emotional regulation strategies, which was discussed by several participants. ‘’I kind of know what helps and what doesn't, for me, because I'm picking up little tools as I'm advising others that I'm able to incorporate within me” (Participant 3). “I think by supporting other people to help regulate their emotions and deal

with complex situations, I think that kind of unconsciously filters back to me as well, like a reciprocal process" (Participant 4).

The participants' work exposed them to people that are struggling in life. For some, hearing a caller's personal journey was a transformative process for the participants because it allowed them to acknowledge their own personal battles and recognise that they needed to attend to their own struggles. Participant 9 acknowledged how the work can be personally healing because it allowed them to recognise their own challenges. "Acknowledging that trauma has been instrumental in me staying in the room, you know. Through working with the services users, I've kind of been in a process of healing myself" (Participant 9).

Theme 4.3. Talking about the work in a personally meaningful context

Professional conversations, specifically post-call debriefings and supervision, could be a supportive element for the participants. A debrief may follow a difficult or challenging call and this could be conducted by a colleague, a team leader, or the shift supervisor. External supervision occurred monthly and it was conducted by someone who was not associated with the organisation. Although, having the option of debriefing or supervision did not guarantee that they will be used or that they will be of benefit to a participant. To produce something beneficial, the debriefing or the external supervision had to be personally relevant, and failing this the participants would avoid the conversations, most notably the post-call debrief. "I don't debrief as much as I should probably, and that's probably something that would benefit [me] a whole lot. But I don't know how to approach that de-brief to benefit me, if that makes sense" (Participant 3). Most participants confirmed that they used the post-call debrief. However, several participants explained that they did not utilise this support when starting in their role because they did not recognise the purpose or the benefits of the debrief.

In terms of external supervision, this appeared to be more effective when it was exclusively focused on one participant and when it was conducted by someone who had common experiences. Participant 5 discussed the format of an external supervision session, which emphasised the importance of customised sessions. When it was focused on a single person the external supervision enabled a participant to fully explore topics relevant to them and their work, which was not possible in a group supervision format. "I think just having somebody that's so experienced and is only there, in that conversation, to help you with that particular thing. It really helped me. It provided a lot of advice" (Participant 5). The participants could explore a previous call that was ineffective, and the external supervisor could offer suggestions on how the call could have been handled, which enhanced the participants' skillset

Debriefing and external supervision provided a safe space that can produce a sense of relief and prepare the participants for the work to come. Participant 7 reflected on the impact of debriefing and Participant 8 outlined the protective nature of individual external supervision. In either case, debriefing

or supervision were spaces to consolidate experiences and they could assist the participant in finding a sense of peace from an incomplete interaction.

> I'm just not left with the what ifs, as much. We speak about it, and it's like I spoke about my worries about it and the things that are bothering me about the session that I've had. It does, kind of, free me up to then just continue with the work. (Participant 7)
> I think just to vent a little bit about the frustration of calls, but maybe sometimes the system and the pressure of the system. With someone who knows what the work is, what's entailed, has experienced it, because my supervisor has. And is totally accepting and validating of that, and then also helpful and guiding in how to manage it. (Participant 8)

Theme 5. The work adds value to my life, which is motivating

Working at the NTS added value to the personal and professional lives of the participants. More specifically, the role provided a sense of purpose or it was an opportunity to learn. While the work was emotionally draining, it was enriching to be able to directly assist people with their daily lives. Interactions with service users were instrumental in securing a sense of purpose or fulfilment and they could also act as a learning experience. For example, the participants were able to ascertain what skills or techniques could be effective with callers and the most appropriate time for them to be used. Increasing experience or gaining a sense of fulfilment acted as a mechanism to promote motivation for the participants. Participant 4 spoke of the motivational nature of the work.

> It would be, for me, a lot more difficult to work the same number of hours in something monotonous, like supermarket work or waiting tables. With this job, I kind of get not only decent pay, a good support team and work colleagues that I can be friends with, but also the satisfaction of knowing that you help people most days, and that you can be meaningful in people's daily life. (Participant 4)

Participants did not have the expectation that their role was to produce long-term or significant change. Despite this, the participants gained a sense of satisfaction in knowing that the call had produced a sense of relief for the caller, which is captured by participant 5. “I'm not there to change people's lives - I'm aware of that – but, if I could just make someone feel good. Even in just a five-minute phone call, then I get the great fulfilment from that, and job satisfaction” (Participant 5).

Participant 1 spoke of the motivation that the interactions can produce, but they underscored how the role provided valuable learning opportunities and how this can be an incentive to remain in the role. “I feel like every day I'm learning something new or I've talked to someone that's inspired me. And, you know, I think that passion keeps me going” (Participant 1).

Theme 5.1. The role fits with my identity

Several participants seemed to naturally gravitate to the helping professions. Many felt that helping was an inherent feature of their identity, which could be well utilised by the TSW role. Many of the participants are working towards a professional helping role, such as counselling, psychology, or social work, but some were satisfied to remain in their current position. In either case, the participants’ role allowed them to align with their helping identities and/or gain clinical experience on their pathway towards registration.

> I thought that telehealth was a good fit of (pause) being able to help people do some counselling, but not have to necessarily do a degree, which I didn't think I was capable of. Or get registered, which I didn't think I could do. Telehealth is a really good, kind of, starting place for a lot of people. It's also a good place for those that, I feel anyway, might not want to go fully into counselling. (Participant 6)

Accommodating the different components of their identities strengthened their morale and confidence, but also working at the NTS allowed the participants natural helping tendencies to flourish. Despite this, there seemed to be a contradiction between this subtheme and *1.3 We may choose to, or we have to, go beyond what we're here for*. The helping role itself may be a good fit for these participants, but the inability to support people long-term or more comprehensively, as stipulated by the scope of the service, may contribute to the participants' frustrations because it may have highlighted that their capabilities are held back.

Theme 5.2. Personal growth

In some capacity, most of the participants recognised that they have personally grown in the role. This growth was captured in numerous ways, such as enhanced confidence, greater resilience, and improved self-worth, which were aspects discussed by several participants. "I was somebody that hated myself before I did this type of work. So, I think, probably self-worth. I've got a lot of self-worth through helping others - and taking a bit of a different learning journey" (Participant 6). "It's made me resilient on conflict because beforehand I would avoid it at all costs. So that's a big thing that I'm going to take away from the role" (Participant 3).

Interactions have exposed the participants to people of different cultures and who have had various personal struggles. Participant 4 discussed growth in connection to a broadening of perspective of the world and of people.

> I think it's really given me a lot more understanding of the world and people how to interact with people. Understanding of people's sadness, their struggles and that everything. What might be a problem for me might not be for them, and what for them is a daily average day for me would be like the worst day of my life. (Participant 4)

The participants' experiences of growth were not associated with hearing a caller's growth; the participants discussed personal growth as a consequence of hearing the daily struggles of the service users that they interacted with. Among the participants that took part, growth was discussed in a personally relevant manner rather than having any wider or societal connections.

Theme 5.3. I'm more prepared to help

Each person had worked for the NTS for over six months and they regularly worked between 24-40 hours per week, which had contributed to their preparedness to perform their role. The time in their role allowed for increased exposure and a growing confidence. During the initial period of their role, several participants spoke of being flooded with service user experiences, but they eventually reached a stage where their learning peaked. The participants would hear a wide array of experiences,

which made them feel like they were being flooded with challenging content. Participant 1 spoke of the early days of their role and how challenging this time was:

> I was worried about what was going to be on the other end of the phone, but one day I just thought, you know, I've supported every different type of person I can think of. I mean, obviously, there's always going to be another one, a new one that comes up, but I felt like I was ready for whatever else came. (Participant 1)

Participant 5 spoke of becoming accustomed to the content and how this familiarity allowed them to thrive in the role.

> Nothing shocks me anymore. It doesn't mean I become numb to it. It's just because I've heard it so many times. It just doesn't have that impact on me anymore, which I think in a way makes me better as a counsellor. (Participant 5)

Preparedness was also influenced by way of the negative feedback or reactions from service users. The participants spoke of calls where they utilised certain skills, which could be deemed ineffective or unsuitable by the service users. Some participants used these experiences as an opportunity to learn and develop their ability for future callers, which was captured by Participant 3. “Like being yelled at the other day that helped me. I was like, maybe that the way I came in wasn't helpful for him. So, I can use it for next time” (Participant 3).

Working at the NTS provided the participants with a platform to learn, by way of interactions with service users. As time progressed, the participants felt more competent in their role because they were not necessarily shocked by the content of the calls. Once reaching this point the participants felt that they could listen to the service users without being consumed or overwhelmed by their words, which meant that the participants felt more prepared.

CHAPTER V: DISCUSSION AND CONCLUSION

Reviewing the purpose of the study

The purpose of the current study was to explore the experiences of mental health and addictions telephone support workers (TSWs), specifically paraprofessionals. Several studies have investigated TSWs, but these have predominantly focused on volunteers rather than paid paraprofessionals (Cyr & Dowrick, 1991; Kitchingman et al., 2017; Kitchingman et al., 2018A; Roche & Ogden, 2017). Although the available evidence provided valuable insight on the consequences for TSWs, there are distinct differences between volunteers and paraprofessionals that may have reduced the applicability of the available data. Research indicated that volunteer TSWs work on a more casual basis, and typically work fewer hours per shift and per week (O'Sullivan & Whelan, 2011; Roche & Ogden, 2017). Meaning that volunteers receive less exposure to the unique stressors associated with the TSW role. Paraprofessionals are paid to conduct their role and can therefore work a greater number of hours, thus increasing their exposure to role demands. Increased exposure to distressed callers, in conjunction with ineffective coping and less work experience, is associated with greater negative outcomes for TSWs, such as stress, burnout, and vicarious trauma (Kitchingman et al., 2018C). Existing research on TSWs had largely focused on the negative consequences of the role and minimal attention has been being given to the positive consequences (Kitchingman et al., 2018C, Willems et al., 2020). This limits our understanding of the TSW role because a one-sided approach does not consider the transformative properties associated with the positive consequences, such as vicarious post-traumatic growth (VPTG) or compassion satisfaction (CS). Consequently, the current study examined the paraprofessional TSW role using a broader lens and intentionally investigated the positive and negative consequences of the TSW role.

A contextualised summary of findings

The participants in the current study highlighted several positive and negative consequences. Some of the positives included enhanced confidence, greater resilience, improved self-worth and negative consequences involved feelings of inadequacy or self-doubt and a fluctuating ability to empathise. A primary concern for the participants was a continuing sense of exhaustion due to their workload. The participants also commented on their ability to empathise, which could fluctuate in response to a large workload that included regular callers. Many spoke of self-perceived inadequacies that would become more pronounced following, what a participant would feel to be, an unsatisfactory outcome for a caller. Many participants recognised that their work was filled with uncertainties that could produce a sense of hopelessness or increased anxiety. Several compensatory actions lessened the negative consequences for the participants, such as creating a physical and cognitive distance between themselves and the work. Additionally, a supportive working space, that provided a sense of control where possible, was an integral feature to keeping the participants in their role. Although difficult, the

work provided aspects that helped to maintain the participants in the role, such as offering a sense of variety in the role by way of different roles or helplines the participants worked on. Overall, despite the difficulties associated with the role, the participants felt that the role had exposed them to circumstances that brought about personal growth.

The demands of the role and associated consequences

Among the participants was a strong sense of exhaustion due to the demands of the work. Several elements constructed the participants' workload, such as the breadth of content in each a call, the quantity of calls and their duration, which contributed to a sense of physical exhaustion. The participants felt that their work demands were unique and that the quantity of calls, texts, webchats, or emails, that they handle daily, were greater than the number of patients a face-to-face practitioner would see each day. This aligns with the work of Maslach et al. (2001) who discusses the idea of a workload mismatch in their concept on burnout. Therefore, a TSWs workload may be greater than they can handle, which suggests that additional resources are needed to compensate for the high demand in this service.

Exhaustion was also heightened by the participants' unique personal challenges that, at times, mirrored that of their callers, which made their circumstances more personal to the participants and emphasised the emotional elements of the interactions. Emotional exhaustion was heightened by the callers' enduring difficulty to move toward wellness, which was more pronounced in regular calls. A lack of change or wellness among the callers became more apparent to those who had maintained their role long-term. Compounding the callers' wellbeing was a constant need for the participants to draw on their sense of empathy to connect with callers, resulting in a decreased empathic ability. This discovery is in contrast with the work of Roche and Ogden (2017) who found low levels of emotional exhaustion in volunteer TSWs. For the participants in the current study, the hours of work per week ranged between 24-40 and the average amount was 33.89, which differed to volunteer TSWs who work a minimal number of hours per week and per shift (O'Sullivan & Whelan, 2011; Roche & Ogden, 2017). The differences in emotional exhaustion between the current study and that of Roche and Ogden (2017) may be related to the participants increased exposure to the role's unique stressors. This would indicate that paraprofessional TSWs are at a greater risk to the negative consequences of the role and may benefit from additional support to compensate for the role demands. Moreover, the physical and emotional demands that TSWs encounter may have wider implications on their ability to work effectively with callers.

The participants discussed caller perceptions, which were shaped by the participants workload and corporate systems. The participants' sense of physical and emotional exhaustion, brought about by challenging calls and regular callers, influenced the participants' perceptions of callers. For the participants, this made it harder to empathise with the caller's difficulties and retain the caller's sense of humanity. The participants' perception of the callers were influenced by corporate systems in the

environment, which intensified a shift in the caller's humanity. More specifically, the caller waiting board, that indicated the number of callers waiting, was a catalyst for transforming the callers' humanity and converted them into a number. This discovery is similar to the depersonalisation component of burnout (Maslach et al., 2001). Depersonalisation is mechanism for coping with excessive work demands and it involves a shift in perspectives (Maslach et al., 2001). This would involve the TSW shifting their perspective of a caller, disregarding their individuality or humanity, as a means of coping with an excessive workload (Maslach et al., 2001). Given that the participants in the current study engaged in this practice, this would suggest that our findings align with that of Cyr and Dowrick (1991), in that TSWs exhibit a susceptibility to features of burnout. A notable consideration is that the unique elements associated with the TSW environment, such as long-term regular callers, the quantity of interactions and corporate systems, were instrumental in producing the participants sense of physical and emotional exhaustion and they contributed to a shift in participants perceptions of the caller's humanity.

The participants had a profound desire to support their callers. It was common for the participants to feel a need to go beyond the brief intervention format of the service. This could be because callers had complex presentations or because callers were not accessing, or able to access, local services, and therefore the participants felt a responsibility of care. In some cases, the participants believed that the callers needed support that was beyond the scope of the service and/or their current level of training. Consequently, the participants drive to help could have created or contributed to their feelings of helplessness and highlighted an inadequacy, which may impact the quality of support that they are able to provide to a caller. This is similar to the theory of professional burnout, specifically the domain of self-perceived ineffectiveness (Maslach et al., 2001). Chronic work demands can lead to exhaustion and compensatory behaviours (depersonalisation) that interfere with one's work, which leads to a diminished sense of efficacy (Maslach et al., 2001). Importantly, a TSW is not expected to bring about long-term change for the caller, their role is to offer emotional support and ensure that callers are heard. It is possible that participants believe they were not meeting an ethical responsibility associated with helping and this may lead to an impression of inefficiency. A similar implication was suggested by Austin et al. (2009) in their work on compassion fatigue in nurses. Some nurses felt that they were unable to provide sufficient care or meet the expectations of the role, and this led to distress or disengagement (Austin et al., 2009). For TSWs, it is possible that failing to meet their own ethical expectations produces a sense of compassion fatigue, and persistent feelings of inefficacy may subsequently lead to the formation of burnout. In the context of a TSWs role, inefficacy could be reinforced by a regular caller's lack of movement toward wellness or the continuous influx of callers who are struggling, but this may depend on the TSWs expectations of themselves and their work. Future studies may want to investigate the expectations that TSWs have of their work and how these influence levels efficacy. Organisations could tailor the support they provide by emphasising the expectations of the service and of their employees, which may reorient a TSWs ethical expectations.

A sense of uncertainty and the concept of wisdom

Uncertainty was a reality that persisted for the participants and it was influenced by several external factors. Present on entering the profession, the features of uncertainty and how it was managed changed as the participants progressed in their role. When they were new it was common to feel unnerved about the next call and what it will bring, which was stressful or anxiety provoking. A greater amount of experience in the role meant that the participants were more prepared in managing the aforementioned uncertainties. A similar finding was discovered by Mishara and Giroux (1993) who found that volunteer TSWs with less work experience reported greater levels of anticipatory stress. A similar conclusion was also made in a systematic review of research on volunteer TSWs (Kitchingman et al., 2018C). Maladaptive coping, less experience and increased exposure to distressed callers were associated with an increased vulnerability to negative consequences. The findings of the current study converge with our understanding of trait intolerance of uncertainty and its influence on state anxiety and worry (Chen et al., 2018). Intolerance of uncertainty is said to be predictive of increased state anxiety and worry (Chen et al., 2018). The findings of the current study would indicate that the early stages of the TSW role may be the most challenging and, perhaps, when TSWs are most vulnerable to various negative consequences. The increase in uncertainty in a TSW's professional life, coupled with a lack of experience in handling or tolerating uncertainty, may be a mechanism for the negative consequences associated with the role. Participants also spoke of uncertainty involving the caller suiciding or self-harming and the lack of knowledge related to long-term outcomes of the callers, which is a finding that may relate to the wider field of mental health. Uncertainty and the subsequent anxiety or worry associated with client-caller safety may be a consequence that impacts TSWs and registered practitioners alike, which warrants further investigation.

There were also indications that participants felt a sense of responsibility to control a caller's behaviour, which may want to be considered in relation to the concept of locus of control. This concept describes the extent to which a person believes that the consequence of a situation is dependent on their behaviour (Linley, 2003). People with an internal locus of control strongly believe that their behaviours are contingent on the outcome of a situation, and they take suitable steps to influence said outcome (Linley, 2003). External factors, such as a caller's suicidal or self-harming behaviours, may have an impact on a TSW with an internal locus of control. Under the impression that they can influence the caller's level of safety, the external factor (caller self-harm) would lead the TSW to propose suitable safety behaviours. If this attempt is unsuccessful, the TSW with an internal locus of control may develop a sense of helplessness. Conversely, TSWs with an internal locus of control may believe it is their responsibility to create safety behaviours, rather than encouraging the caller to construct their own. In this sense, the TSW would not be promoting the caller's own ability to keep themselves safe. Prolonged exposure to these outcomes may draw a TSW's attention to a sense of inefficacy, which may potentially lead to feelings of compassion fatigue or burnout. This proposition would align with existing literature,

in that greater exposure to callers in distress is associated with an increased vulnerability to negative consequences (Kitchingman et al., 2018C). Given the consistency of uncertainty associated with the TSW role, the influence of intolerance of uncertainty warrants further investigation.

The concept of wisdom may be useful when considering the participants experiences of uncertainty. Linley (2003) discusses wisdom as a process and an outcome of trauma adaptation, which is composed of three dimensions: recognising and managing uncertainty, integrating affect and cognitions, and recognising and accepting limitations. A wise person acknowledges that uncertainty is a constant certainty in this world and has learnt to adapt to change rather than resisting it (Linley, 2003). It may be that a person possesses an openness to change and this allows them to recognise, and be more receptive to, uncertainty (Linley, 2003).

Taking the concept of wisdom, uncertainty for TSWs could be managed by way of external influences, such as the post-call debrief. Affect and cognition should not be viewed in a hierarchical sense, each component is essential for higher order functioning (Linley, 2003). A wise person will have adopted a sense of connected detachment to their own internal experiences, rather than becoming embroiled in them the wise person consciously uses them as a guide (Linley, 2003). Some participants' spoke of an acceptance of uncertainty and this was more apparent in the participants who had been in the role longer, but one person also acknowledged how their acceptance to the scope of the service was instrumental in dealing with the uncertainty. To promote coping, the post-call debrief for TSWs could incorporate an exploration of the uncertainty in a call and encourage the TSW to adopt a sense of connected detachment.

The participants in the current study spoke of a separation between their own emotions and the emotions of the callers. This finding might suggest that they had developed elements of wisdom in relation to emotional detachment. Additionally, participants also acknowledged a physical separation, between themselves, the callers, and the space that the participants' work in. Being in a space that was designated for the counselling work and that could be left behind at the end of the day facilitated a separation between a caller and a participant. Similarly, in their study of spatiality of telephone counselling, Davidson & Harrison (2019) noted that TSWs created a separate mental place that contains their work with callers. It is possible that a TSWs environment may be a protective mechanism or it may propel TSWs towards wisdom.

The acquisition of wisdom would be impossible without first recognising and managing one's own limitations (Linley, 2003). A TSW may need to recognise the limitations of the service and fully accept the services scope of practice. Alternatively, it could be suggested that TSWs need to acknowledge the limitations of their own abilities. Reconciling with one's own limitations inspires a more transcendent sense of self wherein a person's concerns expand to include a greater attention to the well-being of others (Linley, 2003). The participants acknowledged that their role should not involve a deep exploration of a caller's problems and that there was no requirement to find a resolution for each problem; however, several underlying elements meant that the participants felt compelled to provide

the callers with more than what was necessary. This may suggest that TSWs need further assistance in accepting the limitations or the boundaries of the service. In the present study, time and experience, along with the working environment and the service boundaries, are potential mechanisms for the formation of wisdom or positive adaption. However, it is unclear if the working environment and the service boundaries were merely protective factors for the participants and the participants did not exhibit wisdom or positive adaption.

External influences on empathy

Empathy was discussed by the participants in relation to the components that deplete their empathic ability and a method that sustains it. Empathy has been described as an essential skill for TSWs and a key element in producing effective change for people in distress (Mishara et al., 2007B). However, evidence suggests that empathic engagement can lead to secondary traumatic stress, burnout and/or compassion fatigue (Temitope & Williams, 2015; Simpson et al., 2018; Figley, 2002; Klimecki & Singer, 2011). Clearly, empathy is a vital ability for TSWs, but it is also a likely intermediary for the negative consequences of this role. In fact, Kitchingman et al. (2018A) found that empathic engagement was a primary mechanism of functional impairment in volunteer TSWs, which highlights a need for effective strategies to counteract the negative impacts of empathic engagement. In the current study, the participants' empathy was influenced by organisational systems and the format of their work. Corporate systems within the service, specifically the variety of roles that the participants adopted, worked as a protective mechanism for preserving the participants' empathy. Some were able to take time away from the TSW role to assume the role of shift supervisor. Additionally, the format in which the participants conducted their work, such as the type of helpline and the medium they worked in (calls or text messaging), also acted as a protective mechanism. The participants felt that the alternative roles and services required varying levels of empathy, which is a strategy of empathy regulation known as exposure control (Hodges & Biswas-Diener, 2007). The participants did not elaborate on alternative forms of empathy regulation techniques, but this does not suggest that alternative practices are not already being used. Although, given the knowledge that empathic engagement can lead to functional impairment (Kitchingman et al., 2018A), future studies may want to investigate strategies that TSWs employ to regulate their levels of empathy. Moreover, organisations may want to devote resources to the training of empathy regulation strategies that can easily be taught to TSWs.

Working in a supportive space

Participants spoke of how important it was to work in a supportive space. An element that helped to construct a supportive space for the participants was their colleagues. The participants were grateful for the close relationships with their colleagues, which had been established through collegial support while on shift. A similar finding was made by Davidson and Harrison (2020) who recognised that the ease of connecting with one's colleagues, in a TSW environment, was a protective element.

Davidson and Harrison (2020) noted that TSWs could easily discuss their concerns about callers and this then allowed them to move on to subsequent calls without lingering feelings associated with a previous call. Participants in the current study emphasised how they worked with likeminded people who were experienced individuals, and they also worked in an environment that embodied a sense of acceptance. Collectively, these features suggest that the participants work in environment that has a strong sense of community, which aligns with the person within context framework of burnout (Maslach et al., 2001). Maslach et al. (2001) explains that the likelihood for burnout increases when people lose positive connections with those in their workplace. Conversely, people will thrive and function effectively when they work in a cohesive environment where they receive praise, that is comfortable and emphasises happiness, and when they work with people that they like and respect (Maslach et al., 2001). The results of the present study add weight to the person within context framework of burnout and suggests that a strong sense of community is a protective factor for the negative consequences associated with the TSW role.

The working environment incorporated a certain amount of control or autonomy that was supportive for the participants. Aspects that are characteristic to a helpline may minimise the amount of control a TSW holds over their work. For instance, TSWs are not able to predict or control the types of calls that they receive while on shift and they are unable to track the progress of callers (Coman et al., 2001), which applied to the participants of the current study. Generally, a mismatch in control over one's work is related to a sense of inefficiency or reduced accomplishment (Maslach et al., 2001). One element of control can come from a person's sense of authority to conduct their work in a manner that they believe to be most effective (Maslach et al., 2001). The participants in the current study could exert a level of control over their work. For instance, each participant could take short breaks when needed, and some had a degree of flexibility in the number of shifts worked per week and/or they opted to work from home. This increased the participants' sense of agency to exert change and highlighted elements that are actually within their influence, specifically the time and place that they conduct their work, which possibly acted as a buffer for components that were beyond their control. This finding warrants further investigation and organisations may want to consider aspects of the TSW role that could be easily modifiable, by their employees, which may compensate for the uncontrollable elements of the role and protect TSWs against the negative consequences of the role.

The debrief and external supervision

The participants utilised two forms of supervision, with the most immediate being the post-call debrief. Experienced members of the mental health and addictions team assumed the role of in-shift supervisor, who would conduct post-call debriefings directly after challenging calls or calls that involved self-harm or suicide. Debriefs were conducted in person if each staff member worked in the same office, otherwise they took place via internal communications systems that recorded the conversation. The participants commented on the effects of debriefing, finding it to be a relieving and

supportive process. They were able to explore residual thoughts about the previous call that may have otherwise been distracting. In essence, the debrief acted as a release for the residual emotional content that might have been distracting in subsequent calls, which then allowed them to return to their role and take calls for the remainder of their shift. A similar finding was discovered in studies focused on volunteer TSWs, the debrief offers a supportive, reflective space for the TSW to express their thoughts and have them heard (Davidson & Harrison, 2020; Vattøe et al., 2019). The post-call debrief is an immediate form of support, it is an opportunity to vocalise the TSW's worries, thus diminishing any negative influences on the TSW's wellbeing and expedite recovery before a stress response can impact their work or personal life (Kinzel & Nanson, 2000). It is likely that the support provided by one's organisation enables the process of affect sharing and facilitates emotion regulation strategies (Vattøe et al., 2019), which are shown to compensate for elevated symptoms of psychological distress in volunteer TSWs (Kitchingman et al., 2017). The relief discussed by the participants suggests that post-call debriefs were effective for some TSWs in the current study. However, the objective of the post-call debrief was not clear to certain participants and this resulted in an avoidance of this support. Therefore, communicating the purpose, perhaps by explaining the structure and benefits of the post-call debrief, may work to ensure that this key form of support is consistently utilised by TSWs. Additionally, the format of the debrief may need to be evaluated, particularly the use of internal systems that record the conversation. Kinzel and Nanson (2000) offer several suggestions for how the post-call debrief should be conducted and within this process they initially stress the importance of confidentiality and trust. The fact that the post-call debrief was recorded may discourage some TSWs from drawing on this form of support due to a concern around confidentiality. Given the benefits of the benefits of the post-call debrief, organisations may want to consider alternative forms of communications that add further privacy protections to encourage the use of this support, particularly for staff based in different offices.

External supervision occurred monthly and the participants used this time to discuss aspects associated with the role, such as challenging calls or work conflicts. Each participant had access to one-to-one external supervision, but, for some, this only came into effect following the outbreak of COVID-19. Prior to this, most participants were only eligible for group external supervision. Research suggests that the negative effects of the TSW role can be reduced through a strong supervisory relationship (Dunkley & Whelan, 2006). A stronger supervisory relationship can lead to lower disrupted cognitive beliefs (Dunkley & Whelan, 2006), which relates to a person's perceptions of control, safety, intimacy, esteem (McCann & Pearlman, 1990). Supervisors that create a more effective supervisory relationship, by establishing a stronger rapport and focussing on the client, may lead to an increased protection for the TSW (Dunkley & Whelan, 2006), which converges with the results of the current study. Several participants had transitioned to one-to-one external supervision, which was reported to be more useful because these sessions had a stronger focus on the individual. Participants could be more open in what they shared, thus allowing the sessions to be more exploratory and more conducive to learning. Several participants explained that they often used this time to learn of new techniques to manage complex or

challenging calls. Available evidence suggests that supervision leads to decreases in distress and increased personal growth for face-to-face practitioners, whereas unsupervised practitioners exhibit greater levels of disrupted believes (Taylor & Furlonger, 2011). Despite this, O'Sullivan and Whelan (2011) found that environmental support did not influence overall levels of growth for TSWs. Meaning that supervision may not be a prerequisite for growth, and it may simply be a protective element of TSW well-being (O'Sullivan & Whelan, 2011). In the current study, it was found that external supervision is a supportive space for TSWs where they can learn new techniques, however, the available data did not reveal further details on the influence of supervision on growth.

Sense of satisfaction

Several elements contributed to a sense of purpose and satisfaction for the participants. Firstly, having the ability to provide a caller with support allowed the participants to feel that they were contributing to their community. Although the participants did not expect to see large amounts of change in a caller, hearing a change in a caller's presentation suggested to the participants that they were successfully fulfilling the requirements of their role, which produced a sense of satisfaction. Secondly, the participants were able to use the role as a platform to learn and develop their skills, with each call being a learning opportunity. It is possible that the TSW role allows a person to fulfil an altruistic need that might not be satisfied by their actions in daily life. The satisfaction derived from meeting an altruistic need, hearing change in a caller's presentation or learning new skills played a vital role in the participants' level of confidence and influenced their motivation. This finding aligns with the work of Stamm (2002) and the concept of CS, wherein a person's motivation is influenced by the satisfaction they acquire from helping. Gaining a sense of satisfaction from one's altruistic actions might indicate that there is a self-sustaining aspect to the work, but it is possible that this could decline throughout the tenure of one's role as a lack of long-term change in the callers becomes more apparent. Additionally, the participants' focus on a caller's short-term change may not be the most effective source of satisfaction. Cyr and Dowrick (1991) highlight several sources of burnout for volunteer TSWs, one being a lack of completion or not seeing the outcome of one's work. Cyr and Dowrick (1991) suggest that the origin of a TSW's satisfaction should be weighted more toward the helping process rather than the results of their work because it may be impractical to source satisfaction from the changes in a caller. The fact that the participants in the current study drew satisfaction from the learning opportunities that each call provided may suggest that they are more focused on the process rather than the outcome of the call. Given the motivational nature of CS, it might be useful for organisations to assist their TSWs in highlighting effective sources of satisfaction other than altruism and the efficacy one's work.

Aspects of the participants growth

Several participants discussed aspects of themselves that had evolved from being in the TSW role. This finding may relate to the concept of VPTG, which is a potential consequence of indirect exposure to traumatic material, instead of the direct exposure to a trauma (Manning-Jones et al., 2015). A meta-synthesis of qualitative studies on vicarious trauma and VPTG, across a range of practitioners, suggested that for positive adaptation to occur for the practitioner they must see a client's growth (Cohen & Collens, 2013). Therefore, the likelihood for growth may decrease for those who conduct interventions that are limited in time and scope (Cohen & Collens, 2013), which could be applicable to TSWs. Contrary to this suggestion, several aspects of growth were identified in the TSWs that took part in the current study. The participants spoke of enhanced confidence, greater resilience, improved self-worth, and a broadening of perspectives on the world, people, and common struggles. This finding aligns with the study by O'Sullivan and Whelan (2011) who recognised that VPTG is a possible outcome for TSWs. The participants in the current sample exhibited growth that was self-focused, which differs from the findings of Manning-Jones et al. (2015). A recent systematic review suggested that, in comparison to post-traumatic growth, VPTG may be more abstract in nature and less integrated with a person's self-concept (Manning-Jones et al., 2015). However, the current study might indicate that the features of VPTG may depend, in part, on the stage of one's career. As paraprofessionals, the participants may be at a stage in their professional development that requires a stronger sense of competence and confidence. The participants acknowledged that the initial stages of the role are the most anxiety provoking, and in time they became more accustomed to hearing distressing content, which meant that they eventually felt more prepared and confident. Across several articles, Manning-Jones et al. (2015) identified time as an external factor that is facilitative of VPTG. Over time, a person's level of distress declines and it is substituted with personal growth (Manning-Jones et al., 2015). When viewed against existing literature, the results of the current study may indicate that TSWs first acquire foundational elements of growth elements, which then allows for other variants of growth to occur over time and with exposure to challenging experiences.

Limitations

There are several limitations of the current work that should be acknowledged. The participants who took part in the current study were from a single organisation, the National Telehealth Service (NTS). To the best of researcher's knowledge, the NTS is the only organisation in New Zealand that offers mental health support across several service lines. The scale of the NTS, in terms of the quantity of mental health service lines, may mean that the participants are exposed to an atypical number of stressors and this may be unlike other organisations, which may limit the generalisability of the research findings to organisations that operate on a similar scale. Additionally, when considering the generalisability, the results of this study should also be considered against the qualitative nature of the

study and the relatively small sample size. Despite this, the sample size of the current study (n=9) was an appropriate amount for a master's thesis when considered against the aim of the study. The intent behind the current study was not to make broad generalisations or conclusions, it was to conduct an in-depth exploration into the experiences of TSW, which justifies the sample size.

Importantly, the study was conducted during the COVID-19 pandemic, which may have added additional personal and professional challenges. For instance, given the increased need for mental health support, the participants' workload may have increased and thus influenced their experiences. Therefore, it is possible that the pandemic obscured or conflated the findings of this study. In addition to this, changes were made to several corporate processes at the NTS. Firstly, the support that the participants received was altered due to social distancing regulations. External supervision shifted from group to (virtual) one-to-one supervision, which the participants noted to be more supportive. Secondly, the organisation altered their operational procedures so that their employees could work from home and rather than being temporary, this change has become a common practice for many participants. The added autonomy or control was a level of influence that had previously been unavailable to paraprofessionals. Therefore, to ascertain a more evolving impression of the participants' experiences and resulting consequences, it may be appropriate to conduct a long-term study that interviews participants at regular intervals.

Qualitative studies are susceptible to various sources of bias, one being the researcher and their interpretation of the findings. This was of concern because the researcher is a TSW and he currently works for the NTS. Given the foundations of the current study, in that it was guided by Critical Realism, the researcher was considered to be a co-constructor of the research findings. Methods of trustworthiness, specifically reflexivity and subjectivity, were utilised to the compensate for the possibility of researcher bias and to ensure that the research findings were accurate representations of the participants' experiences. Despite this, it is impossible to suggest that these methods removed all sources of bias because the findings are a collaborative endeavour that involved all parties i.e., the participants and the researcher. Therefore, the findings of the current study should be considered against the possibility of researcher bias.

Future research

The current study has identified several areas that can be recommended for future research on TSWs. Organisations likely have a scope of practice that is communicated to their employees, however, TSWs may feel that callers need more than what can be offered. It may be useful to ascertain the expectations that TSWs have of themselves in the role, and how these expectations can influence a sense of inefficacy and subsequent negative outcomes.

The nature of the TSW role means that people in this profession are confronted with situations of uncertainty, including the content of the next call or the outcome of a caller. In general research, a low tolerance to uncertainty is associated with stress and anxiety, which could be a contributing factor

to TSW negative outcomes. Therefore, investigating the influence of strategies to tolerate uncertainty may provide credible protective factors for TSWs, which could be explored further.

Empathy has been highlighted as an essential skill for TSWs and a factor that can produce a vulnerability to functional impairment. This study identified that exposure control strategies are commonly used to regulate levels of empathy. Given the relationship between empathy and functional impairment, it may be beneficial to investigate the most effective empathy regulation strategies for TSWs.

New conceptualisations of burnout stress the importance of contextual factors in the manifestation of burnout. It is suggested that retaining a sense of autonomy and control in one's working environment can mitigate the effects of burnout. TSWs often have a minimal amount of autonomy and control over their role. Although several areas of control were identified by TSWs in the current study, such as taking a time limited break and having the ability to work from home, additional areas of influence may exist, which warrants further attention.

The post-call debrief and external supervision were important to the TSWs in this study, and they found these supports to be supportive and relieving. However, some participants did not draw on the debrief due to a lack of clarity on its purpose and the potential benefits of this support. Future studies may want to assess the structure and format of the debrief to ascertain if alterations can improve this method of support. Existing evidence on external supervision suggested that it may be a facilitator of VPTG. External, one-to-one supervision was a space that allowed the participants of the current study to learn new techniques, and this finding confirms the need for a deeper exploration on the aspects of supervision that can influence various forms of growth.

TSWs appeared to draw satisfaction from their altruistic actions and from seeing the outcome of their work, but these may not be sustainable sources of CS. Future studies on TSWs could investigate alternative avenues for CS that could fuel motivation. This study proposed that foundational growth may be necessary before other variants, that are more abstract and less integrated to one's self-concept, can emerge, but this proposition needs to be investigated more extensively.

Conclusion

The current study adds to the existing literature on TSWs, and it offers several unique contributions due to its focus on paraprofessionals and a wider spectrum of consequences. Moreover, this study is also unique in that it explored the experiences of paraprofessionals TSW in the context of a New Zealand organisation. The TSW role is demanding and those working in the field are prone to physical and/or emotional exhaustion. This exhaustion may be increased by personal and corporate processes, such as similar personal challenges and regular callers, which can contribute to a decrease in a TSWs emotional energy and alterations in their perceptions of callers. Elements of the call centre environment can influence caller perceptions, and this may contribute to certain negative consequences, such as depersonalisation in burnout.

TSWs exhibit a strong desire to offer support and they recognise that some callers require support that is beyond the scope of the service and/or the training of the TSW, which can produce feelings of helplessness or thoughts of inadequacies. TSWs are often exposed to callers that do not exhibit change or wellness. It is possible that a caller's lack of movement contributes to TSWs feelings of inefficacy. Consequential to the inherent features of the service, uncertainty is a common reality for TSWs. Although it becomes more manageable with time and experience, new TSWs may benefit from learning strategies to tolerate uncertainty as these strategies could serve as a protective resource for the negative consequences of the role. The concept of wisdom may be a potential framework for creating strategies to manage uncertainty and promoting overall growth.

Existing research on TSWs indicated that empathy is an essential skill, but its use can lead to TSW functional impairment and reduced a likelihood of utilising appropriate skills. Meaning that a caller may not be supported effectively when the TSW experiences functional impairment. The empathy of the TSWs in the current study was preserved through exposure control strategies that are integrated into their environment, specifically organisational systems and the format of the work. Alternative strategies most likely exist but were not overtly elaborated on in this study. This highlights an important area for helpline organisations: teaching empathy regulation strategies that may help to preserve a TSW in their role, while simultaneously developing their professional capabilities.

Working in a supportive space and creating avenues for control or autonomy in the role are additional aspects that helped to retain a person in the TSW role, which may be elements that mitigate the negative consequences of the role. The TSWs utilised two forms of support: the post-call debrief and external supervision. Most found the post-call debrief brought about a sense of relief, but some chose to avoid it because its purpose was unclear. Recommendations for alterations to the post-call debrief are suggested. Prior research indicated that external supervision is a facilitating mechanism for growth. While it was a supportive and inspirational space for the TSWs, the data in the current study did not indicate that external supervision influenced growth.

TSWs seemed to obtain CS from a sense of altruism and from witnessing change in a caller; however, these elements of satisfaction may decline over time because caller's struggle with movement toward wellness. Due to the motivational nature of CS, organisations are advised to assist their TSWs in identifying alternative forms of CS, such as drawing satisfaction from the helping process itself.

Finally, the TSWs discussed aspects related to VPTG, such as enhanced confidence, greater resilience, improved self-worth, and a broadening of perspectives. These outcomes are characteristically different to existing preconceptions of VPTG, in that it is unrelated to one's self-concept and it is more abstract in nature e.g., people acknowledge the resiliency of mankind rather than that of the self. It is possible that the current study identified foundational growth, such as enhanced confidence, greater personal resilience, improved self-worth, and a broadening of perspectives, which may be a prerequisite for other variants of growth, but this needs to be verified by future research.

REFERENCES

Adams, S. A., & Riggs, S. A. (2008). An exploratory study of vicarious trauma among therapist trainees. *Training and Education in Professional Psychology*, *2*(1), 26-34. https://doi.org/10.1037/1931-3918.2.1.26

Austin, W., Goble, E., Leier, B., & Byrne, P. (2009). Compassion fatigue: The experience of nurses. *Ethics and Social Welfare*, *2*(2), 195-214. https://doi.org/10.1080/17496530902951988

Bassilios, B., Harris, M., Middleton, A., Gunn, J., & Pirkis, J. (2014). Characteristics of people who use telephone counseling: Findings from secondary analysis of a population-based study. *Administration and Policy in Mental Health and Mental Health Services Research, 42*(5), 633-633. https://doi.org/10.1007/s10488-014-0613-x

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77-101. https://doi.org/10.1191/1478088706qp063oa

Bygstad, B., & Munkvold, B. (2011). *In search of mechanisms. Conducting a Critical Realist data analysis* [Conference session]. Thirty Second International Conference on Information Systems, Shanghai.

Canfield, J. (2005). Secondary traumatization, burnout, and vicarious traumatization. *Smith College Studies in Social Work*, *75*(2), 81-101. https://doi.org/10.1300/j497v75n02_06

Caplan, G. (1964). *Principles of preventive psychiatry*. Basic Books, Inc.

Chen, S., Yao, N., & Qian, M. (2018). The influence of uncertainty and intolerance of uncertainty on anxiety. *Journal of Behavior Therapy and Experimental Psychiatry*, *61*, 60-65. https://doi.org/10.1016/j.jbtep.2018.06.005

Coetzee, S. K., & Klopper, H. C. (2010). Compassion fatigue within nursing practice: A concept analysis. *Nursing & Health Sciences*, *12*(2), 235-243. https://doi.org/10.1111/j.1442-2018.2010.00526.x

Cohen, K., & Collens, P. (2013). The impact of trauma work on trauma workers: A metasynthesis on vicarious trauma and vicarious posttraumatic growth. *Psychological Trauma: Theory, Research, Practice, and Policy*, *5*(6), 570–580. http://dx.doi.org/10.1037/a003038

Coman, G. J., Burrows, G. D., & Evans, B. J. (2001). Telephone counselling in Australia: Applications and considerations for use. *British Journal of Guidance & Counselling*, *29*(2), 247-258. https://doi.org/10.1080/03069880124904

Crosby Budinger, M., Cwik, M. F., & Riddle, M. A. (2014). Awareness, attitudes, and use of crisis hotlines among youth at-risk for suicide. *Suicide and Life-Threatening Behavior*, *45*(2), 192-198. https://doi.org/10.1111/sltb.12112

Cyr, C., & Dowrick, P. (1991). Burnout in crisisline volunteers. *Administration and Policy in Mental Health*, *18*(5), 343–354. https://doi.org/10.1007/bf00707000

Davidson, D., & Harrison, G. (2019). "Leaning in" and "leaning back": Exploring the spatiality of telephone counselling. *Health & Place*, *58*, 102158. https://doi.org/10.1016/j.healthplace.2019.102158

Davidson, D., & Harrison, G. (2020). Heard but not seen: Exploring youth counsellors' experiences of telephone counselling. *Aotearoa New Zealand Social Work*, *32*(1), 73-85. https://doi.org/10.11157/anzswj-vol32iss1id708

Dunkley, J., & Whelan, T. A. (2006). Vicarious traumatisation in telephone counsellors: Internal and external influences. *British Journal of Guidance & Counselling*, *34*(4), 451-469. https://doi.org/10.1080/03069880600942574

Durlak, J. A. (1979). Comparative effectiveness of paraprofessional and professional helpers. *Psychological Bulletin*, *86*(1), 80-92. https://doi.org/10.1037/0033-2909.86.1.80

Evans, W. P., Davidson, L., & Sicafuse, L. (2013). Someone to listen: Increasing youth help-seeking behavior through a text-based crisis line for youth. *Journal of Community Psychology*, *41*(4), 471-487. https://doi.org/10.1002/jcop.21551

Figley, C. R. (1995). Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized. Brunner-Routledge.

Figley, C. R. (2002). Compassion fatigue: Psychotherapists' chronic lack of self-care. *Journal of Clinical Psychology*, *58*(11), 1433-1441. https://doi.org/10.1002/jclp.10090

Fletcher, A. J. (2016). Applying critical realism in qualitative research: Methodology meets method. *International Journal of Social Research Methodology*, *20*(2), 181-194. https://doi.org/10.1080/13645579.2016.1144401

Furlonger, B., & Taylor, W. (2013). Supervision and the management of vicarious traumatisation among Australian telephone and online counsellors. *Australian Journal of Guidance and Counselling*, *23*(1), 82-94. https://doi.org/10.1017/jgc.2013.3

Ghahramanlou, M., & Brodbeck, C. (2000). Predictors of secondary trauma in sexual assault trauma counselors. *International Journal of Emergency Mental Health*, *2*(4), 229–240.

Gillham, B. (2005). *Research interviewing: The range of techniques*. McGraw-Hill Education.

Gould, M. S., Kalafat, J., HarrisMunfakh, J. L., & Kleinman, M. (2007). An evaluation of crisis hotline outcomes Part 2: Suicidal callers. *Suicide and Life-Threatening Behavior*, *37*(3), 338-352. https://doi.org/10.1521/suli.2007.37.3.338

Gulliver, A., Griffiths, K. M., & Christensen, H. (2010). Perceived barriers and facilitators to mental health help-seeking in young people: A systematic review. *BMC Psychiatry*, *10*(113), 1-9. https://doi.org/10.1186/1471-244x-10-113

Hall, B., & Schlosar, H. (1995). Repeat callers and the Samaritan telephone crisis line—A Canadian experience. *Crisis*, *16*(2), 66-71. https://doi.org/10.1027/0227-5910.16.2.66

Harrison, R. L., & Westwood, M. J. (2009). Preventing vicarious traumatization of mental health therapists: Identifying protective practices. *Psychotherapy: Theory, Research, Practice, Training*, *46*(2), 203-219. https://doi.org/10.1037/a0016081

He Ara Oranga. (2018). *He Ara Oranga: Report of the government inquiry into mental health and addiction*. The Government Inquiry into Mental Health and Addiction. https://mentalhealth.inquiry.govt.nz/inquiry-report/he-ara-oranga

Hensel, J. M., Ruiz, C., Finney, C., & Dewa, C. S. (2015). Meta-analysis of risk factors for secondary traumatic stress in therapeutic work with trauma victims. *Journal of Traumatic Stress, 28*(2), 83-91. https://doi.org/10.1002/jts.21998

Hodges, S. D., & Biswas-Diener, R. (2007). Balancing the empathy expense account: Strategies for regulating empathic response. In *Empathy in mental illness* (pp. 389-407). Cambridge University Press.

Hoffberg, A. S., Stearns-Yoder, K. A., & Brenner, L. A. (2020). The effectiveness of crisis line services: A systematic review. *Frontiers in Public Health, 7*(399), 1-14. https://doi.org/10.3389/fpubh.2019.00399

Howlett, S. L., & Collins, A. (2014). Vicarious traumatisation: Risk and resilience among crisis support volunteers in a community organisation. *South African Journal of Psychology, 44*(2), 180-190. https://doi.org/10.1177/0081246314524387

James, S. L., Abate, D., Abate, K. H., Abay, S. M., Abbafati, C., Abbasi, N., & Abdollahpour, I. (2018). Global, regional, and national incidence, prevalence, and years lived with disability for 354 diseases and injuries for 195 countries and territories, 1990–2017: A systematic analysis for the Global Burden of Disease Study 2017. *The Lancet, 392*(10159), 1789-1858.

Joinson, C. (1992). Coping with compassion fatigue. *Nursing, 22*(4), 116-121. https://doi.org/10.1097/00152193-199204000-00035

Kalafat, J., Gould, M. S., Munfakh, J. L., & Kleinman, M. (2007). An evaluation of crisis hotline outcomes Part 1: Nonsuicidal crisis callers. *Suicide and Life-Threatening Behavior, 37*(3), 322-337. https://doi.org/10.1521/suli.2007.37.3.322

Kinzel, A., & Nanson, J. (2000). Education and debriefing: Strategies for preventing crises in crisis-line volunteers. *Crisis*, *21*(3), 126-134. https://doi.org/10.1027//0227-5910.21.3.126

Kitchingman, T. A., Caputi, P., Woodward, A., Wilson, C. J., & Wilson, I. (2018A). The impact of their role on telephone crisis support workers' psychological wellbeing and functioning: Quantitative findings from a mixed methods investigation. *PLOS ONE*, *13*(12), e0207645. https://doi.org/10.1371/journal.pone.0207645

Kitchingman, T. A., Wilson, C. J., Caputi, P., Wilson, I., & Woodward, A. (2018C). Telephone crisis support workers' psychological distress and impairment: A systematic review. *Crisis*, *39*(1), 13-26. https://doi.org/10.1027/0227-5910/a000454

Kitchingman, T. A., Wilson, C. J., Caputi, P., Wilson, I., & Woodward, A. (2017). Testing a model of functional impairment in telephone crisis support workers. *Crisis*, *38*(6), 403-412. https://doi.org/10.1027/0227-5910/a000435

Kitchingman, T. A., Wilson, C. J., Woodward, A., Caputi, P., & Wilson, I. (2018B). Telephone crisis support workers' intentions to use recommended skills while experiencing functional impairment. *Crisis*, *39*(3), 218-223. https://doi.org/10.1027/0227-5910/a000490

Klimecki, O., & Singer, T. (2011). Empathic distress fatigue rather than compassion fatigue? Integrating findings from empathy research in psychology and social neuroscience. In *Pathological altruism* (p. 368–383). Oxford University Press.

Ledoux, K. (2015). Understanding compassion fatigue: Understanding compassion. *Journal of Advanced Nursing*, *71*(9), 2041-2050. https://doi.org/10.1111/jan.12686

Lelorain, S., Bonnaud-Antignac, A., & Florin, A. (2010). Long term posttraumatic growth after breast cancer: Prevalence, predictors and relationships with psychological health. *Journal of Clinical Psychology in Medical Settings*, *17*(1), 14-22. https://doi.org/10.1007/s10880-009-9183-6

Lifeline Australia. (2019). *Annual Report 2018-2019*. https://www.lifeline.org.au/about-lifeline/resources/annual-reports

Linley, P. A. (2003). Positive adaptation to trauma: Wisdom as both process and outcome. *Journal of Traumatic Stress*, *16*(6), 601-610. https://doi.org/10.1023/b:jots.0000004086.64509.09

Manning-Jones, S., De Terte, I., & Stephens, C. (2015). Vicarious posttraumatic growth: A systematic literature review. *International Journal of Wellbeing*, *5*(2), 125-139. https://doi.org/10.5502/ijw.v5i2.8

Maslach, C., Schaufeli, W. B., & Leiter, M. P. (2001). Job burnout. *Annual review of psychology*, *52*(1), 397-422.

McCann, L., & Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress*, *3*(1), 131-149. https://doi.org/10.1002/jts.2490030110

McIntosh, M. J., & Morse, J. M. (2015). Situating and constructing diversity in semi-structured interviews. *Global Qualitative Nursing Research*, *2*, 233339361559767. https://doi.org/10.1177/2333393615597674

Mental Health Commissioner. (2020). *Aotearoa New Zealand's mental health services and addiction services: The monitoring and advocacy report of the Mental Health Commissioner*. Health and Disability Commissioner. https://www.hdc.org.nz

Merriam, S. B., & Tisdell, E. J. (2015). *Qualitative research: A guide to design and implementation* (4th ed.). Wiley.

Mishara, B. L., & Côté, L. (2013). Suicide prevention and new technologies: Towards evidence based practice. In *Suicide prevention and new technologies: Evidence based practice*. Springer.

Mishara, B. L., & Daigle, M. S. (1997). Effects of different telephone intervention styles with suicidal callers at two suicide prevention centers: An empirical investigation. *American Journal of Community Psychology*, *25*(6), 861-885. https://doi.org/10.1023/a:1022269314076

Mishara, B. L., & Giroux, G. (1993). The relationship between coping strategies and perceived stress in telephone intervention volunteers at a suicide prevention center. *Suicide and Life-Threatening Behavior*, *23*(3), 221-229.

Mishara, B. L., Chagnon, F., Daigle, M., Balan, B., Raymond, S., Marcoux, I., Bardon, C., Campbell, J. K., & Berman, A. (2007A). Comparing models of helper behavior to actual paractice in telephone crisis intervention: A silent monitoring study of calls to the U.S. 1-800-SUICIDE Network. *Suicide and Life-Threatening Behavior*, *37*(3), 291-307. https://doi.org/10.1521/suli.2007.37.3.291

Mishara, B. L., Chagnon, F., Daigle, M., Balan, B., Raymond, S., Marcoux, I., Bardon, C., Campbell, J. K., & Berman, A. (2007B). Which helper behaviors and intervention styles are related to better short-term outcomes in telephone crisis intervention? Results from a silent monitoring study of calls to the U.S. 1-800-SUICIDE network. *Suicide and Life-Threatening Behavior*, *37*(3), 308-321. https://doi.org/10.1521/suli.2007.37.3.308

Mishara, B. L., Daigle, M., Bardon, C., Chagnon, F., Balan, B., Raymond, S., & Campbell, J. (2016). Comparison of the effects of telephone suicide prevention help by volunteers and professional paid staff: Results from studies in the USA and Q uebec, C anada. *Suicide and Life-Threatening Behavior*, *46*(5), 577-587. https://doi.org/10.1111/sltb.12238

Mokkenstorm, J. K., Eikelenboom, M., Huisman, A., Wiebenga, J., Gilissen, R., Kerkhof, A. J., & Smit, J. H. (2016). Evaluation of the 113Online suicide prevention crisis chat service: Outcomes, helper behaviors and comparison to telephone hotlines. *Suicide and Life-Threatening Behavior*, *47*(3), 282-296. https://doi.org/10.1111/sltb.12286

Morrill, E. F., Brewer, N. T., O'Neill, S. C., Lillie, S. E., Dees, E. C., Carey, L. A., & Rimer, B. K. (2008). The interaction of post-traumatic growth and post-traumatic stress symptoms in predicting depressive symptoms and quality of life. *Psycho-Oncology, 17*(9), 948-953. https://doi.org/10.1002/pon.1313

Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology, 52*(2), 250-260. https://doi.org/10.1037/0022-0167.52.2.250

Naghavi, M. (2019). Global, regional, and national burden of suicide mortality 1990 to 2016: Systematic analysis for the global burden of disease study 2016. *BMJ, 364*(94), 1-11. https://doi.org/10.1136/bmj.l94

Newell, J. M., & MacNeil, G. A. (2010). Professional burnout, vicarious trauma, secondary traumatic stress, and compassion fatigue: A review of theoretical terms, risk factors, and preventive methods for clinicians and researchers. *Best Practices in Mental Health, 6,* 57–68.

Newell, J. M., Nelson-Gardell, D., & MacNeil, G. (2016). Clinician responses to client traumas. *Trauma, Violence, & Abuse, 17*(3), 306-313. https://doi.org/10.1177/1524838015584365

O'Connor, K., Muller Neff, D., & Pitman, S. (2018). Burnout in mental health professionals: A systematic review and meta-analysis of prevalence and determinants. *European Psychiatry, 53,* 74-99. https://doi.org/10.1016/j.eurpsy.2018.06.003

O'Sullivan, J., & Whelan, T. A. (2011). Adversarial growth in telephone counsellors: psychological and environmental influences. *British Journal of Guidance & Counselling, 39*(4), 307-323. https://doi.org/10.1080/03069885.2011.567326

Pearlman, L. A., & MacIan, P. S. (1995). Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. *Professional Psychology: Research and Practice, 26*(6), 558-565. https://doi.org/10.1037/0735-7028.26.6.558

Radey, M., & Figley, C. R. (2007). The social psychology of compassion. *Clinical Social Work Journal*, *35*(3), 207–214. https://doi.org/10.1007/s10615-007-0087-3

Rizkalla, N., Zeevi-Barkay, M., & Segal, S. P. (2017). Rape crisis counseling: Trauma contagion and supervision. *Journal of Interpersonal Violence*, 1-24. https://doi.org/10.1177/0886260517736877

Roche, A., & Ogden, J. (2017). Predictors of burnout and health status in Samaritans' listening volunteers. *Psychology, Health & Medicine*, *22*(10), 1169-1174. https://doi.org/10.1080/13548506.2017.1280176

Rosenfield, M. (1996). *Counselling by telephone: SAGE publications*. SAGE.

Sacco, T. L., Ciurzynski, S. M., Harvey, M. E., & Ingersoll, G. L. (2015). Compassion satisfaction and compassion fatigue among critical care nurses. *Critical Care Nurse*, *35*(4), 32-42. https://doi.org/10.4037/ccn2015392

Samaritans UK. (2019). *Samaritans impact report 2018/2019*. https://www.samaritans.org/about-samaritans/our-organisation/annual-reports-and-accounts

Simpson, S., Simionato, G., Smout, M., Van Vreeswijk, M. F., Hayes, C., Sougleris, C., & Reid, C. (2018). Burnout amongst clinical and counselling psychologist: The role of early maladaptive schemas and coping modes as vulnerability factors. *Clinical Psychology & Psychotherapy*, *26*(1), 35-46. https://doi.org/10.1002/cpp.2328

Sinclair, S., Raffin-Bouchal, S., Venturato, L., Mijovic-Kondejewski, J., & Smith-MacDonald, L. (2017). Compassion fatigue: A meta-narrative review of the healthcare literature. *International Journal of Nursing Studies*, *69*, 9-24. https://doi.org/10.1016/j.ijnurstu.2017.01.003

Sindahl, T. N., Côte, L., Dargis, L., Mishara, B. L., & Bechmann Jensen, T. (2018). Texting for help: Processes and impact of text counseling with children and youth with suicide

ideation. *Suicide and Life-Threatening Behavior*, *49*(5), 1412-1430. https://doi.org/10.1111/sltb.12531

Stamm, B. H. (2002). Measuring compassion satisfaction as well as fatigue: Developmental history of the compassion satisfaction and fatigue test. In *Treating compassion fatigue* (pp. 107-119). Routledge.

Stamm, B. H. (2005). *The ProQOL manual. The professional quality of life Scale: Compassion satisfaction, burnout & compassion fatigue/secondary trauma scales*. Baltimore, MD: Sidran Press.

Steel, Z., Marnane, C., Iranpour, C., Chey, T., Jackson, J. W., Patel, V., & Silove, D. (2014). The global prevalence of common mental disorders: A systematic review and meta-analysis 1980–2013. *International Journal of Epidemiology*, *43*(2), 476-493. https://doi.org/10.1093/ije/dyu038

Sturges, J. E., & Hanrahan, K. J. (2004). Comparing telephone and face-to-face qualitative interviewing: A research note. *Qualitative Research*, *4*(1), 107-118. https://doi.org/10.1177/1468794104041110

Suler, J. (2004). The online disinhibition effect. *CyberPsychology & Behavior*, *7*(3), 321-326. https://doi.org/10.1089/1094931041291295

Taylor, W., & Furlonger, B. (2011). A review of vicarious traumatisation and supervision among Australian telephone and online counsellors. *Australian Journal of Guidance and Counselling*, *21*(2), 225-235. https://doi.org/10.1375/ajgc.21.2.225

Tedeschi, R. G., & Calhoun, L. G. (2004). Posttraumatic growth: Conceptual foundations and empirical evidence. *Psychological Inquiry*, *15*(1), 1-18. https://doi.org/10.1207/s15327965pli1501_01

Temitope, K. M., & Williams, M. M. (2015). Secondary traumatic stress, burnout and the role of resilience in New Zealand counsellors. *New Zealand Journal of Counselling*, *35*(1), 1-21.

The National Telehealth Service. (2017). *The National Telehealth Service annual plan 2017/18*. https://www.health.govt.nz/our-work/national-telehealth-service

The National Telehealth Service. (2020). *National Telehealth Service annual plan 2019/20*. https://www.health.govt.nz/our-work/national-telehealth-service

Triplett, K. N., Tedeschi, R. G., Cann, A., Calhoun, L. G., & Reeve, C. L. (2012). Posttraumatic growth, meaning in life, and life satisfaction in response to trauma. *Psychological Trauma: Theory, Research, Practice, and Policy*, *4*(4), 400-410. https://doi.org/10.1037/a0024204

Turgoose, D., & Maddox, L. (2017). Predictors of compassion fatigue in mental health professionals: A narrative review. *Traumatology*, *23*(2), 172-185. https://doi.org/10.1037/trm0000116

Vattøe, I. E., DeMarinis, V., Haug, S. H., Lien, L., & Danbolt, L. J. (2019). Emotional stressors among volunteers operating a diaconal suicide-prevention crisis line in Norway: A qualitative study. *British Journal of Guidance & Counselling*, *48*(4), 563-575. https://doi.org/10.1080/03069885.2019.1646409

Wang, P. S., Angermeyer, M., Borges, G., Bruffaerts, R., Chiu, W. T., De Girolamo, G., Fayyad, J. C., Gureje, O., Haro, J. M., Huang, Y., Kessler, R. C., Kovess, V., Levinson, D., Nakane, Y., Oakley Browne, M. A., Ormel, J. H., Posada-Villa, J., Aguilar-Gaxiola, S., Alonso, J., … Üstün, T. B. (2007). Delay and failure in treatment seeking after first onset of mental disorders in the World Health Organization's World Mental Health Survey Initiative. *World psychiatry*, *6*(3), 177-185.

Weller, S. (2017). Using internet video calls in qualitative (longitudinal) interviews: Some implications for rapport. *International Journal of Social Research Methodology*, *20*(6), 613-625. https://doi.org/10.1080/13645579.2016.1269505

Wild, N. D., & Paivio, S. C. (2004). Psychological adjustment, coping, and emotion regulation as predictors of posttraumatic growth. *Journal of Aggression, Maltreatment & Trauma*, *8*(4), 97-122. https://doi.org/10.1300/j146v08n04_05

Willems, R., Drossaert, C., Vuijk, P., & Bohlmeijer, E. (2020). Impact of crisis line volunteering on mental wellbeing and the associated factors: A systematic review. *International Journal of Environmental Research and Public Health*, *17*(5), 1641. https://doi.org/10.3390/ijerph17051641

Willig, C. (2013). *Introducing qualitative research in psychology*. McGraw-Hill Education (UK).

World Health Organization. (2018). *Preventing suicide: A resource for establishing a crisis line*. Preventing suicide: A resource for establishing a crisis line

Auckland University of Technology Ethics Committee (AUTEC)

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Appendices

Appendix A: Ethics approval

6 July 2020

Giulia Lowe
Faculty of Health and Environmental Sciences

Dear Giulia

Re Ethics Application: **20/127 Telephone support workers at the New Zealand National Telehealth Service: Experiences and meaning making**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC).

Your ethics application has been approved for three years until 6 July 2023.

Non-Standard Conditions of Approval

NSC:

- Phone/virtual counselling sessions through AUT Health Counselling and Wellbeing are available *only* to AUT students. Please delete reference to phone/virtual counselling from the Information Sheet and use the standard wording only. This can be found in the Information Sheet template on the Research Ethics website at http://aut.ac.nz/researchethics.

1.

Non-standard conditions must be completed before commencing your study. Non-standard conditions do not need to be submitted to or reviewed by AUTEC before commencing your study.

Standard Conditions of Approval

1. The research is to be undertaken in accordance with the Auckland University of Technology Code of Conduct for Research and as approved by AUTEC in this application.
2. A progress report is due annually on the anniversary of the approval date, using the EA2 form.
3. A final report is due at the expiration of the approval period, or, upon completion of project, using the EA3 form.
4. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form.

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5. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
6. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEC Secretariat as a matter of priority.
7. It is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard and that all the dates on the documents are updated.

AUTEC grants ethical approval only. You are responsible for obtaining management approval for access for your research from any institution or organisation at which your research is being conducted and you need to meet all ethical, legal, public health, and locality obligations or requirements for the jurisdictions in which the research is being undertaken.

Please quote the application number and title on all future correspondence related to this project.

For any enquiries please contact ethics@aut.ac.nz. The forms mentioned above are available online through http://www.aut.ac.nz/research/researchethics

(This is a computer-generated letter for which no signature is required)

The AUTEC Secretariat
Auckland University of Technology Ethics Committee

Cc: , khm8735@aut.ac.nz

Appendix B: Participant information sheet

(23rd *July 2020*)

Telephone support workers at the New Zealand National Telehealth Service: Experiences and meaning-making

Researchers: Ian Gutteridge and Dr Giulia Lowe

Under the supervision of Dr Giulia Lowe, this study is being conducted by the main researcher, Ian Gutteridge, for his Master of Health Science in Psychology at Auckland University of Technology.

Ian Gutteridge has worked for The National Telehealth Service for approximately two years. His current roles include non-registered telephone support worker (TSW), in-shift support person, and Quality Reviewer. As a TSW, Ian receives in-bound communications from members of the public and offers appropriate support, which could be emotional support, suggestions for self-care or collaborative action planning. As an in-shift support person, Ian has supported his team members after difficult and complex calls. As a Quality Reviewer, Ian routinely reviews the calls of his colleagues and produces feedback, which is moderated and distributed by the managers (People Leaders) of each team.

Research aims and description

Telephone support lines offering mental health and emotional support have become common place in communities around the world. Since their inception there has been an increase in the quantity and variety of services. This expansion is understandable given our understanding of the global increase in mental health conditions. Existing research has highlighted some of the consequences to TSWs. In some cases, staff have experienced greater levels of stress, compassion fatigue and even burnout. Moreover, it is understood these states can influence the effectives of staff by way of the interventions they select. Parallel to this, people have also reported various positive consequences, such as greater satisfaction with life, interconnectedness, and purpose in life. Additionally, the negative states, such as compassion fatigue or burnout, have also been explored in relation to personal growth. In fact, for some, the negative consequences of the call taking role have led to positive adaptation, however, this is thought to occur under certain conditions or circumstances.

You are invited to participate in a study that is supported by the New Zealand National Telehealth Service. The focus of the study is on paraprofessional (unregistered) mental health and addictions TSWs and it will investigate the negative consequences of working in the role and explore the path to impairment. Additionally, the study will also investigate the positive aspects, such as practices that improve one's wellbeing and the conditions that facilitate the adaptation of negative related experiences. It is hoped that the study will enhance our understanding of the practices that may improve the wellbeing of TSWs and how organisations could adapt the support they provide.

How was I identified and why am I being invited to participate in this research?

It is our aim to expand research on paraprofessional mental health and addictions TSWs. In order to accomplish this, we intend to interview people that have been working for The National Telehealth Service for a minimum of 6 months and who are not currently registered with a professional body. The 6-month criterion was included so that the participant will have developed some experience in the role. Worldwide, many services employ paraprofessionals or volunteers, which is why we have chosen to focus on paraprofessionals. Additionally, research tell us that paraprofessionals and volunteers may be more vulnerable to the impacts of their role.

What will participation involve?

If you agree to participate, you will be invited to take part in a 1-1 interview between yourself and the main researcher, Ian Gutteridge. It is expected that the interview will take approximately 1 hour, and it will take place either via a phone call or a video call using Zoom or Skype. This will mean that you are able to participate in a location of your own choosing, however, you are encouraged to select a convenient, quiet and secure setting. While the interview will be done using a semi-structured interview (a short list of predetermined questions), you are encouraged to share your experiences that might go beyond these questions and that are relevant to the research aims. The interview will be audio recorded and it will be transcribed by the main researcher. After the recording has been transcribed, a copy of the transcription can be provided, and you are invited to make amendments to improve clarity. However, once the findings have been produced (approx. date: September 2020), removal of your data will not be possible.

We want to acknowledge and reassure you that as an employee of The National Telehealth Service you are not obligated to participate in this study. Also, if you do or do not participate in the study, The National Telehealth Service will not receive your details or any information that you share with us.

Anonymity and confidentiality:

To maintain your privacy, your name will be removed from all study documents and replaced with a unique identifier, such as 'Participant One.' Your name will only appear on the Consent Form, which will be stored separately from the transcription. Your decision to participate in this research (or not) and all information collected from you will remain confidential to the researchers. The only demographic detail we will collect is the gender that you identify with, however, you are not required to share this with us. When reporting the length of your service with the National Telehealth Service, this will be documented collectively rather than individually (e.g., all participants have worked for the service between 6 months and 3years). Moreover, your personal details will not be shared with The National Telehealth Service. During an interview, you will be asked not to identify a user of the National Telehealth Service, however, if you do, this will be removed from the transcription and the final report. Digital copies of the audio recordings and transcriptions will be securely retained by AUT for a period of 6 years. During the 6-year period, the recordings, transcriptions and consent forms will only be accessible to the researchers. After 6 years, all data will be destroyed (paper records will be shredded, and electronic files will be permanently deleted).

Costs

There are no financial costs involved with participating in the study. The only cost to you will be the time you set aside to participate. It is expected that the interview will take approximately 1 hour and reviewing the transcript may take between 30-60 minutes. Although, reviewing the transcript is up to you and is not an expectation or requirement to participate.

Risks and how these will be alleviated, and the benefits of participating

Given the nature of your work it is possible that the interview may rouse difficult emotions or memories, of both a personal and a professional nature. If this were to occur, the main researcher will suggest either a short break, to postpone the interview or to conclude at that point. We would also suggest and encourage you to access the support options included at the end of this Information Sheet.

In reflecting on your experiences and sharing your story, the interview may also enable you to develop a deeper insight into your work life and self-care practices. In addition to this, the information you share could be used to develop or adapt support systems for you, your colleagues and people around world that work in a similar role. Therefore, your contribution to the study has the potential to inform our understanding of mental health TSWs in New Zealand and it may assist us, the researchers, to expand the limited amount of research on TSWs.

Several measures have been included to counter any coercive influence, conflict of interest or power imbalances. Firstly, your involvement in the study is voluntary and is not a requirement of your role. Potential participants will directly liaise with the main researcher rather than a People Leader. In fact, should you choose to participate, or to not, your People Leader will be unaware of your involvement. Secondly, we have considered that the main researcher holds a position within the National Telehealth Service. As such, to lessen any conflict of interest, only those that work in a different office to the main researcher will be invited to take part. Thirdly, the primary researcher will not discuss any details of the interviews with management, other participants, or other staff members.

The main researcher (Ian Gutteridge) will benefit from this study as the research is being conducted as part of a Master of Health Science qualification. Please do not let this influence your decision to participate in this study or to remain in the study if you wish to withdraw.

Research findings

You are invited to request a summary of the research findings and you can register your interest in obtaining a copy of the final report by indicating on the consent form. Once the final report has been constructed, a copy can be sent to you to an email address of your choosing. Also, you are welcome to request a copy at later date by contacting the main researcher on his email address provided below.

Queries or concerns

After reading this information sheet, if you have any further questions related to the project you are welcome to contact the main researcher, Ian Gutteridge, using the email address that is included below. If you agree to participate, we ask that you to sign a consent form, which will indicate to us that you have understood the information in this letter and are comfortable participating in the research.

Ian Gutteridge (main researcher) khm8735@aut.ac.nz	Dr Giulia Lowe (Supervisor) Gambling and Addictions Research Centre Auckland University of Technology Ph. 09 921 9999 ext. 8164 giulia.lowe@aut.ac.nz

Any queries regarding ethical or conduct concerns should be notified to Dr Carina Meares, the Executive Secretary of Auckland University of Technology Ethics Committee: email: *ethics@aut.ac.nz*; Phone (09) 921 9999 ext. 6038

Please keep this Information Sheet and a copy of the Consent Form for your future reference.

Thank you for taking the time to consider this research.

This research was approved by the Auckland University of Technology Ethics Committee on 6th July 2020, 20/127.

Options for further support

After participating in the study, if you feel that you are needing support, it is possible to access this in several ways, and the options for support are detailed below.

AUT Health Counselling and Wellbeing is able to offer three free sessions of confidential counselling support for adult participants in an AUT research project. These sessions are only available for issues that have arisen directly as a result of participation in the research and are not for other general counselling needs. To access these services, you will need to:

- Drop into our centres at WB219 or AS104 or phone 921 9992 City Campus or 921 9998 North Shore campus to make an appointment. Appointments for South Campus can be made by calling 921 9992

- Let the receptionist know that you are a research participant, and provide the title of my research and my name and contact details as given in this Information Sheet

You can find out more information about AUT counsellors and counselling on http://www.aut.ac.nz/being-a-student/current-postgraduates/your-health-and-wellbeing/counselling.

As an employee of The National Telehealth Service (Homecare Medical) you are entitled to 3 sessions with a trained counsellor. You can access counselling through the Employee Assistance Program (EAP), which is provided by EAP Works. The National Telehealth Service offers this to all staff members, and you can access counselling at your convenience. If additional EAP sessions are required, this can be arranged with the National Telehealth Service and any decisions will be made on a case-by-case basis.

- You can contact EAP Works either by calling them on 0800 735 343 or by booking a session online at www.eapworks.co.nz.

As an alternative to face-to-face counselling, all paraprofessional employees have access to monthly group or individual supervision, which you may see as a suitable outlet to discuss the consequences of the interview.

Appendix C: Consent form

(*23rd July 2020*) *(Telephone interview)*

Telephone support workers at the New Zealand National Telehealth Service: Experiences and meaning-making.

Researchers: Ian Gutteridge and Dr Giulia Lowe

I have read the Participant Information Sheet for the project named above. I understood the nature of the research and why I have been selected. I have had the opportunity to ask questions and have them answered to my satisfaction. I have been given sufficient time to consider my participation.

- I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- I understand that if I withdraw from the study, I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced (approx. date July 2020), removal of my data may not be possible.
- I understand that interviews will be audio recorded and transcribed, and that I can request for recording to be stopped at any time.
  I would like to receive a copy of the transcription Yes/No (please circle)
  If yes, please provide an email address: _____
- I understand that I am able to edit the transcription and return the edited version to the researchers within two weeks of receiving the transcription.
- I understand that all personal information collected from me will remain confidential to the researchers and that no identifying information will be published or shared with the National Telehealth Service.
- I understand that all data will be securely stored for 6 years following publication of findings, after which they will be destroyed.
- I would like to receive a summary of the research findings Yes/No (please circle)
  *If yes, please provide an email address:*_____

Declaration by participant:

I hereby consent to take part in this research.

Name: _____

Signature: _____ Date: _____

Declaration by member of research team:

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

Name: _____

Signature: _____ Date: _____

Approved by the Auckland University of Technology Ethics Committee on 6th July 2020, 20/127.

Appendix D: Interview protocol

Preliminary questions: Age, gender identity, nationality, ethnicity, length of service, hours working per week, quantity of service lines that you work on.

1. What is your background or training experience?
2. What is your role like day to day?
3. In terms of motivations, what brought you to your role and what keeps you in it?
4. Can you describe the approach you use (in how you interact) with people that call the service?
5. Are there any people you've spoken to have that stand out and that continue to influence you each day?
6. How do you feel about your ability to support people? Has this ever changed?
7. After a call/interaction, how do you feel? How about at the end of the day or week?
8. How might a caller interpret the way you interact them?
9. How do you feel about the pace and requirements of your working environment?
10. Have you struggled because of your role and, if so, what signs suggested this?
11. From the work you do, has this altered any of your perspectives on things? Have you recognised any changes in your identity, worldview, or beliefs?
12. On a personal level – and in any form – has the role done anything for you or do you take anything away from it?
13. If you compared the you now to the you before being in your role, what stands out?
14. Can you tell me about how you cope in your role?
15. Can you tell me about the supervision you receive, either after a call or later, and what this does for you?

Finally, is there anything you would like to contribute that I have not asked about?

Appendix E: Email from People Leaders

(*27th April 2020*)

Kia ora Team,

A member of our team (Ian Gutteridge) is doing a piece of research for his Master's in Psychology. He's looking at non-registered mental health and addictions telephone support workers, specifically focusing on their experiences of working in this role. He's asked us, the People Leaders, to distribute the following information to you all.

If you've got any questions on the research you might find the appropriate answer in the attached Information Sheet; however, if you have any additional questions, feel free to contact Ian on his AUT email address (khm8735@aut.ac.nz) and he'll be happy to answer anything you want to know.

If you do decide to take part, please keep in mind that you can keep your participation in the study (or not) anonymous. By this, we mean that you do not need to notify anyone at the National Telehealth Service (Homecare Medical) of your involvement. After reading the Information Sheet, if you are interested in taking part in the study you can contact Ian on his AUT email address (khm8735@aut.ac.nz) to arrange an interview time.

Thanks everyone,

(Insert name of People Leader)